



Latin America and the Caribbean

and The Global HIV/AIDS Program

THE WORLD BANK

Reducing HIV/AIDS Vulnerability in Central America:

Honduras: HIV/AIDS Situation and Response to the Epidemic



December 2006

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Central America**

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

Latin America and Caribbean Region
and Global HIV/AIDS Program

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World Bank Global HIV/AIDS Program Discussion Paper

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Reducing HIV/AIDS Vulnerability in Central America ***Honduras: 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, Honduras, World Bank

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Acronyms and Abbreviations

AED	Academy for Educational Development and the Futures Group
AIDS	Acquired Immunodeficiency Syndrome
ALCA	Free Trade of the Americas
ART	Antiretroviral Therapy
ARV	Antiretroviral Medicines
ASONAPVISIDAH	Association of People who Live with HIV/AIDS
BNPP	Bank-Netherlands Partnership Program
CA	Central America
CAFTA-DR	Central American Free Trade Agreement – Dominican Republic
CAI	Integrated Care Clinics
CDC	Centers for Disease Control
CEFAS	Female Center of Social Adaptation
CEPRESI	Center for AIDS Education and Prevention (Nicaragua)
CEPROSAF	Center for Health Promotion and Family Assistance
CESAMO	Health Center with Physician and Dentist
CIPE	Center for International Private Enterprise
CONADEH	National Human Rights Commission of Honduras
CODEH	Commission for the Defense of Human Rights
CONASIDA	National Commission against AIDS (El Salvador)
COGAYLESH	Coalition of Gay Organizations of Honduras
DDHH	Human Rights
EU	Education Unit
FEUH	Federation of University Students of Honduras
FONASIDA	National AIDS Forum
GTZ	German Agency for Technical Cooperation
HCP	Health Communication Partnership
HIV	Human Immunodeficiency Virus
IADB	Inter-American Development Bank
ICAS	Central American Institute for Social Action
IEC	Information, Education and Communication
IHSS	Honduran Institute of Social Security
IIDH	Inter-American Institute of Human Rights
LAC	Latin American and the Caribbean Region
LCSHD	LAC Human Development Department
LCSHH	Health Sector
MSM	Men who have Sex with other Men
NGO	Non-Governmental Organization
OPS	Pan-American Health Organization (Spanish acronym)
PAHO	Pan-American Health Organization
PASCA	Central American AIDS Action Project
PASMO	Pan-American Association for Social Marketing
PENSIDA	Strategic National Plan to Fight HIV/AIDS
PLWH	People Living with HIV
PNS	National HIV/AIDS/STD Program

PPTMH	Program for Prevention of HIV Transmission from Mother to Child
SICA	Central American Integration System
SIDA	Swedish International Development Cooperation Agency
SIDALAC	Latin American and Caribbean AIDS Initiative
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
TF	Trust Fund
UARI	Impact Reduction Unit
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
USASER	Sexual Health and Reproductive Units
UVEI	Epidemiological Control and Research Unit
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.

Honduras: HIV and AIDS Situation and Response to the Epidemic

This paper presents information on the HIV and AIDS situation in Honduras. It begins with a discussion of the epidemiology of HIV and AIDS, and describes how the epidemic is perceived among the population. It then presents information on the national response.

HIV and AIDS Situation

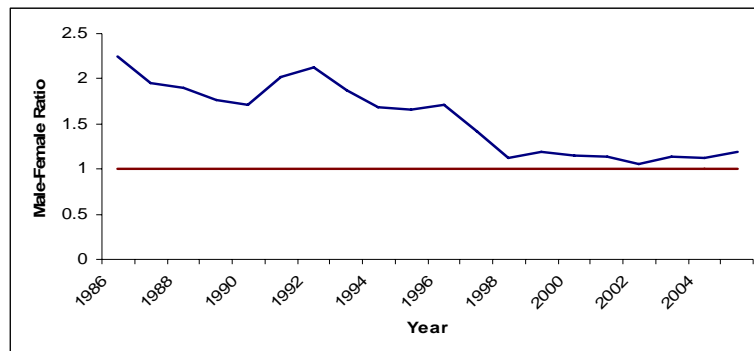
Honduras is one of the countries in Central America in which the HIV epidemic has hit with greatest intensity; half of all AIDS cases in the region are concentrated in this country. Although infection rates are higher in urban areas, one can find HIV patients throughout the country.

The epidemiological system uses data-gathering tools such as the epidemiological control chart, which enters information including transmission data and serological results into a computer system. The system faces many challenges common to other Central American countries, such as under-reporting, and inadequate support for the laboratory network. In addition, the Guidelines and Control Manual needs improvement, and an integrated information system with a focus on sexual and reproductive health needs to be developed.

The analysis of data from each of the Honduran health authorities showed that between 1985 and March 2005, a total of 21,617 HIV-positive cases were reported; of these, 22% were asymptomatic carriers (Ministry of Health HIV/AIDS and STI Department, 2005). A total of 16,672 AIDS cases were reported during the period. According to organizations such as the Honduran Association of People Living with HIV/AIDS (ASONAPVISIDAH), there is considerable under-registration of cases, especially of cases diagnosed by private laboratories.

In the past, AIDS cases were predominantly men. However, that changed in the 1990s. As Graph 1 shows, the male-female ratio began to decrease around 1993, which may be attributed to improved registration, particularly of cases involving women. The ratio shows a slight tendency to increase again since 2002.

Graph 1. Evolution of the Male/Female Ratio of AIDS Cases in Honduras 1986-2005



Source: Honduras Ministry of Health

In 2003, Honduras had the highest adult HIV prevalence in Central America (1.6%), followed by Guatemala and Panama (1.1% and 0.9% in 2003-2004, respectively).¹¹

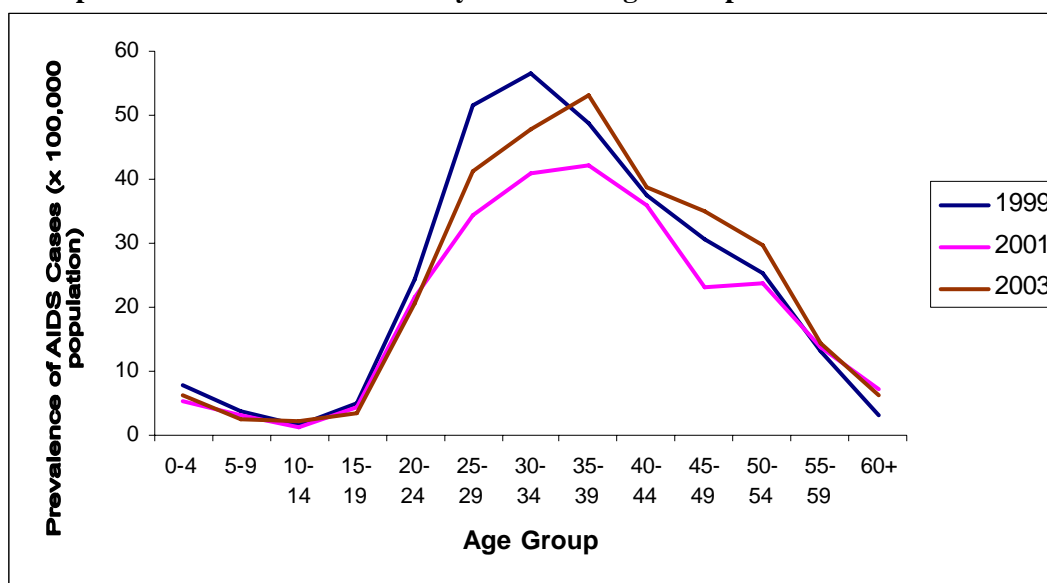
Table 1. HIV and AIDS Indicators in Honduras, 2003

HIV Rate of Prevalence in Adults (15-49)	1.6 % (range: 1.0%-3.2%)
Adults (15-49) living with HIV.	59,000 (range: 33,000-100,000)
Children and Adults (0-49) living with HIV	63,000 (range: 35,000-110,000)
Women (15-49) living with HIV.	33,000 (range: 19,000-59,000)
Deaths from AIDS (Adults and children – 2003).	4,100 (range: 2,300-7,200)

Source: http://www.unaids.org/en/Regions_Countries/Countries/honduras.asp

Graph 2 shows the numbers of age specific AIDS cases per 100,000 population. There is a clear concentration of cases in the 20-39 age group. In 1999, the prevalence of AIDS among 30-34 year olds exceeded 50 cases per 100,000 populations, while in 2003 it slightly decreased to 47 cases per 100,000 inhabitants.

Graph 2. AIDS Prevalence Rate by Year and Age Group in Honduras 1999-2003



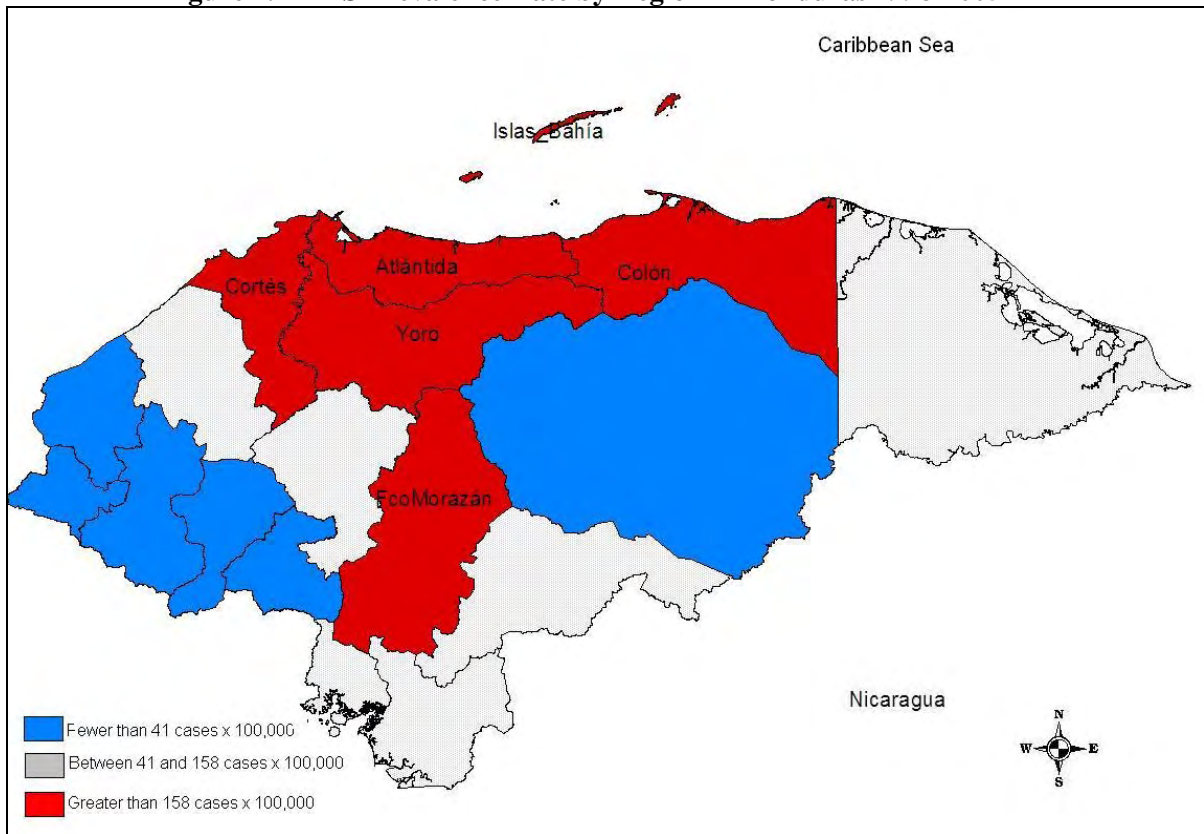
Source: Honduras Ministry of Health

Figure 1 presents the geographic distribution of AIDS cases in Honduras. The northern coast of Honduras had the highest number of AIDS cases per 100,000 inhabitants during the period analyzed. For example, 416 cases per 100,000 were reported in the Region of Cortés and approximately 110 cases per 100,000 were observed in the Region of Atlántida. On the other hand, the spread of the epidemic was less dramatic in Regions along the Pacific Coast. A unique case is the Region of Gracias a Dios, located on Honduras's eastern coast, where the presence of numerous lagoons and rivers and the absence of proper roads reduce accessibility and complicate correct and timely reporting

¹¹ Information obtained from the Population Reference Bureau (www.prb.org)

of cases. Representatives from the Health Secretariat have confirmed that accurate epidemiological information from this Region is still lacking.

Figure 1. AIDS Prevalence Rate by Region in Honduras 1998-2005



Source: Honduras Ministry of Health and Geographic Data from the Central American Population Center

Vulnerable Groups

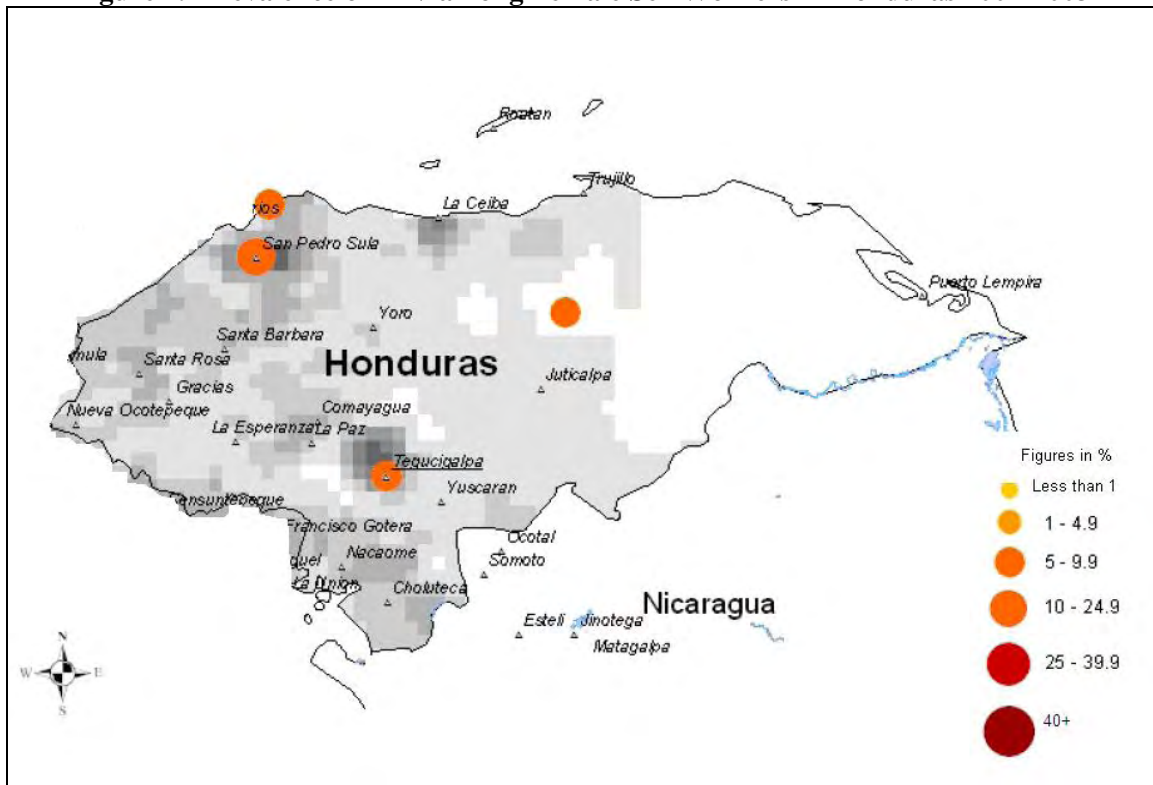
This section presents information regarding the situation of the epidemic for the different vulnerable groups in Honduras.

Sex workers. The first study of HIV among sex workers was carried out in 1989. It involved 518 sex workers from Tegucigalpa and San Pedro Sula. The study estimated that prevalence was approximately 5.5% in Tegucigalpa and 20% (a very high prevalence for the period) in San Pedro Sula. Between 1991 and 1996, various studies on the prevalence of HIV were conducted at a health facility (CESAMO Miguel Paz Barahona) located in San Pedro Sula in order to provide further evidence on HIV prevalence among this vulnerable group. The findings of this study suggested that HIV prevalence among sex workers was between 15% and 20%.¹² The results of a study conducted between February and June 1997 in the cities of Comayagua, La Ceiba, San Pedro Sula, Tegucigalpa and Puerto Cortés showed that HIV prevalence was 10% among sex

¹² PASCA. Antecedentes VIH/SIDA Honduras 2003

workers.¹³ Another study carried out by UNAIDS, Central America HIV/AIDS Prevention Project (PASCA), CDC, PAHO and the University of Washington in 2001 estimated that HIV prevalence in sex workers was 9%. Figure 2, which is adapted from the UNAIDS Fact Maps, shows HIV prevalence in sex workers in different regions of the country.¹⁴ As the map shows, the highest prevalence was observed in San Pedro Sula and in Tegucigalpa. Likewise, along the north-eastern border with Guatemala, a remarkably high prevalence that exceeded 10% was noted during the same period.

Figure 2. Prevalence of HIV among Female Sex Workers in Honduras 2001-2003



Source: Adapted from UNAIDS Fact Map.

Men who Have Sex with Men. AIDS has had a considerable impact on Honduran men who have sex with men. According to the Health Secretariat, 8% of reported AIDS cases involved homosexual relations in the period 1985–2001. A multi-center study in 2001 estimated that HIV prevalence was approximately 13% for this population group. In San Pedro Sula, one of the provinces most affected by the epidemic, this figure was 16% – eight percentage points higher than the figure observed in Tegucigalpa.

Prisoners. Due to the nature of the living conditions that prison inmates must endure in Honduras, this group is considered to be at high risk. Between 1997 and 1998, a study by

¹³ Health Secretariat, Department of Control and Prevention of Sexually Transmitted Infections, HIV/AIDS, and Tuberculosis. Epidemiological Study on Syphilis, Hepatitis B, and HIV in Sex Workers on the Streets of the Cities of Comayagua, La Ceiba, San Pedro Sula, Tegucigalpa and Puerto Cortés.

¹⁴ UNAIDS, PASCA, CDC, PAHO and the University of Washington, 2001.

Sierra (1998) confirmed the severity of the epidemic in this group, with an estimated 6.8% HIV prevalence.

Women. The HIV and AIDS epidemic in Honduras has become increasingly feminized. In 1989, the male-female ratio of AIDS cases was 2:1. By 2005, this gap had practically closed. According to UNAIDS data, 33,000 women 15-49 years of age were living with HIV in Honduras in 2003. There are many factors that increase the vulnerability of women, including gender relations related to marriage, lack of autonomy and empowerment among women, as well as socio-economic factors such as increasing employment of women in factories and human mobility.

Vulnerable Youth. People under 20 years of age are particularly vulnerable to HIV. In 2004, 12% of all registered AIDS cases were among youth below 20 years of age.

Orphans. There is insufficient information on the situation of minors younger than 15 years who have lost their parents to AIDS. One of the few studies, which was carried out by UNICEF in 2002, estimated that 14,000 Honduran children have become orphans due to the epidemic.¹⁵

Military. According to UNAIDS data, the prevalence of HIV in military personnel was 6.8% in 1997. The United Nations Population Fund signed an agreement with the Honduran Armed Forces to improve health care provided to PLWH in the armed forces.

Migrant Groups and Mobile Populations in Affected Regions. In 1998, the Ministry of Health conducted a study of truck drivers working on international routes; the HIV prevalence for this population was 1.3%.

Indigenous Groups and Descendants of African Origin. In a 1999 population study carried out by Sierra on the Garífuna population in the communities of El Triunfo de la Cruz, Bajamar, Sambo Creek and Corozal, with stratified sampling (176 women and 134 men), HIV prevalence was reported at 8.4%. The estimated prevalence among women was 8.5%.¹⁶

In recent years, the Garífunas have migrated not only toward cities such as La Ceiba and San Pedro Sula, but also to foreign cities such as New York, Los Angeles and London, where the HIV situation is of significant concern. Some of the causes for this migration include pressure generated by diminished opportunities and scarcity of land, as well as a desire by a number of young people to seek a better future elsewhere for themselves and their families. When migrant Garífunas return to their places of origin, they become possible carriers of the epidemic.

¹⁵ Children Affected by or Living with HIV/AIDS in Honduras. UNICEF, 2002.

¹⁶ Ministry of Health. Department of Control and Prevention of Sexually Transmitted Infections, HIV/AIDS, and Tuberculosis. Epidemiological Study on Syphilis, Hepatitis B, and HIV in the Garífuna population in the communities of El Triunfo de la Cruz, Bajamar, Sambo Creek and Corozal 1999.

The Health Communication Partnership¹⁷ believes it is important to gather more information on the Garifuna ethnic group. To accomplish this, researchers will have to conduct community research supported by local Garifuna leaders, since taking into account the perceptions of the community will allow for greater understanding of the main factors determining this ethnic group's experience with HIV.

The Gemelos de Honduras Organization, which is a part of the Center for Health Promotion and Family Assistance (CEPROSAF, Spanish Acronym) suggest that people living with HIV in the Garifuna region need human rights protection. Among other things, they need to learn about legal procedures to file complaints. Handling complaints is one of the local services offered by the Human Rights Commissioner in Honduras.

Disabled People. As in other Central American countries, no data were found on the HIV and AIDS status of disabled people. Apparently, this population has not been included in studies – a deficiency in situational analyses done in the region.

Perceptions of the Honduran Population Regarding HIV and AIDS. In 2003, PASCA and the Central American HIV/AIDS Prevention Project sponsored a survey that was conducted by CID-Gallup. The purpose of this survey was to measure public perceptions about HIV and AIDS among Central American adults. The following are the most important findings from Honduras:

- Approximately 75% of the people who were interviewed had heard about HIV/AIDS.
- 99% agreed that HIV/AIDS was a serious problem for the country.
- Almost 100% agreed that information about HIV/AIDS should be distributed in high schools.
- 86% thought that companies should request HIV tests as an employment requirement.
- 90% said women with HIV should not become pregnant.

¹⁷ An NGO that works on HIV/AIDS communications in Honduras.

The National Response to HIV and AIDS

Honduras was one of the first countries in Latin America to develop a national Epidemiological Control System and a network of laboratories that guarantee free HIV tests for the entire population. Some of the most significant achievements of the national response to HIV/AIDS are the following:

- The National AIDS Commission was initially established to document and follow up cases, and propose recommendations to the Health Secretariat.
- The National HIV/AIDS Program was established, and in 1994 it was merged with the STI Program. In addition to a Coordinating Unit, there is an Education Unit (EU), an Impact Reduction Unit (UARI) and an Epidemiological Control and Research Unit (UVEI).
- In 1998–2001, a National Strategic Plan was prepared in consultation with stakeholders working on HIV/AIDS.
- The system currently includes a Country Coordinator Mechanism that integrates various agencies.

LEGAL AND REGULATORY FRAMEWORK

A study prepared for CONADEH identified the most common violations of the human rights for PLWH:¹⁸

- HIV testing without a person's consent
- Violation of confidentiality with respect to test results
- Refusal to allow PLWH to enter a medical center
- Denial of medical treatment (the study includes a number of statements attesting to deficiencies in care between 2001 and 2002 at the Medical School Hospital of Tegucigalpa and at the San Felipe Hospital)
- Denial of antiretroviral treatment
- Isolation at hospital facilities.

A number of steps have been taken to draft, approve, and put into practice special legislation to deal with the epidemic. The National Policies on Sexually Transmitted Infections (STIs) and HIV/AIDS were prepared at the end of 1997, and officially implemented by the Ministry of Health in 1999. In the same year, the Ministry of Health approved the National Guidelines for Sexual and Reproductive Health to comply with commitments of the International Conference on Population and Development held in Cairo in 1994. These guidelines set clear goals for improving sexual and reproductive health, with an emphasis on meeting the needs of the female population (Ministry of

¹⁸ CONADEH. Estimates of integrated healthcare quality for People living with HIV/AIDS, from the standpoint of human rights. Tegucigalpa, Honduras, 2004.

Health, 1999). In September 1999, the Honduran government approved the Special Law Regarding HIV/AIDS – Decree No. 147-99. The main objectives of this law are:

- (1) To establish mechanisms for institutional coordination of prevention, treatment, and research activities involving HIV/AIDS;
- (2) To assign duties of both the civil sector and the government related to the HIV/AIDS response; and
- (3) To define the rights and obligations of PLWH.

The law established the National Council on HIV/AIDS (CONASIDA), a commission in charge of the institutional organization and drafting of policies related to the epidemic. The law also established that any legal framework designed to promote the fight against the epidemic would have to prevent discrimination against PLWH. This is explicit in the law, and supported by various articles listed in Box 1.

Box 1. Protection of the rights of PLWH - Special Law Regarding HIV/AIDS

Article 2: In this article, the fight against HIV/AIDS is declared to be in the nation's interest. Moreover, a response to the needs of PLWH is mandated.

Article 47: This article establishes and recognizes the right of PLWH to receive health services – whether public or private.

Article 48: Denial of timely and appropriate services for PLWH is recognized as an offense that merits punishment.

Article 49: This article establishes that no healthcare professional may refuse to treat PLWH.

Article 51: Educational centers may not restrict PLWH from participating in their programs. If this guideline is violated, a fine equivalent to the legal minimum wage is imposed for the first offense, and three times the amount of that fine will be applied for repeat offenses.

Article 52: This article stipulates that no one may be fired from a job because he or she has HIV/AIDS.

Article 63: Prison inmates must be treated the same as others with respect to prevention of HIV/AIDS. Evidently, they may not be forced to undergo HIV diagnostic testing.

Article 64: Prison inmates who live with HIV have the right to receive appropriate treatment under suitable conditions.

Article 65: PLWH have the right to receive information and instruction regarding their condition.

Source: Special Law Regarding HIV/Aids, Republic of Honduras

Article 37 of the Special Law Regarding HIV/AIDS establishes that the Ministry of Health, through the National Commission on HIV/AIDS, is in charge of preparing a list of drugs and medical supplies that have proven to be effective to treat HIV/AIDS. The law only refers to general medical treatment, without making special reference to antiretroviral medicines.

In May 2003, additional guidelines for the implementation of the Special Law Regarding HIV/AIDS were approved. Designed to complement the special legislation, they emphasized HIV/AIDS outreach, prevention, and research, as well as the rights of PLWH. Also in 2003, the National Strategic Plan to Fight against HIV/AIDS was established. The document included plans for long-term responses to the epidemic. The department of HIV/AIDS and STIs of the Health Secretariat was put in charge of implementing the plan.

These documents and initiatives provide the regulatory framework in Honduras regarding HIV/AIDS. Some coincide with the UNAIDS protocol against discrimination towards PLWH. However, existence of a special law protecting the rights of PLWH does not necessarily ensure its appropriate enforcement.

A study jointly directed by the United Nations Development Program (UNDP) and CONADEH in 2003 indicated that the Special Law on HIV/AIDS in Honduras does not state that a person has the right to refuse to undergo a medical examination before being admitted to an educational institution. This situation could clearly lead to restricted access to education.¹⁹ Article 79 of the Special Law establishes that the “Intention of a couple to adopt a child cannot be favorably ruled for if both members are infected with HIV or if they are sick with AIDS, given the shortened life expectancy for both, thus rendering the adoption senseless.” The merits of this article are debatable in light of the availability of treatment and the constitutional and human rights related to having a family of one’s own.

Prisoners at the Women’s Social Adaptation Center (CEFAS) were unaware of the existence of the Special Law Regarding HIV/AIDS.²⁰ This study also found that there were unreported cases of discrimination towards female inmates with HIV at this detention center – not only by their peers, but also by prison wardens and guards. As described in the study, women inmates living with HIV felt that their particular situation (being detained along with having tested positive for HIV) increased the chances of discrimination towards them.

The National Human Rights Commission of Honduras (CONADEH) answered the questions in Annex 5 of the UNAIDS protocol regarding arbitrary discrimination in Honduras for this study. The findings are summarized below.

Health Care. Four of the seven issues that may arise in the health care environment have occurred in practice. These include differential treatment for HIV/AIDS patients, HIV testing without the patient’s prior knowledge, and quarantine and segregation in hospitals, clinics and hospices. Differential treatment occurs when patients have diseases such as tuberculosis or skin lesions. Only one of the seven issues analyzed is regulated by internal procedures and protocols – namely, the requirement that a patient’s sex partner and/or family be informed that he or she is a person living HIV.

Employment. Different forms of discrimination against PLWH in the work environment occur in practice. Compulsory HIV testing before hiring occurs in the private sector, generally in manufacturing plants known as Maquilas. Questions on recruitment forms about a person’s serological status, while not referring directly to HIV, enable employers

¹⁹ UNDP/CONADEH. Compliance with the Special Law Regarding HIV/AIDS in Honduras, and comparison with legislation on HIV/AIDS in Central America and Panama. Tegucigalpa, 2003.

²⁰ CIPE/CONADEH. Baseline diagnostic for identifying violations of the human rights of people living with HIV/AIDS. 2004.

to make inferences about the health of potential employees. There are people who lose their jobs due to their serological condition, even though Article 53 of the law states that “the employer cannot terminate, sanction, degrade or diminish the salary of his/her employees infected with HIV.” Article 54 of the HIV/AIDS Special Law determines that any compulsory test is against the law, and states that seropositive employees are not required to inform others about their serological status provided that it does not imply placing others at risk of infection.

Legal Processes. Of four aspects of discrimination that involve legal processes, only two occur in practice in Honduras. These include categorizing the deliberate transmission of HIV as a criminal act and differential sentencing based on the serologic status of the person being tried. Honduran law clearly provides for the first practice. Article 80 of the Special HIV/AIDS Law states that purposely propagating HIV will result in sanctions under Articles 180, 184 and 191 of the Criminal Code. There is no evidence related to the criminalization of certain behaviors, such as prostitution and sexual relations among men, which may spread the epidemic.

Public Administration. Article 81 of the Immigration Law for Honduras (2004) states that the Immigration Department of Honduras has the right to deny entrance or residency to foreigners if the person suffers a disease that prohibits him or her from entering the country according to guidelines from the Health Secretariat.²¹

Social Welfare, Housing, Education, and Family and Reproductive Health. Social security and welfare benefits are said to be denied to people on the basis of their HIV status. But the evidence is not substantial enough to draw clear conclusions, and the issue requires further analysis. HIV tests are required of people seeking housing, generally by banks and other lenders. There are cases in which parents and relatives of people living with HIV have violated confidentiality regarding a student’s serological status, creating conditions that lead to the student’s being denied education. Of the four issues studied in the area of family and reproductive health, two occur in practice: requirements for pre-matrimonial and prenatal HIV tests. Article 32 of the Special HIV/AIDS Law states that “The corresponding authority will require the HIV/AIDS test for couples before marriage” and certain municipalities require the test.

Annex 5 of the UNAIDS protocol against arbitrary discrimination presents questions about agencies that fight discrimination within the country. In Honduras, the situation is the following:

- In 2001, country authorities established the National AIDS Forum (Foro Nacional de SIDA). This forum comprises 12 regional chapters in the central and southern regions of the country, as well as in the cities of San Pedro Sula, Gracias a Dios and the Bahía Islands. It defends and promotes rights of PLWH, and increases social capital to fight the epidemic and strengthen the community response to HIV/AIDS.

²¹ Law N° 208-2003 – Honduras Department of Immigration (2004). HIV/AIDS is not specifically mentioned. However, this article may imply the denial of the right to enter the country for people who have the disease.

In addition, the Forum supports institutional coordination related to prevention and treatment efforts.

- The National Human Rights Commission was established to defend the rights of all human beings in Honduras. This agency has a program that is dedicated to protecting the rights of PLWH.
- CONADEH is the agency responsible for following up discrimination or rights violation complaints. CONADEH analyzes reports and complaints, and presents them on a case-by-case basis to the competent legal authorities.
- Honduran PLWH have established the Association of People who Live with HIV/AIDS (ASONAPVISIDAH), which is in charge, among other things, of protecting and defending the right of PLWH to adequate treatment. The organization is also helping to raise awareness regarding the epidemic. It was created in San Pedro Sula in 2000, and currently has 28 support groups throughout the country. ASONAPVISIDAH and CONADEH interact with each other. ASONAPVISIDAH has organized various national conferences and campaigns to help fight discrimination against PLWH in recent years.

PREVENTION AND CARE FOR VULNERABLE GROUPS

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

Human Rights and HIV/AIDS Program

National Human Rights Commission (CONADEH)

The main objectives of the program include promoting and defending the human rights of people living with HIV, contributing to quality of life and providing a forum for complaints; and diminishing stigmatization and discrimination of PLWH. The population that benefits from this project includes PLWH, sex workers, MSM, descendents of people of African origin, migrant groups in affected regions; people directly affected by HIV/AIDS, as well as the general population.

This project reflects provisions in the National Strategic Plan for the Fight against HIV/AIDS that address the promotion and defense of human rights based on liberty and equality. When the program started in 2002, the Inter American Institute for Human Rights provided funding for it. Since 2003, it has received funding from the Global Fund.

The main objective of CONADEH is to guarantee that the human rights of all people living in the national territory are respected, and to make sure that the actions and resolutions of public authorities are in accordance with the precepts of the Constitution of the Republic, laws, treaties and international agreements subscribed to by Honduras. The Commission operated between 1992 and 1995 as an office of the Executive Branch, and it was granted constitutional rank in 1995. Its roots go back to a human rights movement in 1981, in which the Federation of University Students of Honduras (FEUH) protested before the Inter American Human Rights Commission after the forced disappearance of 20 people in one day. That same year, the Commission for the Defense of Human Rights (CODEH) was founded, and 10 years later it requested the United Nations to provide human rights capacity-building during the administration of Rafael Leonardo Callejas (1990-1994). As a result, CONADEH became an office that is part of the Executive Branch.

The constant violation of human rights of PLWH arises from the lack of information and education, which persist despite efforts by government and civil society organizations. The problem is most apparent in socially disadvantaged sectors, mainly in rural areas. The absence of a culture of filing complaints, combined with a general lack of empowerment and a specific lack of knowledge about the mechanisms available for exercising the right to file a complaint, contribute to discrimination against PLWH. Slowness in the judicial system has led to a loss of public faith that state ombudsmen agencies will restore violated rights.

CONADEH in an alliance with the National Association of People Living with HIV/AIDS, the National AIDS Forum, organizations from the civil and government sector, seeks to strengthen human rights protections for people living with HIV by:

- (1) Strengthening PLWH Human Rights Ombudsmen and Promoters;
- (2) Developing an itinerant system to collect and act on complaints about human rights violations;
- (3) Restoring rights that have been violated.

At the beginning of 2002, CONADEH initiated actions regarding HIV/AIDS and human rights by taking steps to strengthen institutions supported by the International Institute for Human Rights. Its actions were then coordinated with different organizations and institutions, and a conference was organized that same year. In 2003, the Program for HIV/AIDS Human Rights was implemented. This program coordinates all actions regarding HIV/AIDS within CONADEH, with the support of the Global Fund.

CONADEH has 15 Delegations throughout the different Regions of the country and 132 National Level Employees. In order to carry out its HIV/AIDS activities, the program includes the following personnel for coordination and management at national level: 1 Coordinator, 1 Technical Assistant, and 1 Administrative Assistant.

The future plans and priorities of CONADEH are the following:

- (1) Reduce stigma and discrimination towards people living with HIV.

- (2) Change attitudes about acceptance of PLWH.
- (3) Train the population in issues related to HIV/AIDS and human rights as well as the work of CONADEH.
- (4) Improve the quality of responses by the ombudsmen and promoter network to any violations of human rights of PLWH.
- (5) Coordinate and improve the support received by the agencies that work with HIV/AIDS and human rights from all of the different sectors and institutions of society.

Results. This is an innovative and permanent process which promotes self-defense of human rights in order to reduce stigma and discrimination. The program is considered successful for the following results:

- (1) It has strengthened organizations that defend the human rights of different population groups such as prison inmates, MSM, and sex workers.
- (2) It handled 53 complaints, and restored the rights of petitioners. Nearly 80% of the complaints coming from calls, visits and emails were investigated.
- (3) The program covered 39 municipalities throughout the country where the HIV/AIDS epidemic is concentrated.
- (4) The program implemented and strengthened 20 networks of ombudsmen for HIV/AIDS human rights in various municipalities.
- (5) It made 16 visits and inspections to detention centers, prisons, centers rendering public services (educational centers, hospitals, work centers, tolerance centers, etc), in coordination with ASONAPVSI DAH and the National AIDS Forum.
- (6) It held 76 training workshops on human rights and HIV/AIDS, stigma and discrimination and access to the CONADEH complaint system for network members, ASONAPVSI DAH, municipalities, and others. A total of 2,622 people received training.
- (7) An information, education and communication (IEC) campaign was designed for the itinerant mobilization process. Radio spots, banners, posters and information brochures were developed.
- (8) Mobile units travel to the farthest townships and municipalities which otherwise would not have access to this service. The units provide information and education, gather information and analyze complaints. They also inspect the different centers through local networks, which become the defenders of the rights of PLWH, referring violations to CONADEH. The 44 units are in the following municipalities: Erandique, Langué, Valle, Marcovia, Monjaras, Cedeño, Pespire, Roatan, Islas de la Bahía, Utila, Jutiapa, Tela Atlántica, Progreso and Villanueva, Lepaterique, Valle de Angeles, Maraley Maraita, Municipality of Jocón and Santa Rita de Yoro, Orica, Reitoca, Alubaren, San Miguelito, La Libertad, FM, La Entrada, Copan, San Manuel, Lempira, Vallecillo, Reitoca, Alubaren, San Miguelito, La Libertad, and the Tamara Penitentiary, Dulce Nombre de Culmi y

- Campamento, El Paraíso y Yuscaran, Valle de Angeles, San Marcos de Santa Bárbara, the municipalities of La Lima , Cortes, Choloma, Santa Cruz de Yojoa.
- (9) The design of the system to guarantee the rights of people required CONADEH to review and strengthen its complaint system, which is reflected in an increase in the number of complaints received and processed.
 - (10) Strategic alliances between the government and civil society were strengthened.
 - (11) There is close coordination with the National AIDS Forum (FONASIDA) and the National Association of PLWH (ASONAPVSI DAH)
 - (12) Methods have been developed for designing and validating educational curriculum on DDHH and HIV/AIDS in order to better educate the population.
 - (13) Education and communication have been incorporated into the process of community mobilization by distributing materials (brochures and radio spots) specifically developed for that purpose.
 - (14) Control and social auditing processes have been developed in coordination with the National AIDS Forum and other organizations to manage the supply of medication to care centers and ensure adequate attention for PLWH.

Diversity and Integration for Prevention Project

National Program for STIs and HIV/AIDS Prevention and Care for Gay, Bisexual, and Transvestite Men, as well as for Men Who Have Sex with Men - Kukulkán Association

According to a multi-center study carried out in 2001,²² the prevalence of HIV among MSM was 13%, a figure that demonstrates the strong impact that the epidemic has had on the gay community in Honduras and their families, and consequently on the economy and other aspects of social life. The principal objective of this project is to reduce the incidence of HIV by 20% through health protection, promotion and defense of human rights, and to strengthen, integrate, and support institutional development of groups of gay, bisexual, and transvestite men, as well as men who have sex with men aged 18-39 in 22 selected municipalities. The project is projected to reach 21,000 men by 2008.

The project is part of the actions set forth in the Strategic National Plan to prevent HIV/AIDS among high-risk groups, and is financed by UNDP and the Global Fund. With support from UNDP and the Global Fund, it is expected that other international funding sources such as the government and UNAIDS will continue the project beyond 2008.

The Kukulkán Association is an NGO founded in 2002 by a group of males interested in addressing the needs of gays, bisexuals, transsexuals and lesbians for human rights protection, healthcare and participation in society as full citizens. It is particularly interested in making the public aware of male sexuality and social equality for groups that have been socially excluded. The name of the organization, Kukulkán, is linked to the Mayan name of a god known as “Quetzalcoatl” or feathered serpent in the Nahuatl

²² A study conducted in different surveillance areas.

language. This god symbolized and was mainly related to the beginning of new stages or eras in the life of the Maya.

Kukulcán's organizational units, listed in descending order of decision-making power and authority, include the Founders' Assembly; Committee of Head Directors; Organizational Directors; Technical Project Coordinators for the Department of Communications and Public Relations, Technical Assistance; Monitoring and Evaluation; Administration and accounting ; collaborators and volunteers who support the various units; and a Consulting Committee composed of people with experience in organizing work and who provide technical assistance to support and ensure the quality of the programs.

The "Diversity and Integration for Prevention Program" was conceived in 2002 by the organizations and groups that comprise the Coalition of Gay Organizations of Honduras (COGAYLESH), and is expected to end in 2008. These organizations include:

- (1) Kukulcán Association
- (2) Violet Collective Association
- (3) Sampedrana Gay Community for Integrated Care
- (4) Ceibeña Pro-Union Gay Organization
- (5) Rainbow Association (in Spanish, *Asociación Arcoiris*)
- (6) Positive Images Integrated Center
- (7) San Pedro Sula Transvestites Collective
- (8) Seropositive Gay Men's Network
- (9) Center for Prevention in Health, Sexuality, and AIDS

Results. Some of the results that explain why the project is considered a success are the following:

- (1) Grassroots response from the community affected by HIV.
- (2) United support among all relevant grassroots associations for a single primary goal – combating homophobia. This marks a departure from earlier, isolated efforts.
- (3) Interventions which are suitable for groups that have been excluded by the *macho* or male chauvinist culture.
- (4) More than 7000 men who have sex with men approached using different strategies and provided with individualized prevention information.
- (5) Facilitators foster the values of friendship and leadership in small groups whose members, once trained, become normative references for healthy behaviors and avoidance of HIV and other STIs.
- (6) Establishment of institutional alliances with grassroots organizations to provide access to care in medical centers for men who have sex with other men in four

major Honduran cities (i.e. La Ceiba, Tegucigalpa, San Pedro Sula and Comayagua).

Prevention of HIV/AIDS among Adolescent Ethnic Garífuna

Center for Promotion, Health and Family Assistance (CEPROSAF), La Ceiba, Atlántida, Honduras.

In 2005, CEPROSAF initiated joint projects with 12 organizations in the Atlantic community and eight in the Garífuna community. The general objective was to contribute to the reduction of HIV and STIs through the implementation of joint projects that address prevention through behavioral change and adoption of healthy practices, with a focus on vulnerable and priority populations, including pre-school, adolescent and young Christian populations at risk (including members of maras²³) and grammar and high school students from indigenous, afro-descendant and other vulnerable groups. The interventions involved different training modalities, including workshops, retreats, talks, and educational sessions.

The Center has two clearly defined objectives: promoting family health, strengthening processes directed at improving the quality of life; and supporting interventions to preserve and maintain the family in a healthy environment. The organization works with young and adult PLWH. Interventions with adolescents are crucial because adolescents have a high risk of contracting HIV due to a lack of sex education, the disintegration of the family and the high index of poverty. The Center also has experience in the defense of human rights, fighting stigma and discrimination, sexual and reproductive health, fostering organizational development, and organizing small businesses with people who have HIV.

The community project is closely related to the National Strategic Plan since its objectives include:

- (1) Strengthening community organization and participation in order to provide efficient and timely services to vulnerable groups.
- (2) Contributing to the reduction of gender violence by making more information available to youngsters.
- (3) Promoting behavioral changes and adoption of healthy practices for reducing the spread of HIV.

The Global Fund allocated Lps. 6,536,305.55 (about US\$327,000) for interventions with different demographic groups, 48% of which was spent on adolescents.

CEPROSAF is a non-profit organization created to develop health programs that promote and assist families. Its headquarters are at La Ceiba, Atlántida, and the NGO has a Board of Directors including an Executive Director, a Sub-Director, a treasurer, a chairperson,

²³ Central American term for gangs.

board members and a secretary. The organization's members are academics trained in research and epidemiology. Some have backgrounds in school and adolescent health, monitoring and evaluation, NGO management and quality processes – skills that give the organization an effective and efficient approach to executing projects. The organization develops projects in urban and rural areas. CEPROSAF has an extensive background implementing projects with national organizations such as the HIV/AIDS and STIs Program and international projects supported by PAHO, the National AIDS FORUM, the Agency for Educational Development (AED), UNDP, Global Fund, The World Bank and GO Joven (Go Youth).

CEPROSAF provides technical and administrative assistance based on a sustained, consistent and periodic follow-up through a system of monitoring and evaluation included in the Administrative Procedures Manual. The modality of joint projects is established by consensus among the different participating organizations, which seek to maximize efforts, resources and capacities, facilitate human development through the exchange of experiences and work methodologies, and avoid duplicating efforts of other organizations targeting the same population. In this way, the groups seek to widen coverage and improve resources and technologies for acquiring knowledge.

The organization's future plans and priorities are to:

- (1) Increase coverage of the adolescent population.
- (2) Provide follow-up and sustained support so that communities and organized neighborhoods have the capacity to solve their own problems, such as consumption of alcohol, drugs, violence, pregnancy and HIV in adolescents.
- (3) Maintain and strengthen alliances in the fight against HIV in schools.
- (4) Continue to manage financial and logistic resources with national and international agencies in order to strengthen and address this population.
- (5) Systematize learning about interventions to highlight achievements and difficulties.

Results. CEPROSAF representatives believe that participating organizations have achieved more than 90% of their goals. The organizations were monitored and evaluated on a monthly basis by work teams, thus promoting strategic review and adjustment of their activities. The main results are the following:

- (1) Coverage of IEC actions directed to adolescents and children during a six-month period was unprecedented in Atlántida:
 - a. 70% of the young population 11-25 years of age were covered by the projects; 35% of this population group is found in the joint Garífuna community (7 projects).
 - b. In all projects aimed at children, facilitator networks were formed in order to discuss sexual and reproductive health, with emphasis on knowledge of HIV/AIDS and STIs, values, self-esteem and systematic condom use. Various methodologies were applied to empower the different groups with knowledge.

These groups include 2,602 adolescents (44% Garífunas), 224 parents, 74 PLWH, 160 teachers, 270 women and 63 owners of nightclubs and bars.

- (2) Youth leaders were involved in training, mobilization and participation in radio and television spots as a result of previous training from different participating organizations.
- (3) Most of these organizations are headquartered in the locality where the target population lives, thus providing the population with easy access to the projects.
- (4) CEPROSAF has gained work experience in managing the joint projects of 20 organizations in the cities of La Ceiba, Tela, Masica, Trujillo, Iriona, San Pedro Sula and Tegucigalpa – 6% of all municipalities in Honduras.
- (5) A baseline has been established in order to measure impact in four or five years. The project includes constant research that will provide data on the various activities and the results. For example, in 2005, a study analyzed the knowledge, attitude and practices of the Garífunas and mestizos as well as youth towards STIs, HIV and AIDS. These studies served as a baseline for identifying and evaluating strategies that take account of the culture, perceptions and customs of the different groups.
- (6) Work teams have received technical and administrative assistance. Participative work methodologies have been shared in order to heighten organizational skills in effective communication, working with couples, testimonials, mass mobilization, parades, educational fairs, inter-organizational forums and arranging social events for educational centers.
- (7) The project has developed a methodology for monitoring interventions in order to manage and advance them, as well as measure achievement.

HIV/AIDS Prevention Program in Garífuna Youth 15-24 years

Health Communication Partnership (HCP)

The Garífuna from Honduras are one of the most vulnerable groups where the epidemic is concentrated. In 2003, HCP began its work in 26 Garífuna communities in Honduras. All of HCP's work in prevention of HIV has been done in coordination with the Ministry of Health and the Garífuna community. The objective of the project is to contribute to the reduction of HIV incidence in Garífuna youth 15-24 through communication strategies based on educational training. Funds for the project come from USAID. The program is set to end in 2007.

The project is directly tied to the first objective of PLANSIDA II: Strengthening the IEC Development Process Regarding Sexual and Reproductive Health that integrates a focus on vulnerability to HIV and STIs with elements of sexuality, gender, masculinity, human reproduction and sexual and reproductive rights directed at change in behavior and the promotion of healthy behaviors.

The most important and innovative element of this project is the production and broadcast of the first Garífuna soap opera, “Ancestors Do Not Die” (“Los Ancestros No Mueren”). It was produced in Spanish and the Garífuna language with Garífuna actors (former stage actors trained by HCP/Ministry of Health/IEC Garífuna community). The storyline of the soap opera follows Garífuna daily life. The main topic is HIV prevention. The soap opera comprises 90 15-minute chapters with two short promotional songs and printed material. It has been aired in two different four-month periods on eight local radio stations. The cost for production of the Garífuna radio soap opera was Lps. 5, 118,410 (about US\$ 255,920). Simultaneously, HCP developed a community mobilization plan in the 26 communities.

A new installment of the Garífuna radio soap opera will air on May 1, 2007. It is expected to reach 36 Garífuna communities on the Northern coast of Honduras. In addition, a community mobilization effort will include participation of Garífuna volunteers who will also evaluate the impact of the soap opera “Ancestors Do Not Die.”

HCP is an NGO whose goal is to promote healthy communities through advancements in health communications. Its activities have been directed at children of both genders, men who have sex with men, commercial sex workers and people living with HIV. It also develops communications activities for the mother-child sector. Specific objectives of the organization include:

- (1) Efficiently using communication to improve health, stabilize the population and advance towards a healthy society;
- (2) Strengthening the capacity of countries to provide strategic health communication;
- (3) Implementing efficient initiatives for health communication that effectively reach the population;
- (4) Integrating communication in a variety of programs in order to improve health;
- (5) Conducting research to serve as a guide for advancement in health communication.

HCP was founded in 2002 as an alliance among the Johns Hopkins University Bloomberg School of Public Health/Center for Communication Programs, the Academy for Educational Development (AED), Alliance, Save the Children, Tulane University and the University of North Carolina’s Carolina Population Center at Chapel Hill. The organization has its headquarters in Washington D.C., and has a director, coordinator, community mobilization technician, monitoring and evaluation technician, script writer and an HIV/AIDS specialist, as well as volunteers from the Garífuna communities.

Results. The project is considered successful since it reached 26 Garífuna communities from the Regions of Atlántida, Cortés and Colón. “Ancestors Do Not Die” successfully communicated the objective of the project. A quick survey in 2005 showed the following response among people aged 15-24 two months after the first airing of the soap opera:

- (1) 61% remembered having heard it;

- (2) 68% mentioned HIV/AIDS as the main theme of the radio soap opera;
- (3) 71% remembered hearing the songs, 42% were able to sing the first song, and 22% were able to sing the second;
- (4) 76% mentioned the radio soap opera to someone else;
- (5) 97% said that they would continue to listen to the soap opera;
- (6) 54% reported that adults between 25 and 59 years-old also listened to the soap opera.

IEC in Garifuna Communities

In an effort to stop the advance of HIV among different ethnic groups residing in la Mosquitia – Region of Gracias a Dios, United Nations volunteers have carried out information campaigns since 2003 to show people how to protect themselves against the epidemic. Since national television channels have difficulty reaching la Mosquitia, the information was disseminated through local radio stations such as Winanka Radio in Puerto Lempira and Radio Católica in Trujillo in Spanish and two indigenous languages – Misquito and Garífuna. In addition, local volunteers have distributed 79,200 condoms, along with instructional material on HIV and AIDS, 5,000 posters, 1,800 brochures for adolescents and 3,000 T-shirts with slogans in the Spanish, Garífuna and Misquito languages.²⁴

Program for Prevention of HIV Transmission from Mother to Child

Honduran Health Secretariat

This program's goal is to reduce the rate of mother-to-child HIV transmission by 50%. It aims to provide prenatal care to 200,000 pregnant women. Since the prevalence of HIV is approximately 0.6% in this group, it is estimated that the program will detect, on average, 1,200 HIV-positive pregnant women a year. In the 39 municipalities that have received financial resources from the Global Fund, it is expected that approximately 468 of these women will have their medical needs covered.

The Strategic National Plan to Fight HIV/AIDS (PENSIDA I) was devised for the 1999–2002 period, followed by the second phase (PENSIDA II) for the 2003–2007 period. Under PENSIDA II, strategies for working with groups that have been most affected by the epidemic were developed. One such program, the program for prevention of mother-to-child transmission, is a priority. Pregnant women – especially those living in the areas most affected by the epidemic – are a vulnerable group.

The Ministry of Health, through its HIV/AIDS and STIs Department, and with the support of cooperation agencies, initiated the Pilot Program for Prevention of Mother-to-Child HIV Transmission in 2001. In 2004, officials of the Ministry made the

²⁴ Survey carried out in 2006; http://www.unv.org/infobase/unv_news/2005/98/05_04_30_HON.htm

accomplishment of this prevention objective a top priority, proposing a National Program for Prevention of Mother-to-Child HIV Transmission – a move that meant broadening coverage throughout the country. Funding sources include the Global Fund (\$300,000), UNICEF (\$60,000) and national funding (\$200,000).

The Health Secretariat is responsible for the supervision and regulation of the nation's health. By constitutional mandate, it contributes to improving the health of the population through policy-making, formulating plans, and developing programs to achieve national priorities with the support of various key figures, groups and sectors. To accomplish these objectives, it is organized into 18 regions, two metropolitan areas, and 41 designated Health Areas, through which all of the nation's public health care services are integrated: hospitals with varying levels of complexity, ambulatory or out-patient services, emergency clinics, maternity clinics, centers for primary health care, and a network of volunteer health workers who, besides carrying out the tasks that they have been trained to perform, also strengthen the links between the institutional system and the community.

The Ministry has formed strategic alliances with different sectors, including the civil sector, in order to offer a planned, organized and high-quality response to the HIV epidemic. A series of interventions combining national governmental and non-governmental efforts with aid contributed by international cooperation and assistance organizations have been developed. In 2004–2005, the country devised an IEC strategy to prevent mother-to-child HIV transmission with technical and financial support of the Global Fund, UNICEF and USAID. This strategy is being implemented in the project's 39 priority municipalities, and an evaluation of the effort is planned for the year 2008. In 2005, the program was running in 215 healthcare facilities in 35 municipalities. The goal for 2007 is to extend coverage to 100% of municipalities and healthcare units, as well as extend the coverage of the rapid HIV test for pregnant women and strengthen the nationwide system of public information on the issue.

The specific objectives of the program include the following:

- (1) Ensure that 100% of health workers where the program is being implemented obtain information about issues related to prevention of mother-to-child HIV transmission.
- (2) Strengthen local teams that apply the treatment protocol for preventing mother-to-child HIV transmission.
- (3) Increase to 80% the proportion of pregnant women who receive pre-test counseling during prenatal care out of the total number of women being treated within the program (the 2002 baseline figure was 40%).
- (4) Ensure that 90% of women who receive pre-test counseling during prenatal care voluntarily undergo testing (the 2002 baseline figure was 80%).
- (5) Treat approximately 90% of HIV-positive women who are detected according to established protocols (the 2002 baseline figure was 50%).

- (6) Follow-up on 100% of children born to seropositive mothers who are in the program.
- (7) Offer counseling on child feeding options and HIV to 100% of seropositive women who are detected.
- (8) Implement an IEC strategy to promote prenatal healthcare services and to improve access for pregnant women to the National Program for Prevention of Mother-to-child HIV Transmission.

Interventions are intended to improve access to counseling, diagnostic tests, treatment, and follow-up services for all pregnant women who undergo prenatal care and for their children, both in urban and rural areas. Part of the program involves a *Protocol of Integrated Care for Pregnant Women Infected with HIV*, which is being implemented through multidisciplinary teams of the Ministry of Health Network Services and the Honduran Institute of Social Security (IHSS), which underwent training in a week-long workshop. Constant supervision, monitoring, and evaluation at the different levels of the program, through visits, meetings and follow-up workshops, are designed to guarantee suitable, appropriate and adequate implementation of the program. The network of laboratories is being strengthened through provision of new supplies.

The government hopes to extend the program's coverage nationwide; currently, the program covers 132 municipalities and 312 healthcare units. Attracting more pregnant women who receive prenatal care into the program and persuading them to accept counseling and free HIV testing is another significant challenge, along with providing follow-up to 100% of women who are detected as being HIV-positive, as well as their children during the first year of life. The second strategic plan (PENSIDA II) proposes promoting antiretroviral medication for PLWH according to medical, social and epidemiological criteria. The proposed indicator for this activity is the percentage of selected HIV positive pregnant women in the prenatal care clinics who receive ARVs to prevent transmission to their children.

Results. The main results of this program are the following:

- (1) HIV-infection in children has decreased.
- (2) The program covers 17 out of 20 regions. Among these regions, the municipalities with the highest rates of prevalence have been prioritized.
- (3) Counseling and free HIV testing are being offered to 100% of pregnant women undergoing prenatal care. HIV positive women are ensured not only nutritional support, but also the needed prophylaxis for their children.
- (4) Women who participate in the program receive differentiated and quality services during pregnancy, the birth process and nursing period, with follow-up and examinations of mother and child, as well as nutritional assistance for newborns with feeding formula and special care.

Home Visits

National Association of People Who Live with HIV/AIDS in Honduras (ASONAPVISIDAH)

Of the 45 self-help groups operating throughout Honduras, 35 are part of ASONAPVISIDAH; they represent about 1,500 organized PLWH nationwide. The association's mission is to coordinate, follow up, and strengthen self-help groups nationwide. In addition, it seeks to affect public policy relating to HIV and AIDS by establishing alliances, fostering political debate and encouraging participation by citizens. Its goal is to have all people living with HIV receive health care and be organized and integrated into society in a productive fashion.

This project represents one of the first times in Latin America that healthcare workers have worked in a coordinated style. The project is community-based, and functions both in urban and rural areas. In the self-help groups, people who are living with HIV, and/or those who have affected family members, are involved. ASONAPVISIDAH believes it is important to value the human being as a whole. As a result, it has also become a place where PLWH search for job opportunities through the various self-help groups, entities, and organizations that work with HIV/AIDS.

There is a close relationship between the home visit project and the Strategic National Plan on HIV/AIDS in Honduras. This plan has an Integrated Care component whose commitments and indicators are described in Table 2.

Table 2. Integrated Care Component of the Strategic National Plan (PENSIDA II) to Fight HIV/AIDS

COMMITMENT	INDICATOR
Reduce by 50% the mortality rate of PLWH who receive antiretroviral treatment	Death rate of PLWH who receive antiretroviral treatment
Access to antiretroviral treatment for PLWH who require it	Number of PLWH in advanced state of infection who receive ART
Reduce by 50% the hospitalization rate associated with HIV/AIDS	Number of hospitalizations due to HIV/AIDS by PLWH on ART

A nationwide undertaking, the Home Visits Project was developed with financial resources from the Global Fund in coordination with the Health Secretariat. Key participants include members of the different self-help groups and PLWH from communities where Integrated Care Centers operate. The primary goals of the project are to improve participation and adherence of PLWH to antiretroviral treatment; and ensure maintenance and improvement of quality of life and productivity of PLWH. The beneficiary populations are highly vulnerable and vulnerable groups.

ASONAPVISIDAH was established in the city of San Pedro Sula within the framework of the First National Meeting of People living with HIV/AIDS, which was held in 2000. It was established to provide an organizational structure for self-support groups throughout

the country. Since its establishment, ASONAPVISIDAH has developed the capacity for inter-sector and inter-institution coordination of public and private entities, as well as organizations engaged in international assistance and cooperation. It was officially registered as an NGO in 2002, through a resolution of the Secretary of State of the Departments of Internal Affairs and Justice.

The organization is composed of a general assembly, which elects a board of directors every two years. The board of directors consists of a coordinator, a sub-coordinator, a treasurer, a comptroller, a secretary, and five spokesmen. In order to make the organization's procedures and decision-making more effective, the general assembly delegates authority to the board of directors and the national coordinator to manage policies, represent the organization externally, and handle various other issues of interest to the organization. The project has 40 facilitators and a project coordinator. The organization's main office is in San Pedro Sula, and it has another office in Tegucigalpa. Both sites include a basic logistical team necessary to handle the organization's administrative tasks.

The first phase began in January 2004, and included the following activities:

- (1) Recruiting facilitators
- (2) Developing a plan for training facilitators
- (3) Training instructors who, in turn, will train facilitators
- (4) Selecting facilitators
- (5) Establishing support networks
- (6) Procuring and supplying resources
- (7) Home visits

The second phase began in February 2005, and included the following activities:

- (1) Assigning facilitators to the Integrated Care Clinics (CAI, in Spanish)
- (2) Personalized training
- (3) Launching a program for on-line visits
- (4) Support and companionship, monitoring and evaluation

The plans for the third phase include the following activities:

- (1) Community activities
- (2) Stronger presence at the CAI
- (3) Incorporating new facilitators
- (4) Ongoing training sessions
- (5) Addressing areas that need strengthening for families of PLWH

The home visit project addresses prevention, treatment and care, harm reduction, gender issues, and legal aspects of the daily life of PLWH. Its first phase started in 2004, and the whole project is projected to end in 2008. Everyone with a chronic health problem has needs beyond medical care and nursing – including emotional, social, spiritual and economic care and support, as well as help with caring for oneself. The Home Visit project is designed to help meet all of these needs in an integrated fashion, thus improving quality of life and easing the burden of living with HIV. The project was

launched in part because the public health system is overloaded. Whether provided at the residence of the person affected or in a substitute domicile, home visits must be of high quality and, if possible, personalized, warm and in tune with the patient's emotional needs.

Home visits also allow for a greater understanding of the true needs of PLWH so that the type of support provided can be prioritized in ways that minimize the oppression and pain of living in a world that stigmatizes and discriminates against PLWH. Moreover, home visits empower PLWH to learn to deal with the opportunistic infections associated with HIV, and show the importance of antiretroviral therapy as a way to improve both the quality of their lives and their life expectancy. Home visits also help foster an integrated approach to care, in which PLWH become the eyes of the Integrated Care Center in the communities, seeing what doctors cannot see, and reinforcing professional care with the support and follow up given directly within the patients' own homes. In the process, they reduce costs for families of PLWH.

Finally, home visits help improve the quality of care. Doctors who provide care for PLWH face diverse problems. Many patients abandon therapeutic treatment: of 3,963 infected people who received ART in 2005, 488 abandoned treatment.²⁵ By improving adherence to treatment, resistance is prevented and the quality of life of this group is improved.

Among the reasons for carrying out home visits are: (i) the need to provide integrated and personalized care; (ii) the fact that many PLWH have difficulties accessing health services to receive care; (iii) economic constraints on PLWH; (iv) abandonment of treatment by PLWH; (v) failure of PLWH to keep medical appointments; (vi) the fact that without home visits, PLWH may end up receiving non-specialized healthcare; (vii) reducing caseloads of hospitals; and (viii) the need to increase the comfort and improve the quality of life for PLWH. The following criteria are used in selecting people to receive home visits:

- (1) People who are beginning therapy
- (2) People who have missed clinical checkups and testing
- (3) People who have problems adhering to treatment protocols
- (4) People who have tested positive and may not be aware of what steps to take
- (5) People who need palliative care
- (6) People with infections
- (7) People who have abandoned therapy
- (8) People who need emotional support
- (9) People who have tested positive and spend most of their time alone
- (10) Women in the vertical transmission program
- (11) PLWH who have been absent from self-help groups.

The people who belong to self-help groups coordinate with staff members who work at Integrated Care Centers in different municipalities throughout the country. The Integrated

²⁵ ASONAPVISIDAH, Tegucigalpa Workshop 2006.

Care Centers constitute the logistical base for the home visits. Details of the places where these centers operate are given in Table 3. The project is implemented nationwide, with facilitators for home visits assigned in different zones surrounding the Integrated Care Centers and the residence of the facilitators.

Table 3. Integrated Care Centers where ASONAPVISIDAH Self-help Groups Operate

ZONES	CITIES	Integrated Care Centers (in Spanish, CAI)
NORTHERN ZONE	San Pedro Sula	CAI Mario Catarino Rivas Hospital
		Mario Catarino Rivas Pediatric Hospital
		Episcopal Church Clinic (<i>Clínica Iglesia Episcopal</i>)
		El Progreso Hospital
	Puerto Cortés	Puerto Cortés Hospital
WESTERN ZONE	Santa Rosa de Copán	Western Hospital (<i>Hospital Occidente</i>)
	Ceiba	Atlántida Integrado Hospital
ATLANTIC COAST ZONE	Islas de la Bahía	Episcopal Church (<i>Iglesia Episcopal</i>)
	Tela	Tela Integrado Hospital
		Health center with attending physician (CESAMO) and at the Sexual and Reproductive Health Unit (USASER)
	Trujillo	Salvador Paredes Hospital
SOUTHERN CENTRAL ZONE	Tegucigalpa	Thorax Care Hospital (<i>Hospital del Tórax</i>)
		Teaching Hospital (<i>Hospital Escuela</i>)
		Alonso Suazo CESAMO
		Las Crucitas CESAMO
		El Carrizal CESAMO
	Choluteca	Southern Hospital (<i>Hospital del Sur</i>)
	Comayagua	Santa Teresa Hospital
	Siguatepeque	Episcopal Church Clinic (<i>Clínica Iglesia Episcopal</i>)
	Danlí	Danlí Hospital

Results. In 2005, a total of 6,379 home visits were made to HIV positive patients and their families, who were provided with information, counseling and support. Some of the results of the project are:

- (1) 20 self-help groups involved
- (2) 90 trained facilitators
- (3) 40 facilitators hired in accordance with job profile specifications
- (4) 17 Integrated Care Centers supported
- (5) Three training sessions carried out
- (6) Three performance evaluation sessions carried out
- (7) One brochure on home visits developed
- (8) Institutional recognition of ASONAPVISIDAH

Below are statements made by some beneficiaries of the project:

- “I like home visits because I have someone to talk to about my problem, and I can’t do that with my family; now I don’t feel lonely, and I know that there are people looking out for me, and I hope they always come.” (Choluteca)

- “Thanks to the visits and the support that I’ve gotten, I have learned how important it is to take my medication; they taught me that it’s hard at first but that it all changes later, and now I take them and don’t feel any bad effects.” (Comayagua)
- “I went to the self-help group but I didn’t like it; I didn’t want to be looked at; but the home visit worker invited me to try again, and took me there; this helped me to accept my condition. Now I’m better, and I try not to miss any meetings.” (Siguatepeque)
- “I didn’t want to go to the hospital, but the home visit workers gave me confidence and some company, and they are always looking after my condition and whether I’m taking my medication; I’m glad that they visit me.” (San Juan Tela)
- “It’s great that they visit me; the neighbors ask me who they are, and I say that they’re my friends; I hope they keep coming. They keep track of my medication even though I’ve been taking them the right way.” (San Pedro Sula)

TREATMENT

The official estimate of the number of people who need ART is 6,000. In 2004, approximately 41% of the people who required treatment at that time (5,550) received it, according to PAHO. This represented a 33% increase in relation to 2003. Of the people who received treatment in 2004, approximately 37% were women. Honduras has had a protocol for preventing vertical transmission since September 2004. In 2003, 1% of women screened by the Vertical Transmission Program tested positive for HIV. Discussions are underway concerning the impact that the CAFTA-DR Agreement²⁶ is likely to have on drug procurement.

The HIV/AIDS and STIs Department notes several issues related to the ARV situation in Honduras, including:

- The demand for treatment exceeds the financial capacity of the country for purchasing ARVs.
- The rapid mutation of HIV and its resistance to ARVs makes it necessary to change ARVs included in the basic medication protocol constantly. This affects the cost of medication.
- The purchase of medication requires procedures that will guarantee transparency in the selection and adjudication of contracts to pharmaceutical companies.
- There seems to be a need for standardizing and disseminating information on ARVs being purchased by the government and how they reach the population. At the workshop on successful experiences held in Tegucigalpa in May 2006, representatives of ASONAPVSI DAH said there had been six ARV supply shortages in recent years.

²⁶ CAFTA-DR: Central American Free Trade Agreement – Dominican Republic. The reference to the Dominican Republic accounts for this country’s participation in the agreement along with other Central American nations.

- An information campaign is needed to help the general population understand the dynamic of purchasing and using ARVs in the country.

Medications and medical supplies for HIV/AIDS patients are regulated by the Technical Unit for Medications Supply – a unit of the Networks, Medical Goods and Services Department of the Health Secretariat. Since 2001, medications for HIV/AIDS have had to be registered by the National Pharmaceutical Regulatory Entity. Since 2003, Quality Control Certificates have been required for ARVs before they are used.²⁷

ARVs are purchased through national and international bidding processes. This is a centralized purchasing process. Purchasing policies reflect the economic reality of the country. Given the high prices of brand name medications, Honduras has been purchasing generic ARVs since 2004 from pharmaceutical companies such as CIPLA and RAMBAXY.

In 2004, the average annual cost for first line treatment in adults through the public system (triple therapy) was approximately US\$ 608 per person. The main sources of financing for the purchase of ARV are the Global Fund and the Honduran government's Department of Health. In 2005, the Global Fund contributed US\$1.4 million for ARVs, while the Department of Health allotted US\$3.3 million.

Diagnostic kits for HIV infection are purchased with national and USAID funds. According to the Latin American and Caribbean AIDS Initiative (SIDALAC), the cost to purchase and distribute condoms was approximately US\$ 1.7 million in 2001. While 5% of this was covered by public sources, and another 5% was covered by external sources (donors, cooperation agencies), the rest was covered by private sources.

²⁷ Information Pages PAHO/WHO, 2004.

References

CIPE/CONADEH. (Baseline diagnosis to identify human rights violations of people who live with HIV/AIDS) *Diagnóstico de Línea Base para identificar las violaciones a los derechos humanos de las personas viviendo con VIH/SIDA*. 2004.

CONADEH. (Calculating quality healthcare of people living with HIV/AIDS from a human rights perspective) *Estimación de la calidad de atención integral en salud en las personas viviendo con HIV/AIDS desde una perspectiva de los Derechos Humanos*. Tegucigalpa, Honduras, 2004.

CONADEH/UNDP. Compliance of the Special Law on HIV/AIDS and comparison with legislation on HIV/AIDS in Central America and Panama, Tegucigalpa, 2003

Decree No. 208-2003 – Honduras Immigration Law, 2004.

Epidemiological data provided by the STD/HIV/AIDS Department of the Ministry of Health, Honduras. 2006.

Ministry of Health, Department of Control and Prevention of STDs, HIV/AIDS and Tuberculosis. Sero-epidemiological study of Syphilis, Hepatitis B and HIV in Commercial Sex Workers in the cities of Comayagua, La Ceiba, San Pedro Sula, Tegucigalpa and Puerto Cortés, 1998

Onsite interview from March 2006

http://www.unv.org/infobase/unv_news/2005/98/05_04_30_HON.htm

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

Sierra, Ministry of Health, Department for Control and Prevention of STDs, HIV/AIDS and Tuberculosis. Sero-epidemiological study of Syphilis, Hepatitis B and HIV in the Garifuna population from El Triunfo de la Cruz, Bajamar, Sambo Creek and Corozal. 1999.

Special Law on HIV/AIDS. Decree No. 147-99, September 9, 1999. Republic of Honduras. Law for Promoting, Protecting and Defending Human Rights regarding AIDS (1996)

UNAIDS, Protocol for the identification of discrimination against people living with HIV, UNAIDS Best Practice Collection, UNAIDS, Geneva, 2000. Available on line at: http://data.unaids.org/Publications/IRC-pub01/jc295-protocol_en.pdf?preview=true

UNDP/CONADEH. Compliance with the Special HIV/AIDS Law in Honduras and comparison with legislation in Central America and Panama, *Cumplimiento de la Ley Especial de HIV/AIDS en Honduras y comparación con legislación sobre VIH/SIDA de Centro América y Panama*. Tegucigalpa, 2003)

UNICEF. (An Affected Orphaned Childhood or Living with HIV/AIDS in Honduras)
Niñez huérfana afectada o conviviendo con HIV/AIDS en Honduras. 2002.

Website research, http://www.unaids.org/en/Regions_Countries/Countries/honduras.asp

ANNEX 1. FORM FOR EVALUATING DISCRIMINATION

Questions about discrimination, from 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 PLWH?
- 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. SUMMARY TABLE OF SUCCESSFUL EXPERIENCES IN HONDURAS 2006

Institution	Project	Initiated	Direction	Population Benefited	Zone
National Human Rights Commission	HIV/AIDS and Human Rights Program,	2002	Promotion and protection of PLWH human rights	All vulnerable groups, PLWH	Urban and rural
Ministry of Health	Program for preventing the transmission of HIV from mother to child (PPTMH),	2001	Prevention, promotion and treatment	Pregnant women who are identified as HIV-positive, pregnant women in general	Urbana y rural
Kukulcán Association	Diversity and integration for prevention/ National Program for Prevention and Care of STDs, HIV/AIDS.	2002	Prevention and promotion	Gay men, bisexuals, transvestites, MSM (18-39)	Urban and rural
Health Communication Partnership (HCP)	HIV/AIDS prevention program in Garífuna youth between the ages of 15 and 24.	2003	Prevention and promotion	Young adult population (15-24) (Garífuna Indian group) in 26 communities	Urban and rural
Center for Promotion of Family Health and Care (CEPROSAF).	HIV/AIDS Prevention in the adolescent population of the Garífuna Indian population	2005	Prevention and promotion	Adolescent population – particularly the Garífuna population	Urban and rural
National Association of People Living with Aids in Honduras (ASONAPVSI DAH).	House visits,	2004	Treatment, mitigating damage, gender and legal aspects related to living with PLWH	PLWH and vulnerable groups	Urban and rural

ANNEX 4. ARBITRARY DISCRIMINATION IN HONDURAS 2006

Area	Finding	Evidence
Healthcare		
HIV testing without consent	Although this practice is banned by law, it still takes place	This occurs in the case of pregnant women, as it is part of a guideline established by the Health Secretariat for the protection of the unborn child
Lack of confidentiality: informing others of the identities of people who have tested HIV-positive, or allowing in a deliberate or negligent way, confidential files to be consulted	This offense occurs in practice	This generally occurs within the health and justice systems
Employment		
Compulsory testing prior to being hired	Although this practice is banned by law, it still takes place	This happens in the private sector, generally in manufacturing plants known as Maquilas
Questions asked about the person's HIV/AIDS viral condition, and/or "lifestyle" on forms or during recruitment interviews	This occurs in practice	Questions are not directly related to a person's serological HIV/AIDS status, but seek information about high-risk behavior
Denial of employment based on one's HIV/AIDS viral condition.	This occurs in practice	This occurs in the private sector
Justice/legal proceedings		
Creating specific criminal offenses in the case of deliberate transmission of HIV/Aids	Stipulated by law	Special Law Regarding HIV/Aids, Criminal Code Article 80 – the propagation of HIV by deceptive or guilty means will be subject to the sanctions and penalties set forth in Articles 180, 184, and 191 of the Criminal Code
Differences in sentences imposed on PLWH	This occurs in practice	Representatives from CONADEH suggest the existences of differences in sentencing due to the HIV status of a person
Housing		
Mandatory testing, declaration of HIV state, or certificate stating that the person is HIV-negative as conditions for access to housing or for the right to live in a housing project	This occurs in practice	Cases generally observed in banks and lending institutions.

Education		
Lack of confidentiality	This occurs in practice	Stigmatization by acquaintances and instructors who violate the confidentiality and privacy of the individual with HIV/AIDS
Family and Reproductive Matters		
Mandatory pre-matrimonial and pre natal testing	This occurs in practice	Some city hall/mayor offices require this test
Insurance and Other Financial Services		
Rejection or restrictions with respect to insurance policies (i.e, life insurance policies) due to a person's having tested positive for HIV/Aids, or belonging to what is considered a high-risk group	This occurs in practice	On life insurance forms, the information is obtained indirectly (i.e., Do you have an infectious/contagious disease?)

Source: Honduras National Commissioner for Human Rights



For more information, please contact:

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