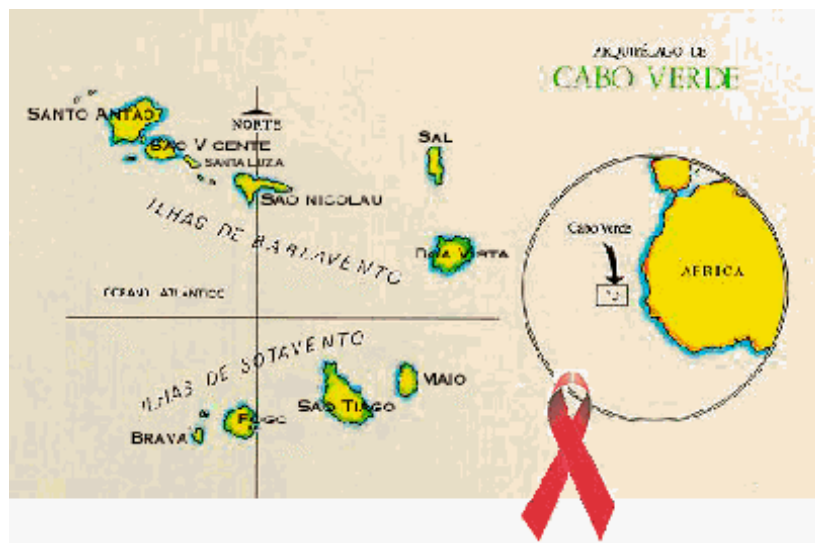




**República de Cabo Verde**

Comité de Coordenação de Luta contra a SIDA

Secretariado Executivo



# National Strategic Plan

## Against AIDS

**2002 - 2006**

**February / 2002**

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## **1.INTRODUCTION**

From the emergence of the first AIDS case in the world, in the beginning of the eighties, the number of cases reported to WHO didn't stop increasing, becoming the first mortality cause at African continent level and the fourth at world level, in the adults.

Since then, many progresses were already made in research and treatment areas. However, the results of the efforts made in the fight against AIDS are not very visible, mainly in the countries in development, where poverty reaches most of the population. The strong sexual and behavioural components also contributed to HIV transmission.

In Cape Verde, the first AIDS case was reported in 1986. In 1987, the Ministry of Health established an "Action Group against AIDS", that accomplished the first awareness and information activities directed to health staff and the population. A short-term plan was then developed and executed up to 1988, when the National Program to Fight against AIDS was established.

The main accomplished activities were the National Seroprevalence Survey, the implementation of the laboratories to assure the blood transfusion safety and the surveillance of the infection, as well as training for social organisations workers, mass media staff, among others. In 1989, a mid term plan was adopted for 1990-1992 (MTPI). In 1992, STI were integrated in the Program to Fight against AIDS.

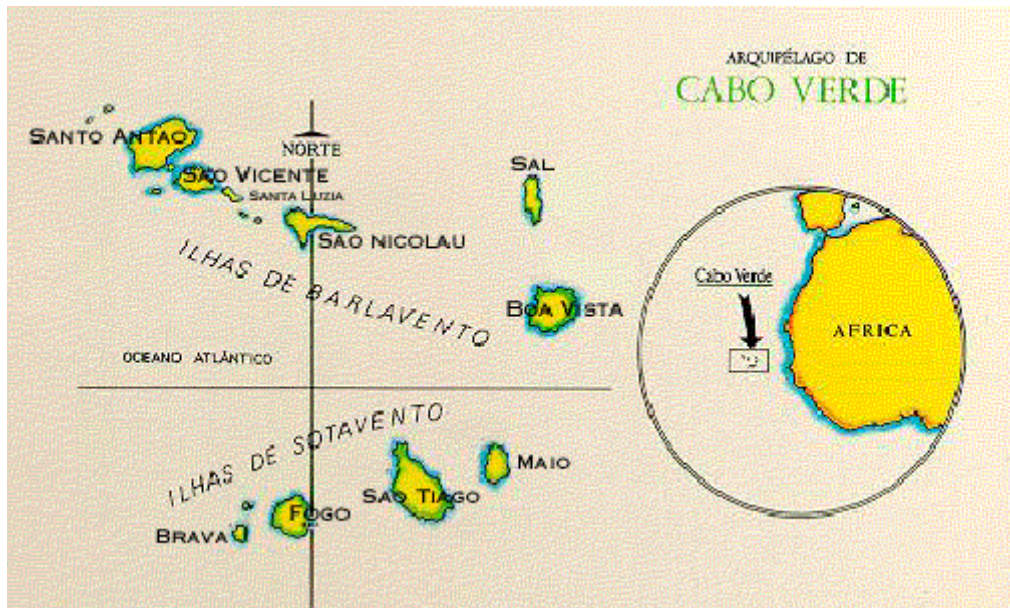
In December 1993, MTP II was developed for 1994-1998, financed by WHO, French Cooperation and, especially by the European Union. MTPII had a weak implementation rate, particularly IEC component financed by the European Union which accomplishment term was extended up to 31<sup>st</sup> March 2000. However MTP II was not evaluated.

With the support of UNAIDS, the process of strategic planning for the next five years started. In June of 2001, it was created a national technical team, which worked in the Analysis of the Situation and Response, advised by an international consultant. Starting from this date, representatives of NGOs, CBOs, municipalities and partners of the United Nations and bilateral participated in activities seeking the elaboration of a strategic plan. The NATIONAL STRATEGIC PLAN AGAINST AIDS - 2002/2006 and the Plan of Action of Reference were validated by representatives of the public services, churches and NGOs and CBOs, in representation of the civil society during an workshop accomplished in Praia, in January 14th and 15th, 2002.

The general objectives of the National Strategic Plan of Fight against AIDS are:

- 1) The reduction of the prevalence of HIV infection;
- 2) To improve the quality of IHV/AIDS infected and affected people's life;
- 3) To strengthen the national capacity to answer to the epidemic;
- 4) To have a better knowledge of the epidemic, of its dynamics and its impact.

The National Strategic Plan to fight AIDS, approved by the Deliberation of the Ministries Council on February 28th. 2002, is the document of reference in the fight against AIDS in the country, for next five years (2002-2006), along which its application will be regularly evaluated, for its adaptation to the needs and the progress that has been reached. It shall guide public, private sector and civil society initiatives relating to HIV/AIDS prevention and control.



## **PART I - Summary of the Analysis of the Situation and the Response**

### **1. THE DEVELOPMENT CONTEXT**

#### **1.1 General data on the country**

##### **1.1.1. Geographical location**

With an area of 4.033 Km<sup>2</sup>, Cape Verde is a volcanic origin archipelago, formed by ten islands and eight islets. It is located in the Atlantic Ocean about 455 km far from the cable with the same name, in the African western end. Geographically, the archipelago is divided in Windward and Leeward groups according to the prevailing winds. Administratively the country is divided in 17 municipalities.

##### **1.1.2 Demography, population and culture**

According to the data of the Census 2000, the resident population is 434.625 inhabitants. It is mostly young, women representing about 51,6%. The family medium size is 4,6 people and the male ratio is 93,7 men for each 100 women.

The population density is 109 inhabitants for square kilometre, with extremes that reach 410 inhabitants per Km<sup>2</sup>, in the municipality of Praia, and 6,8 inhabitants per Km<sup>2</sup>, in Boa Vista. About 53,4% of the population live in urban areas. The population growth rate, depending on the migratory flows, was about 2,4% in the decade 1990-2000.

##### **1.1.3 Migration and population mobility**

The migratory culture is very old, representing an inherent element to the formation process of the Capeverdean society. In addition to the strong international component, it also occurs

among the islands and within them, especially towards the urban centres, with prominence for the capital, Praia.

The effects of capeverdean migratory phenomena are important for the development process, both to the economic extent and to the cultural one. The development of tourism, the proximity of the African western coast (a very high HIV/AIDS prevalence zone) can also contribute to the transmission of HIV/AIDS.

#### **1.1.4 Ethnic groups and communication languages**

As a mixed nation, in Cape Verde there are no ethnic groups. The communication languages are the capeverdean - Creole spoken in different patterns in each island - and Portuguese, that is the official language.

#### **1.1.5 Religion**

Most of Cape Verde population is catholic; however Nazarene and Adventists of the Seventh Day Churches are strongly established in all islands. During the last years, new beliefs have been emerging, being professed freely according to the will of each faithful.

#### **1.1.6 Health and welfare systems**

Both the Constitution of the Republic and the Health Bases Law assure the right to health to all capeverdean citizens, regardless of his social and economic state, being one of the priorities of the health national policy the implementation of an operating health primary cares system.

Health policy in Cape Verde is based on the fundamental principles of equity to provide health cares and access to the services; on the prioritisation of geographical and socially less favoured zones and on the coordination among health strategies with those of the related sectors, taking into account the interdependence of health levels with the development of other social, economic and cultural sectors.

#### **1.1.7 Political system**

Cape Verde was a Portuguese colony for five centuries. It ascended to national independence on July 5, 1975, and in the following 15 years the country knew important social and economic growth indicators, with important gains in health and education. In that period there was a single party government. In February 1990, the Constitution of the Republic was changed, paving the way to the multiparty system and the country knew deep changes in democratisation terms, political alternation, exercise of citizenship, liberalisation of the economy, legislation, decentralisation and involvement of the civil society for the life conditions improvement of capeverdean population.

#### **1.1.8 Social and economic development**

Cape Verde development is based on the profitability of its geo-strategic location and the development of its resources and natural potentialities. Cape Verde economy is essentially of services, with the tertiary sector representing 64% in the composition of GDP, while the primary sector has only 13%, in spite of using 47% of the national workforce.

According to Human Development Index, the country, that in 1999 was ranged as 105th among 174 countries, ascended, in 2000, to 91<sup>st</sup> due to its relatively favourable social indicators.

In 1999, life expectancy was 71,6 for women and 65,8 for men. In 2000 the infant mortality rate was 23,1 per 1000 and the mortality rate was 5,6 per 1000. Basic education level reached 91,9% of the population aged between 6 and 15 years, of which 91,4% were girls and 92,4% boys; adults' literacy (64% for women and 81% for men) and GDP per inhabitant was estimated in 1.354 USD in 2000.

However, those data cannot hide the reality of the social-economic situation in which lives the great majority of Cape Verde populations, in spite of the significant improvements that, from year to year, are being reported in the fight against poverty and exclusion all over the country.

It shall be stressed that, according to a survey data carried out by the Institute for Employment and Vocational Training, the poverty levels are higher in the urban centres, where it went from 17,9% in 1990 to 38,9%, in 1995. In the year 2000, the Census reports an activity rate of 68,9% (64,1% for women and 74,4% for men).

## **1.2 National Program to fight against Poverty**

Cape Verde set up as one of its governance priorities the fight against poverty, that reaches most of the population (30% are poor and 14% very poor - Census 2002) with great difficulties in acceding to goods and services, such as food, drinking water, health, sanitation, education, housing and instruction.

The National Program to fight against Poverty (PNLP), includes:

- 1) Health Sector Development Project funded by IDA, World Bank. It is present in all municipalities, especially in facilities building extending until August 2003.
- 2) Program to Fight Against Poverty in rural areas. Local activities, establishment and legal formalisation of community based associations. Building of social facilities (cisterns, kindergarten, social housing and support to artisan fishing), extending until 2006;
- 3) Economic and Social Promotion Project for Needy Groups. It will act in Santiago, S. Vicente and Santo Antão. The intervention areas are health, education, water and sanitation, economic integration of target groups and development of beneficiaries and

stakeholders capacities. The target groups are women, specially house heads, unemployed, namely young people, and FAIMO workers. Not yet launched, it will last five years.

Although PNLP doesn't mention HIV/AIDS explicitly, it contributes with its interventions in reducing the vulnerability of the less favoured populations.

## **2. JUSTIFICATION OF THE STRATEGIC PLAN**

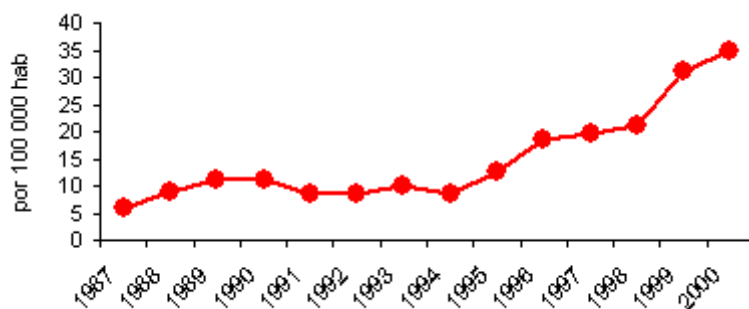
### **2.1 Analysis of HIV/AIDS epidemic situation in Cape Verde**

The first AIDS case was reported in Cape Verde in 1986, when, in Paris, the virus Lav2/HIV2 was isolated in a patient from the island of Fogo. Two seroprevalence surveys were carried out, one in 1986 in Praia and Sal and another in 1987 in Praia, Fogo and S. Vicente. The only national seroprevalence survey was carried out in 1988 and published in 1989 having been detected a prevalence rate of 0.46% among 5790 sample of people aged 15 to 55 years.

The HIV sentinel surveillance system in pregnant women that had operated until 1997, identified, for 1996, prevalence rates of HIV infection between 0,37% and 1,37%, in Praia, and from 0,23% to 2,1%, in Mindelo. With the support of the model of demographic projection "*demproj*", the evolution of the epidemic was analysed up to 2010. According to this model, in 1995, the prevalence rate of HIV/AIDS infection in Cape Verde would be 1,3%. The number of new cases would be 79 instead the 24 notified cases. In 2000 that number would reach 216 cases. In 2010 it would be of 2451 cases.

From 1986 until December 31, 2000, in the laboratories ELISA at Praia and Mindelo, were detected, and notified to PNLS<sup>1</sup>, 775 people living with HIV, of which 406 have developed into AIDS (52,4%) and, of these, 205 died. Based on these data the infection incidence rate increased from 17,2 for 100.000 inhabitants in 1997, to 28,6 in 2000. The prevalence rate (patients) passed from 19,67, in 1997, to 35 for 100.000 inhabitants in the year 2000. The main transmission way is the sexual one with more than 90% of the cases. Mother-to-child transmission is responsible for 4,6% of all diagnosed cases (36/775). In the year 2000, 3,3% of the detected seropositive was drug users.

**CASOS DE SIDA DECLARADOS  
TAXA DE PREVALÊNCIA POR ANO  
CABO VERDE, 1987 - 2000**

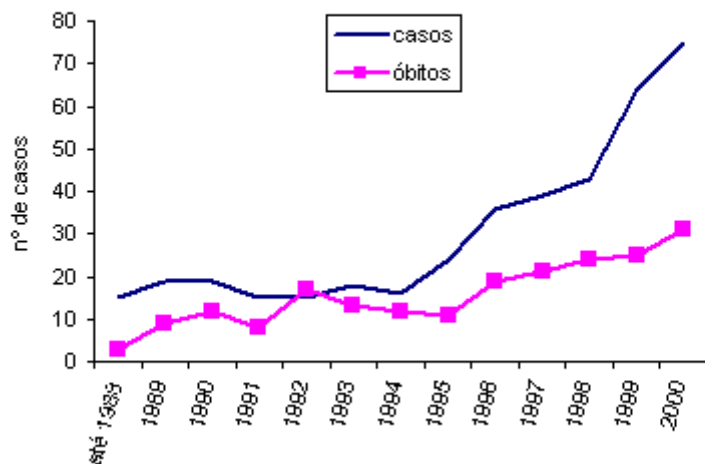


Prevalence rate per year in Cape Verde (1987/2000)

Fonte: PNLG\GEP\MOH

The seroprevalence rate in potential blood donors in Praia Blood Bank passed from 0,5%, in 1998, to 1,2%, in the year 2000.

**Evolução dos Casos e Óbitos de SIDA por ano**



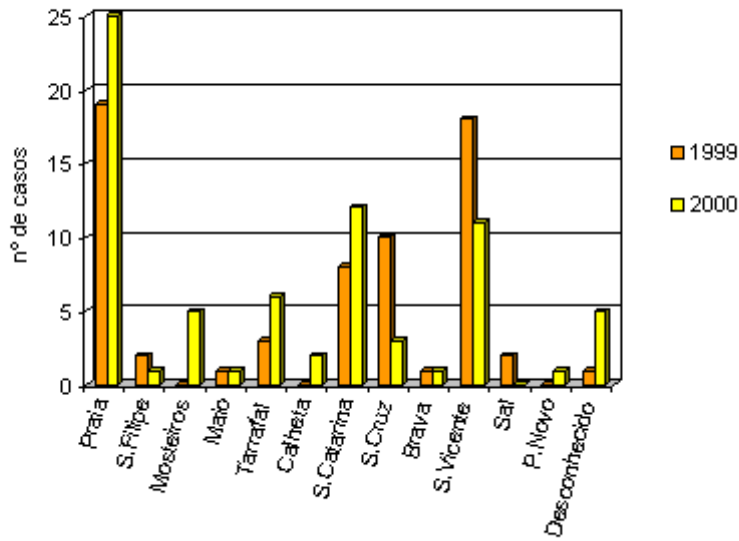
The number of cases of

AIDS and deaths

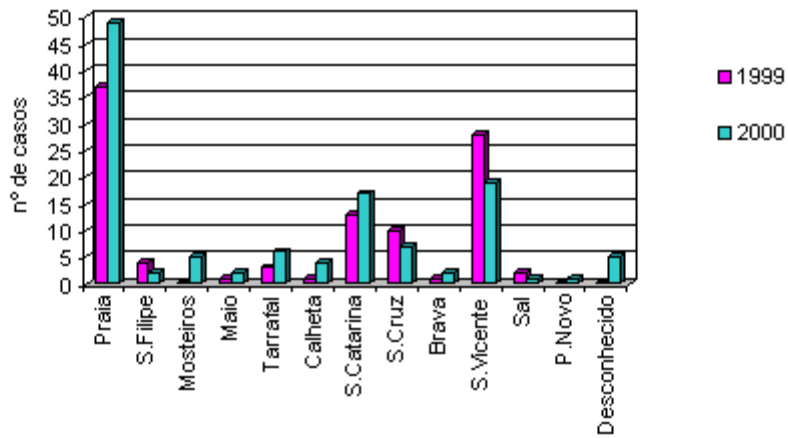
Source: PNLG\GEP\MOH

By regions, Leeward is the most affected, with 81,1% of the cases. By islands, Santiago, Fogo and S. Vicente have the largest number of cases. A progressive increase of cases is verified in rural zones, feminine sex and younger ages.

### CASOS DE SIDA POR CONCELHO



### NOVOS SEROPOSITIVOS NOTIFICADOS POR CONCELHO. CABO VERDE, 1999 - 2000

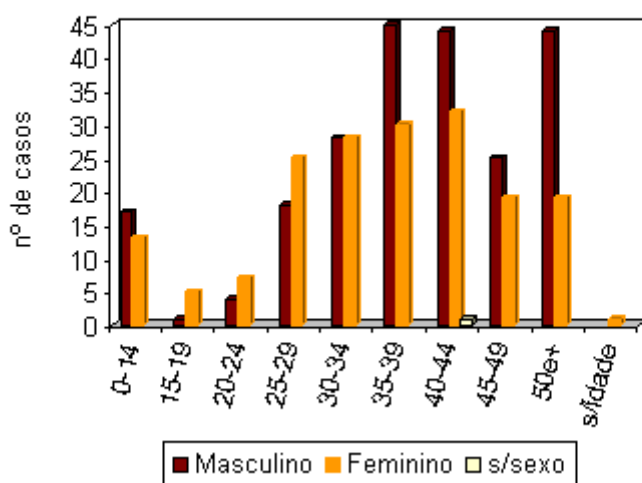


Number of cases

of HIV, per municipality, in 1999 and 2000. Source: PNLS\GEP\MOH

Number of notified new cases, per municipality. Source: PNLS\GEP\MOH

**TOTAL CUMULATIVO DOS CASOS DE SIDA POR GRUPO ETÁRIO E SEXO. CABO VERDE, 1987-2000**



By virus type, since the beginning of the epidemic, 464 cases of seropositives by VIH2, 257 cases by VIH1 and 18 by VIH1+2 were already reported.

Cumulatively, for the seropositives, the sex ratio M/W is 1,13 (399/353) and the most affected ages are those between 25 and 44 years with 62,8%. Out of the AIDS cases 51% were aged between 30 and 44 years.

Cumulative cases of AIDS, per group of age and sex, from 1987 to 2000

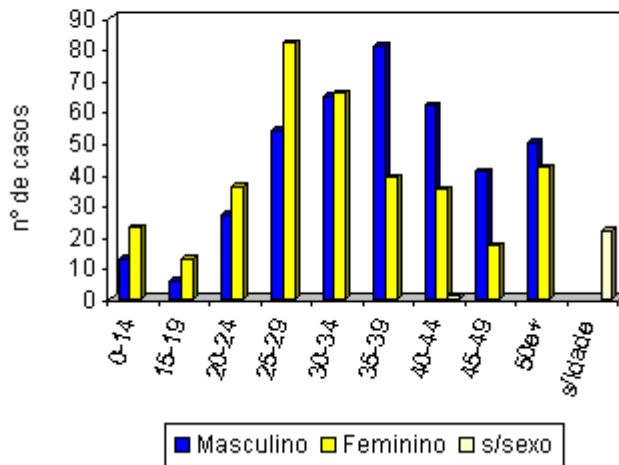
Source: Laboratórios ELISA, Praia e S.Vicente

The most frequent identified opportunistic infections are tuberculosis, chronic diarrhoea, oral candidiase and chronic herpetic infection.

The Sexually Transmitted Infections (STI) represent one of the main morbidity causes among the young adults, of both sexes. Uretrites/vaginites as Syphilis, the Hepatitis B and other STI have been increasing in the last years. The municipalities with larger number of cases of all reported sexual transmissible diseases are Praia and S. Vicente.

Cumulative cases of people tested HIV positive, per group of age and sex, from 1987 to

**TOTAL COMULATIVO DE SEROPOSITIVOS POR GRUPO ETÁRIO E SEXO. CABO VERDE, 1987-2000**



2000

Source: Laboratórios ELISA, Praia e S.Vicente

### **Important conclusions:**

In the last five years, the available data on the epidemic evolution, by sex, age group and geographical distribution, allow us to draw the following conclusions:

- The only National Seroprevalence Survey dates from more than one decade (1989);
- The number of cases has been increasing progressively, since 1996;
- The sexual transmission continues predominant for more than 90% of the cases;
- There is a progressive increase of the number of cases in the rural zones, in the feminine sex and in the younger age groups;
- The number of cases by HIV1, increased from 1996, contrarily to the previous years when HIV2 was more frequent;
- There is a significant increase of the number of cases in S. Vicente;
- The number of reported cases is higher in Santiago, Fogo and S. Vicente;

### **2.1.1 Vulnerability and risk factors face to HIV/AIDS**

In Cape Verde, the following factors can be considered as vulnerability and risk factors:

- Low social economic and school level of great part of the population.
- Conflict of values that affect behaviour.
- A certain weakness of control power and social pressure
- Incipient knowledge about sexuality by part of the population
- Unemployment reaching a large youth groups;
- High number of single mothers with multiple "children's parents"

- The social and economic fragility of women;
- Mobility and internal and external migrations.
- Existence of conditions that facilitate the consumption of alcoholic drinks.
- Unsafe sexual practices (multiple partners, sex without protection in hetero, bi-and/or homosexuality).
- The adolescents' precocious sexual initiation (before the age of 16)
- Signs of drug consumption cases increase and its geographical expansion.
- Weak awareness of the HIV/AIDS infection risk and persistence of wrong ideas on STI;
- Matrimonial instability and infidelity;
- Parents' deficient preparation in order to guide their children to a correct sexual life and responsible behaviours;
- Hidden prostitution and absence of concerning legislation.
- Weak political engagement and capacity of the country to face the epidemic.

### **2.1.2 Vulnerable and high risk groups**

- Individuals that practice prostitution (men or women) and sexually promiscuous;
- Young people specially in urban areas;
- Population with social, economic and education low level, particularly women;
- Individuals in situation of frequent mobility;
- Children of and in the street;
- Consumers of alcohol and drugs.
- Prisoners
- Health workers and traditional attendants.

### **2.1.3 Actual impact of HIV/AIDS infection**

The true dimension of HIV/AIDS impact is ignored at all levels.

The actual perception of the epidemic impact is essentially focused on the infected person and his relatives. Infected are, usually, men and women in productive age, guarantee of revenue and support for the households. The diagnosis of the disease has been made late and the death comes quickly, being the family very often in a difficult situation.

PLWHA have a tendency to self-isolation, fearing social stigmatisation, discrimination by the services and rejection by the family. The psychological and physical degradation leads to the abandon and to the indifference, increasing the vulnerability to opportunistic diseases. The infected with HIV/AIDS doesn't still have access neither to all opportunistic infections nor anti-retroviral treatment

The child victim of AIDS, both the infected and the orphan, faces a worse situation when he comes from a poor family.

### **Conclusion**

In Cape Verde knowledge on HIV/AIDS impact is incipient and actually it centers at the individual's level.

## **2.2 The National Response to HIV/AIDS epidemic in Cape Verde**

### **2.2.1 Epidemiological surveillance**

Several survey, were carried out namely two on seroprevalence in specific groups in 1986 and 1987; a national survey on seroprevalence in 1988; CACP survey in 1991/92 - and sentinel posts worked between 1993 and 1997 for pregnant. The institutional weakness, the frequent changes on the leadership of PNLIS and the lack of reagents and consumable led to the sentinel posts' temporary suspension, since 1998.

The system of detection/notification of the cases and deaths initially proposed and centred in the Director of PNLIS worked with a lot of deficiencies in the last five years, situation that worsened with frequent leadership changes.

**Conclusion: the epidemiological surveillance of HIV/AIDS is deficient.**

### **2.2.2 Prevention of the infection transmission by sex**

Several social and cultural barriers specially those related to gender hampered the success of IEC activities, considered one of the most essential prevention strategies. The objective was to promote safer sexual behaviours, with the involvement of sectors such as mass media, education, youth and sport, NGO/CBO, youth and community-based associations, journalists' network (REJOP), unions, municipalities and others.

The data of the Demographic and Reproductive Health Survey (DSR) show a high level knowledge on AIDS (97%). The same survey indicates that risk behaviours, persist namely the weak adhesion to condom's use (28,5%).

At school's level the integration of the problem was made in the curricula, through the discipline of Personnel and Social Training. In collaboration with the Project "Education in matter of Population and for the Family Life" (EMP/EVF) pedagogic material for the student's awareness and information was produced.

There is a deficient coordination among the several institutions that intervene in IEC for HIV/SIDA and a scattering of messages without any harmonization.

### **Conclusions:**

∩ IEC interventions' inadequacy

∞ No links between knowledge and practice.

### **2.2.3 Fight against other STI**

The implementation of mechanisms for the effective launching of the STI/AIDS activities at the level of health facilities was not systematized. The central level had discussed a strategy document containing protocols of diagnosis-conduct for the main STI syndromes, in 1992, but it was never approved officially, what hindered its implementation. In 1999 nurses and doctors received training on STI syndromic approach and counselling on HIV/AIDS, activity that didn't proceed. Self-medication habits and the sale of medicines in the street worsen this situation.

At STI prevention level, free delivery of masculine condom preservatives has been carried out.

#### **Conclusions:**

- Absence of an effective STI integration policy in the program fighting against HIV/AIDS;
- Habit of self-medication, facilitated by the sale of medicines in the streets;
- Non organized STI integrated cares (syndrome approach);
- Insufficient access to medicines.

### **2.2.4 Blood transmission prevention**

The activities aimed, above all, reducing the transfusion risk and the reinforcement of asepsis, sterilization and bio-safety measures in health care centers.

The country has not yet a national policy for blood transfusion. However, the transfusion safety is assured by the only two transfusion centers existing in the central hospitals of Praia and Mindelo, where there is lack of qualified staff.

In spite of problems in the supply of the laboratories in reagents and consumables, all blood transfused in the country was submitted to HIV testing.

Asepsis and sterilization rules were elaborated and distributed to all health structures; however they are applied in a deficient way.

Concerning drug addiction and beauty and aesthetics practices, no specific action was undertaken.

#### **Conclusions:**

- Absence of national blood transfusion policy.
- Deficit in number and training of blood bank staff and in the number of facilities (centers).
- Deficient supply of reagents to the laboratories

- Inadequate application of asepsis and sterilization rules in health centers
- Ignorance of the real situation on drug addition as well beauty and aesthetics practices.

### **2.2.5. Vertical transmission prevention**

Vertical transmission prevention was inserted in the general prevention measures by sex transmission as well as of counselling and follow-up of the seropositive pregnant. However, counselling services, limited to Praia and S. Vicente municipalities, have worked in an inadequate way. Some pregnant women have opted for PVI. Prevention with ARV was not introduced.

**Conclusion:** Absence of specific measures preventing vertical transmission

### **2.2.6 Legal and ethical aspects of HIV/AIDS problematic**

The Constitution of the Republic states the right of all citizens to health, the duty to defend and promote it, as well as the special protection of children in case of illness. In Cape Verde, however, there are no specific laws that consider HIV/AIDS problematic, particularly in what concerns confidentiality and non-discrimination.

Scattered legislation, in particular Health Basic Law has been serving as reference to assure medical and psychosocial cares to people living with HIV/AIDS.

Cape Verde ratified the main international legal instruments, namely the Universal Declaration on Human Rights, the African Chart of Human and People Rights, the Convention related to the Children' Rights, the Convention to Fight against all the discrimination forms related to woman and the Beijing Platform, among others. However, there is not a practical application of those instruments.

There is a deficient awareness, information, and education work face the behaviours and attitudes based on discrimination prejudices towards PLWHA, lacking solidarity nets for them.

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Prostitution and sexual disruption are a social reality in Cape Verde. The first one having, in the past, subject to public health protection measures is not regulated and the latter has had a favorable environment for spreading.

### **Conclusions:**

- Absence of specific legislation to safeguard the right to non discrimination and privacy of infected and affected people;
- Stigmatisation of PLWHA
- Weak awareness of the decisors and the community, in general, to PLWHA;
- Absence of PLWHA solidarity associations and PLWHA associations;

- Absence of brainstorming on ethical-juridical subjects related to HIV/AIDS;
- Absence of any legislation that regulates prostitution.

## **2.2.7 Reducing HIV impact on the individual, the family, the community and the society.**

### **2.2.7.1 Integrated cares to patients and seropositives**

There is no integrated cares policy for AIDS infected and patients. Cases were based, essentially, in the psychological support and in the treatment of the opportunistic infections. In Praia and Mindelo, two teams to attend and follow-up the seropositive and patients were created and qualified, both formed by a doctor and a psychologist.

Its extending to the other regions of the country and the conditions for the diagnosis and treatment of the opportunistic infections were not implemented.

The HIV/AIDS infected have not yet access to anti-retrovirals treatment.

#### **Conclusions:**

- Absence of an integrated cares policy;
- The psychological and social attendance is insufficient in the whole country;
- Insufficient conditions for the diagnosis and the treatment of all opportunistic infections in PLWHA;
- Inexistence of Anti-retrovirals (ARV)

### **2.2.7.2 Reducing the social impact on seropositives, patients and their families**

The mechanisms of assistance, envisaged in MTP II, towards organized communities, NGO and associations for the development of support actions to the infected, patients and affected families were not created.

However, awareness actions were carried out to some NGO and community-based associations, having some of them provided house cares to terminally ill patients and their relatives.

**Conclusion:** the answer for the reduction of the social impact was insufficient

### **2.2.7.3 Reducing the social and economic impact of AIDS epidemic**

The awareness and training of the decisors and opinion leaders, as well as the accomplishment of studies that would allow appreciating the determinants of the social and economic impact of AIDS epidemic in Cape Verde were not carried out although envisaged in MTP II.

**Conclusion:** HIV/AIDS social and economic impact is not known.

## 2.3 Institutional framework and management of the fight against HIV/AIDS.

### **2.3.1 Structures and coordinating bodies responsible for the fight against AIDS in Cape Verde**

The organization of the fight against AIDS was launched in 1988, having adopted the following operation structure:

- National Program to Fight against AIDS, under the Ministry of Health and depending directly from the General Directorate for Health;
- Multisectorial Group to Fight against AIDS, coordinated by PNLS and constituted by National Centre for Sanitary Development, Division of PMI/PF, General Directorate for Education, General Directorate for Adult Education, Secretariat of State for Youth, General Directorate for Social Promotion, Cape Verde Institute for Minors and Confederation of Unions;
- Decentralized structures of Ministry of Health (Health delegacies).

The inefficacy of the created coordination mechanisms made that the coordination, intended as multi-sectorial, had centred in PNLS leadership.

### **2.3.2. PNLS management**

#### **Central level**

The Ministry of Health, through PNLS, is responsible for the implementation of the Program to fight against AIDS, for the multisectorial coordination and for the mobilization of resources.

At central level the management of the program is just assumed by the Director, who doesn't have staff, and also answers for the programs fighting the other STI, Tuberculosis and Leprosy; this situation was aggravated due to the inconstancy of the management in the last five years.

In addition, the institutional framework is inadequate, in particular relating to the necessary autonomy for the program running.

#### **Outlying level**

The Health delegacies should assume the training, follow-up, and coordination of IEC activities as regards to HIV/AIDS inter and intrasectorial prevention at municipal/local level. However, logistics problems, staff instability and the lack of the personnel's training in IEC/Counseling, integrated cares and management were weak points. To these it shall be added a deficient coordination and supervision, what contributed to a stagnation of the

accomplishments. Of all the aspects related to the problem, only IEC was accomplished, although in a discontinuous way.

The creation of a formal or informal advisory council at municipal level, that would have as function the piloting, coordinating of activities and resources mobilization by the partners, did not take place.

### **2.3.3 Training management**

Training actions directed to doctors, laboratory technicians, transfusionists, community workers and nurses, among others were carried out. The community workers' training in IEC/AIDS was prioritised as well as of members of associative groups in planning and management of micro-projects. Such actions were insufficient, affecting the quality of the rendered service.

### **2.3.4 Management of the operational research**

It is an area that is not very developed. Studies of characterization of the consequences of the epidemic at individual, community, sanitary and economic levels, etc. were not carried out. It is not known the weight of some factors involved in HIV transmission, as beauty and aesthetics practices (tattoo, piercing, manicure/pedicure, shaving, etc.). The several underlying reasons to the weak use of condoms are not well known.

### **2.3.5 Management of the prevention activities**

In order to strengthen PNLS and CNDS capacity to improve the production of IEC/AIDS materials, an institutional framework defining the collaboration between these two services was established, that however needs a better clarification.

The information and education activities for the prevention of HIV transmission were carried out with the involvement of NGO, CBO and other public sectors.

IEC actions began to be developed in an autonomous and spontaneous way by the parties, without coordination and without any evaluation of their impact.

### **2.3.6 Financial management and logistics**

At central level, the lack of human resources and the deficient coordination contributed to delays in the disbursement of funds what jeopardized the accomplishment of the activities in the scheduled time.

The diversity and the procedural demands of each lender, concerning the project management modalities were an additional difficulty in the management process.

### **2.3.7 Follow-up and evaluation of the program to fight against HIV/AIDS**

Half-yearly reports and external evaluation at the end of the first and third years of the program would allow the follow-up and evaluation. In the last years, however, half-yearly reports were not drafted and the external evaluation of MPT II is not yet done.

**Conclusions:**

- Weakness of the structure and bodies, centred in the Ministry of Health;
- Undefined institutional framework between PNLs and CNDS;
- Weak management capacity and deficient coordination mechanisms;
- Inadequacy of logistics means and of human resources;
- Inconstancy of the leaderships;
- Inefficacy of the national multi-sector structure;
- Absence of municipal multi-sector structures;
- Diversity of leader management procedures;
- Follow-up and evaluation inadequacy.
- Inadequate coordination and non-harmonization of IEC interventions and respective messages.

**PART II - Guidelines for 2002-2006 Strategic Plan**

**3. 2002-2006 STRATEGIC PLAN**

**3.1 Legal framework**

The Constitution of the Republic states the right of all citizens to health, the duty to defend and promote it, as well as the special protection to childhood in case of illness. The ordinary legislation, in particular the Health Basic Law, has been serving as reference in providing integrated medical and psychosocial cares to people living with HIV/AIDS.

The country ratified the main international legal instruments, namely the Universal Declaration of the Human Rights, the African Charter of People and Human Rights the Convention related to Child's Rights, the Convention to Fight against all the discrimination forms related to woman and the Beijing Platform, among others. However, there is not a practical application of those instruments.

The new Cape Verde Penal Code, that is not still into effect, states rules related to HIV/AIDS, in the articles 160 - Exposing somebody to illness by sexual intercourse, article 161 - Danger of infection by severe illness - and article 164. Attendance refusal by doctor or nurse, as well

as the rules that envisage crimes as defamation, slander, calumny, and offence to died person's memory.

### 3.2 Institutional framework

There is a unique institutional framework, with a high level HIV/AIDS coordinating bodies. This body is the Coordination Committee Against AIDS (CCS-SIDA) led by the Prime Minister (Dispatch nr. ° 50/2001, of July 4, O. J. Nr.° 23, July 30, 2001). With a broad representation of key stakeholders from all sectors, CCS shall coordinate the implementation of the Government's global policy as regards the fight against AIDS and follow-up all the programs and projects developed at the country in that area. CCS-SIDA meets quarterly and extraordinary when convened by its President.

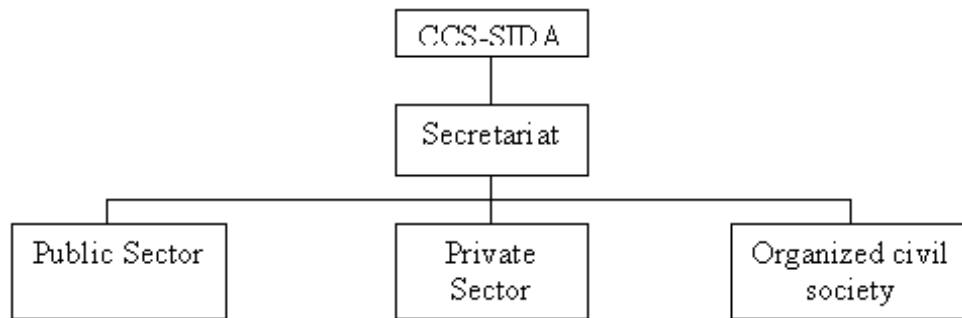
CCS-Sida, according to the mentioned dispatch, is composed by the General Director of Health, General Director of Education, General Director of Youth, General Director of the Social Communication, Director of the National Program to Fight Against AIDS, the President of CCCD, representatives of the youth's organizations, three from the women's organizations, three from the religious institutions, a representative of the Association of Cape Verde Municipalities, one from the international cooperation, government department, one of the sports sector and a representative of the Armed Forces.

A standing secretariat will be the CCS functional support structure in implementing the activities and linking CCS with public entities (at governmental and municipal levels) private entities and the organized civil society. Individuals whose profile and competence will be previously defined. The secretariat is also responsible for the management of the mobilized financial resources. It should have a unit of permanent administrative and financial management (AU) responsible for administration and management of all possible financial resources. Each stakeholder can also mobilize its own resources, especially to its traditional partners, for the financing of its plan. It will previously inform the secretariat that should pronounce on the compatibility of the action.

Each Ministry will implement its HIV/AIDS action plan, will inform CCS-SIDA regularly and will have its focal point.

In all the extent of its competences area the Ministry of Health will assure technical support and define the protocols related to seropositive and patient integrated cares, syndromic approach of other STI, transfusional safety, epidemiological surveillance, STI prevention, vertical transmission prevention and research.

CCS-SIDA decentralized body in each municipality will be an AIDS Municipal Committee, which composition will be soon defined. This Committee will assure the coordination among the activities led by the several actors in the municipality including NGO and CBO.



### 3.3 Guiding principles

The political engagement at the highest level is fundamental for decision-making and its effective application.

The fight against AIDS is a multi-dimensional subject that demands a multi-sector approach.

The development of partnerships for the mobilization of resources and sharing of responsibilities strengthens the synergies.

The decentralization (municipal, local and community) of activities and resources coordinating bodies, (human, material and financial) at all levels is fundamental to reach the envisaged results.

The intra-sectorial coordination and articulation at MHES level becomes a factor of strengthening the response capacity of health sector in general and PNLs in particular.

The involvement and the effective participation of the civil society and NGO should be extended and strengthened.

The involvement of people living with HIV/AIDS will be guaranteed, in order to raise society awareness for the existence of the problem in Cape Verde.

The promotion and the respect of HIV/AIDS infected and affected people's rights are all citizens' duty and shall be established by law.

The involvement of the entrepreneurial sector (public and private) is important to assure workers' social security as well as for the development of national partnerships in order to have a better answer, particularly in prevention area.

The support of international cooperation in the fight against AIDS is indispensable due to the high costs that the country, alone, cannot support.

The institutional strengthening and human resources development are fundamental for a better management capacity and activities implementation.

Assuring specific cares to people living with HIV/AIDS with a view to the improvement of their life quality.

The strong mobilization and education power of religious, community and union leaders and others should be taken in advantage for the adoption of responsible behaviours.

The development of a national strategy for communication that takes into account the combination of mass and inter-personnel communication as well as the needs and expectations of the different target groups for a better understanding of the messages.

It will be promoted the civil society solidarity around the problem of HIV/AIDS infection, for the seek of orphans, patients, infected, through the establishment of associations, clubs, groups, etc.

### 3.4 Intervention areas

In order to face HIV/AIDS epidemic in Cape Verde, for the period 2002-2006, interventions should be focused in the following areas, taking into account the identified problems.

#### **3.4.1 Epidemiological and behavioural surveillance**

##### **Identified Problems**

- National real situation on the prevalence of HIV infection, at national level unknown;
- Infection spread and distribution unknown;
- The information/detection of cases and death system is not organized;
- Inadequate monitoring of behaviour evolution face to HIV/AIDS;

#### **3.4.2. Sexually Transmitted Infections**

##### **Identified Problems:**

- Available data indicate a high prevalence;
- Infections ignored by part of the population;
- Women don't know STI symptoms;
- Self-medication;
- Medicines sold in the streets and other non-authorized places;
- Lack of confidentiality;
- STI integrated cares not organized (syndromic approach);
- Policy absence, availability and access to STI medicines are insufficient.

#### **3.4.3 Persistent risk sexual behaviours**

##### **Identified problems:**

- No correspondence between knowledge and practice;
- Inadequacy of IEC strategies;

- Absence of social marketing promoting the use of condom;
- Inadequacy in using interpersonal communication;
- Non continuous information action.

#### **3.4.4. Psychosocial and medical integrated cares**

##### **Identified problems:**

- Absence of an integrated cares policy;
- Absence of an integrated cares protocol and inadequate diagnosis conditions and treatment for all opportunistic infections in PLWHA;
- Absence of anti-retroviral, inadequacy of the laboratories and clinical services to follow-up the treatment with ARV;
- Deficient reference and counter reference system;
- Psychosocial support services limited to Praia and S. Vicente due to personnel's lack of trained staff;
- Existence of only one free anonymous voluntary centre for counselling and testing, which is not well known.

#### **3.4.5 Vulnerable groups**

##### **Identified problems:**

- Young people, particularly in the urban areas;
- Prostitute (men or women) and sexually promiscuous people;
- Population with a social, economic and school low level, particularly women;
- People in permanent mobility;
- Children of and in the street;
- Alcohol and drug consumers;
- Prisoners;
- Health workers and traditional attendants.

#### **3.4.6 Management/Coordination/Institutional Aspects**

##### **Identified problems:**

- ⌘ PNLs director overloaded with work; lack of logistics and human resources;
- Inadequate structure and bodies, centred in Ministry of Health;
- Ineffective management capacity and inadequate coordination mechanisms;
- Inadequate decentralization of the activities and resources;
- Inefficacy of national multi-sector structure;
- Absence of municipal multi-sector structures;
- Institutional framework between PNLs and CNDS not defined;

- Frequent leadership changes;
- Different project management procedures financed by bilateral and multilateral cooperation;
- Inadequate follow-up and evaluation.

### **3.4.7 Operational research**

#### **Identified problems:**

- Weak research capacity.
- The epidemic impact at all levels is not known.
- Importance is not attached to some factors concerning HIV transmission like beauty and aesthetics practices (tattoo, piercing, manicure/pedicure, shaving, etc.).
- The underlying reasons for the weak use of condoms are not known.

### **3.4.8 Human resources**

#### **Identified problems:**

- Deficit of qualified personnel, at central and decentralized level
- Lack of personnel's motivation;
- Difficult work conditions;
- Absence of a continuous training policy.

### **3.4.9 Other HIV transmission ways (that not the sexual one)**

#### **3.4.9.1 Vertical transmission**

##### **Identified problems:**

- Absence of specific measures to prevent vertical transmission.

#### **3.4.9.2 Blood transmission**

##### **Identified problems:**

- Absence of a transfusion safety policy, although, in practice, safe rules are assured during transfusions;
- Lack of updating and application of asepsis rules;
- Signs of increase of intravenous drugs abuse;
- Non-safe aesthetic beauty practices.

### **3.4.10. Rights of the infected and affected by HIV/AIDS**

#### **Identified problems:**

- Stigmatising of PLWHA
- Weak awareness of the decisors and the community, in general, to PLWHA/AIDS;
- Absence of brainstorming on ethical and legal subjects related to HIV/AIDS;

- Absence of specific legislation to safeguard the right to the non discrimination and privacy of infected and affected people;

### **3.4.11. Priority areas**

Of all these intervention areas, the following are priority ones:

- Sexually transmitted infections;
- Vertical transmission;
- Psycho-social, medical and integrated cares of PLWHA;
- Vulnerable groups.

## **4. OBJECTIVES AND STRATEGIES**

PENLS general objectives are the reduction of the HIV infection prevalence, the improvement of life quality for HIV/AIDS infected and affected people and a better knowledge of the epidemic, its dynamics and impacts.

These general objectives will be reached through the accomplishment of the ten specific objectives below designed:

### **4.1 Objective 1: Assuring the HIV infection epidemiological surveillance, associated to the behavioural surveillance**

#### ***Strategies:***

- Carrying out national seroprevalence and socio-behavioural surveys on HIV infections;
- Relaunching, increase and sustainability of sentinel posts;
- Setting up and adjusting of a database at national level;
- Popularising the information in a regular basis;

#### **Process indicators**

- 2 seroprevalence and behavioural surveys (one in 2002 and another in 2006) carried out;
- Up to 2002, 6 sentinel posts implemented;
- Up to 2003, functional database implemented.

#### **Result indicators**

- Up to 2004, existence of reliable and published epidemiological data
- **Key-stakeholders** PNLs; Epidemiology services; PNSR; Laboratories and NIE

### **4.2 Objective 2: Reducing STI prevalence (that not HIV/AIDS)**

#### ***Strategies:***

- Information, awareness and education targeted to the population (IEC-STI/HIV/AIDS);
- Promoting condom's use; (see Objective 3)

- Organizing STI integrated cares and facilitating the access to medication.

#### **Process indicators**

- Up to 2003 all public and private bodies, NGOs and CBOs will have qualified staff in IEC-STI/HIV/AIDS and will be developing related activities;
- Up to 2003, health and social centers, NGOs and CBOs will be delivering condoms.
- Up to 2006, 100% of health structures will be applying the syndromic approach in STI treatment;

#### **Result indicators**

- STI prevalence reduced of 50%, with reference to the year base, up to the end of the PENLS period.

**Key stakeholders:** PNLs, PNSR, other services and Ministries, NGOs, CBOs and civil society

### **4.3 Objective 3: Promoting the adoption of safer sexual behaviors**

#### ***Strategies:***

- Development of a national IEC-STI/HIV/AIDS strategy;
- Promotion of condom's acceptance and use;
- Strengthening the intervention at formal education level in STI/HIV/AIDS area;
- Updating the services affected to Reproductive Health to the promotion and popularisation of safer behaviours on STI/HIV/AIDS.

#### **Process indicators**

- Up to 2003, all ministries have IEC-STI/HIV/AIDS qualified personnel;
  - Up to 2004, all primary, secondary, public and private schools apply revised curricula that integrate STI/HIV/AIDS;
  - Up to 2003, all ministries, public services, NGOs and CBOs implement IEC-STI/HIV/AIDS plans;
- Up to 2004, IEC national strategy document applied;
- Up to 2003, condom' social marketing defined and applied;
- Up to 2003, all services affected to Reproductive Health disseminate safer behaviours.

#### **Result indicators**

- In 2006, the medium age of the first sexual intercourse as for boys as well for girls in relation to PENLS year base, increased in one year;
- Men and women's proportion, between 15 and 49, that affirm to have used condom in their last sexual intercourse with a non-regular partner, increased, at least, from 28,5% (IDSR) to 45%;

- Percentage of sexually active people with non-regular partners during the last 12 months reduced from 44% (IDSR) to 30%.

**Key stakeholders:** All Ministries, NGOs, CBOs and civil society

#### **4.4 Objective 4: Assuring psychosocial and medical integrated cares to PLWHA**

***Strategies:***

- Definition and implementation of a national integrated cares policy;
- Development of partnerships (national and international) and mechanisms for the introduction of anti-retroviral (adhesion to the Initiative of access to ARV, customs exemption, among others);
- Improving and extending the psychosocial and medical follow-up to people living with HIV/AIDS/ (PLWHA);
- Involvement of the family, community and civil society in PLWHA integrated cares;
- Extending and popularising anonymous and voluntary HIV testing counselling centers;

**Process indicators:**

- Up to 2003 psychosocial and medical integrated cares policy, defined and applied;
- Up to 2004 at least 50% of NGO and CBO related to the fight against AIDS support HIV infected and affected;
- Up to 2004 and 2006, 60% and 100% respectively of all municipalities provide counselling and voluntary test services;
- Up to 2004, at least an association to support PLWHA, set up and operating;
- Up to 2006, the adhesion to the "Initiative to have Access to ARV", established.

**Result indicators:**

- Up to 2006, 80% of PLWHA have medical and psychosocial follow-up;

**Key stakeholders;** MHES, other Ministries of social character, NGOs, PLWHA Association, Municipalities, public and private companies.

#### **4.5 Objective 5: Reducing the vulnerability of the groups identified as vulnerable**

***Strategies:***

- Integration of the fight against HIV/AIDS in the National Program to fight against Poverty;
- IEC directed to the identified groups;
- Adaptation of adult education and vocational training curricula;
- Plea, to the institutions, parents and society in general, for the application and enforcement of the law that regulates the consumption of alcohol and the permanence of minors in the establishments selling alcoholic drinks;

- Improvement of the social and economic conditions for girls and women.
- Creation of leisure spaces and programs for youths.

**Process indicators:**

- Up to 2003, the component HIV/AIDS integrated in PNLP;
- Up to 2004, all Ministries have IEC-STI/HIV/AIDS qualified personnel and apply the respective IEC plans;
- Up to 2004, all primary, secondary, public and private schools apply school programs that integrate STI/HIV/AIDS;
  - Up to 2004, 50% of IEC-STI/HIV/AIDS strategies for specific groups implemented;
  - Up to 2006, the Law that regulates the sale of alcoholic drinks to minors as well as their permanence in night entertainment places, generally enforced in 70%.

**Result indicators:**

- Vulnerability of the identified groups reduced: girls and women unemployment rate reduced, young people taking more advantage of their free time and vocational training, cultural constraints settled.

**Key stakeholders:** Program to Fight against Poverty (PNLP), all Ministries, NGOs, CBOs, private sector and civil society

**4.6 Objective 6: Improving the institutional capacity**

**Strategies:**

- Establishment of national management and coordination teams;
- Strengthening of Ministry of Health PNLs;
- Establishment of partners' coordination mechanisms (national, bilateral and multilateral);
- Human, material and financial resources available at central and decentralized level.

**Process indicators:**

- Up to 2002, CCS-SIDA operating;
- Up to 2003, municipalities have operating management and coordination teams;
- Up to 2002, the proposed PNLs organic framework implemented

**Result indicators:**

The fight against HIV/AIDS better managed, in order to produce the expected results, integrated in a systematic way in the regular operation plans of all concerned institutions.

**Key stakeholders:** Government, Municipalities.

**4.7 Objective 7: Developing the Research**

**Strategies:** Carrying out researches in the identified areas as lacking of knowledge (STI/HIV/AIDS at all levels, weight of some transmission ways, factors that inhibit the use of condoms, impact of the interventions and others).

**Process indicators:**

- Up to 2004, carried out a research on each identified domain;

**Result indicators**

- Up to 2006, research results available.

**Key stakeholders:** MHES, NEI, Education, Youth, national and international partners

**4.8 Objective 8: Strengthening the capacity of the different personnel's categories**

**Strategies:**

- Development and implementation of training.

**Process indicators:**

- Up to 2004, training policy implemented at all levels

**Results indicators:**

Up to 2006, trained, available and operational personnel

**Key stakeholders:** CCS-SIDA, MHES, national and international partners

**4.9 Objective 9: Reducing HIV transmission by other ways (that not the sexual one)**

**Objective 9.1- Reducing vertical transmission**

*Strategy: Adaptation of health centers for counselling, voluntary (and anonymous) HIV testing in the pregnant women, their follow-up and treatment with Anti-retroviral.*

**Process indicators**

- Up to 2003, health centers adapted and providing counselling and voluntary (and anonymous) HIV testing in pregnant women;
- Up to 2004 and 2006, 50% and 100% respectively of all seropositive pregnant receive prevention treatment against mother-to-child transmission.

**Result indicators**

- In 2006, HIV vertical transmission reduced between 50% and 70%, relating to the year base.

**Key stakeholders:** MHES, national and international partners

**Objective 9.2- Reducing blood transmission:**

**Strategies:**

- Maintenance of transfusion safety;
- Warranty of applying the asepsis rules;

- IEC-STI/HIV/AIDS directed to the professionals of beauty saloons, barber's shop, etc.;
- IEC-STI/HIV/AIDS directed to drug users.

#### **Process indicators**

- Up to 2002, transfusion safety policy document, approved;
- Up to 2002, supply sustainability mechanisms of ELISA laboratories in reagents and consumable, established and implemented;
- Up to 2002, all health services implement the asepsis rules;
- Up to 2004, IEC-STI/HIV/AIDS programs directed to drug users and professionals of beauty and aesthetics saloons, implemented.

#### **Result indicators**

- Keep the transmission level by blood transfusion in 0%;
- Up to 2006, reduce by 30%, in relation to the first PENLS year, the percentage of infections in injected drug users and iatrogenics reduced.

**Key stakeholders:** MHES, CCCD, and private sector

#### **Objective 4.10 Assuring the protection of people infected and affected by HIV/AIDS.**

##### ***Strategies:***

- Dissemination of the texts that assure the citizens' fundamental rights;
- Setting up an effective legal support mechanism to the infected people and/or their relatives;
- Development and dissemination of specific legislation, encompassing all the situations of the several branches of law that deal with HIV/AIDS.

#### **Process indicators**

- Up to 2003, texts that assure protection of the citizens' fundamental rights, published;
- Up to 2004, effective legal aid provided to people infected and affected by HIV/AIDS;
- Up to 2004, existence of an ethical and legal support net on HIV/AIDS;
- Up to 2004, specific legislation on HIV/AIDS, developed and published.

#### **Result indicators**

- Up to 2006, specific legislation on HIV/AIDS approved and implemented.

**Key stakeholders:** CCS-SIDA Ministry of Health, Ministry of Justice, Courts, national partners working in popularisation, Association of lawyers and Human Rights

## **5. IMPLEMENTATION OF 2002-2006 THE NATIONAL STRATEGIC PLAN**

## 5.1 Modalities / Process

The National Strategic Plan serves as guiding framework for all the interventions concerning the fight against HIV/AIDS.

PENLS is based on the principle of multi-sector and integrated participation leaving space to public and private initiatives, under the coordination, at the highest level, of the Coordination Committee to Combat AIDS (CCS-SIDA), headed by the Prime Minister. The guidelines contained in it aim defined goals that will contribute to change the situation, namely in reducing the vulnerability of the populations to HIV/AIDS and its impact.

PENLS envisages the promotion of activities focused on the individual, on the family and on the community, with the involvement of CBOs and NGOs, municipal and governmental bodies, formulating them in an harmonized way and extending them based on their relationship with the problem to face.

As a Strategic Plan, it contains guidelines for the development and implementation of the Reference Action Plan and sector actions plans of several intervention areas identified as priority at the level of all ministries, public services, national NGOs and CBOs, Municipalities, public and private managerial sector.

## 5.2 Financing 2002/2006 Strategic Plan

The activities from this PENLS can be financed by:

- State Regular Budget;
- Multilateral cooperation;
- Bilateral cooperation;
- International institutions;
- National Private sectors

World Bank provides a fund from IDA Credit, the remaining being financed by other partners.

## 5.3 Mobilization and resources management

CCS-Sida, through its secretariat, is responsible for the management of the financial resources mobilized, through an Operations Manual designed for the effect.

The Secretariat should have a permanent administrative and financial management unit responsible for administration and management of all possible financial resources. Each stakeholder can, also, in accordance with the secretariat, mobilize its own resources, mainly to its traditional partners, for the financing of its action plan.

## 5.4 Follow-up and evaluation

The progresses accomplished in PENLS implementation are measured through the classic methods, namely meetings, periodic reports of all the programs and its internal and external evaluation.

Having in view an effective reprogramming, an internal evaluation should be carried out at all levels and a midterm external evaluation and at the end of PENLS period.

The quarterly meetings established by CCS-Sida also allow the follow-up of the planned interventions. CCS-Sida should receive and integrate the reports of all stakeholders in the fight against HIV/AIDS with the view to popularise the situation at all levels and to all partners.

The coordination meetings of the municipal committees also allow the follow-up of the activities at local level.

## **ABBREVIATIONS**

ADF - Forum de Desenvolvimento de África

ARV - Anti-Retroviral

CACP - Conhecimentos, Atitudes, Crenças e Práticas.

CCCD - Comité de Coordenação do Combate à Droga

CCS-SIDA - Comité de Coordenação do Combate à Sida

CNDS - Centro Nacional de Desenvolvimento Sanitário

CPLP - Comunidade dos Países de Língua Portuguesa

EU - União Europeia

FAO - Fundo das Nações Unidas para a Alimentação e a Agricultura

FNUAP - Fundo das Nações Unidas para a População

GEP - Gabinete de Estudos e Planeamento

IDSR - Inquérito Demográfico e de Saúde Reprodutiva

IEC - Informação, Educação, Comunicação

IPPF - Federação Internacional para o Planeamento Familiar

IST - Infecções Sexualmente Transmissíveis

MSES - Ministério da Saúde, Emprego e Solidariedade

OBC - Organização de Base Comunitária

OMS - Organização Mundial da Saúde

ONG - Organização Não-Governamental

ONUSIDA - Programa comum das Nações Unidas sobre a Sida

PAM - Programa Alimentar Mundial

PENLS - Plano Estratégico Nacional de Luta contra a Sida

PIB - Produto Interno Bruto

PIT - Programa de Infra-estruturas e Transportes

PMI-PF - Programa Materno-Infantil e Planeamento Familiar

PMT - Plano a Médio Termo

PNLS - Programa Nacional de Luta contra a Sida

PNSR - Programa Nacional de Saúde Reprodutiva

PNUD - Programa das Nações Unidas para o Desenvolvimento

PVVIH - Pessoas vivendo com o Vírus da Imunodeficiência Humana

Sida - Síndrome da Imunodeficiência Adquirida

UNESCO - Organização das Nações Unidas para a Educação e Cultura

UNICEF - Fundo das Nações Unidas para a Infância

VIH - Vírus da Imunodeficiência Humana

## **GLOSSARY**

- *Abordagem sindrómica*: procedimento para tratamento das doenças sexualmente transmissíveis de acordo com os sintomas apresentados pelo paciente.
- *Aconselhamento*: comunicação face a face na qual uma pessoa auxilia a outra a tomar decisões e a colocá-las em prática.
- *Anti-corpos*: células e substâncias libertadas pelo sistema de defesa do organismo em presença de infecção;
- *Anti-retrovirais*: medicamento contra o VIH. Não cura a Sida, mas melhora e prolonga um pouco mais a vida das PVVIH;
- *Assepsia*: são procedimentos para evitar a infecção.
- *Candidíase oral*: infecção que afecta a boca e a garganta, provocada por um fungo, cobrindo-as com manchas esbranquiçadas parecidas ao algodão;
- *Doença crónica*: doença de longa duração;
- *Economia de serviços*: referente e serviços não produtivos prestados.
- *Elisa*: exame de laboratório mais utilizado para se saber se uma pessoa está infectada com o VIH. Nome também dado aos laboratórios que realizam este teste;
- *Epidemia*: propagação rápida de uma doença numa comunidade ou numa região;
- *Epidemiologia*: estudo das epidemias.
- *Iatrogénica*: dano físico ou psicológico provocado a um paciente, pela acção médica.

- *Incidência*: número de casos novos (numa determinada população e num determinado período de tempo);
- *Infecção de transmissão sexual*: qualquer infecção que se contrai através das relações sexuais, por exemplo, Gonorreia (esquentamento), Sífilis e Sida;
- *Infecção herpética*: infecção provocada pelo vírus do Herpes;
- *Infecção oportunista*: infecção que aproveita um momento de fraqueza do organismo para se revelar, causando doença.
- *Intervenientes-chave*: instituições mais importantes na realização de determinadas tarefas;
- *Migração*: movimentação da população de um local para outro, provisória ou permanente, quer seja no interior do país, quer seja para o exterior.
- *Mobilidade*: frequente deslocação de um indivíduo por motivo laboral ou de mudança de residência;
- *Morbilidade*: estado de doença;
- *Notificação*: comunicação obrigatória à autoridade sanitária, de casos e óbitos devidos às doenças transmissíveis ou doenças importantes do ponto de vista de saúde pública.
- *Pneumopatias*: doenças que atacam os pulmões;
- *Práticas de beleza e estética*: práticas de barbeiro e cabeleireira, manicure e pedicure, perfuração das orelhas e outras partes do corpo (piercing), tatuagem, etc;
- *Prevalência*: número total de casos, novos e antigos (numa determinada população e num determinado período de tempo);
- *Seropositivo*: alguém em cujo sangue se detectaram anti-corpos contra o VIH, não tendo, ainda, desenvolvido sintomas da Sida;
- *Sida*: conjunto de doenças que aparecem depois do VIH ter enfraquecido as defesas do organismo;
- *Síndrome*: o mesmo que Síndrome, conjunto de sinais e sintomas que, de um modo frequente, se apresentam associados de igual forma, mas que podem corresponder a causas diferentes;
- *Sistema de referência e contra referência*: sistema pelo qual se encaminha um doente de uma estrutura sanitária a outra, com melhores condições de diagnóstico e tratamento, se esta o referenciar; sistema pelo qual o doente é enviado de volta ao serviço de origem, se este o contra referenciar.
- *Taxa de actividade*: relação entre a população activa e a população total do país.

- *Taxa de incidência*: frequência de aparecimento de novos casos (numa população dada e num período de tempo determinado).
- *Taxa de prevalência*: frequência de aparecimento de casos novos e velhos (numa população dada e num período de tempo determinado).
- *Teste anónimo (não identificado)*: teste feito sem a pessoa que o realiza conhecer a identificação do indivíduo cujo sangue está sendo analisado.
- *Transfusionista*: técnico responsável pela transfusão do sangue e seus derivados.
- *Transmissão vertical*: transmissão do VIH de mãe para o filho, durante a gravidez, o parto ou a amamentação;
- *Tuberculose pulmonar*: doença pulmonar muito contagiosa provocada pelo micróbio de nome Mycobacterium Tuberculosis;
- *VIH*: Vírus da Imuno-deficiência Humana, o vírus que provoca a Sida;

## **ANEXOS**

### **Technical Team for the elaboration of the 2002-2006 National Strategic Plan Against AIDS**

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Teresa Paula Barros - Membro da Associação "Alcides Barros" para a defesa dos Direitos Humanos.

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- For this document collaborated, still, the Minister of the Health, Employment and Solidarity, Dario Laval Dantas dos Reis.

- The General Director of Health, Conceição Carvalho.

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### Consulted bibliography

1. Análise da Situação da Infecção VIH/SIDA em Cabo Verde. BRITO, Carlos. 1996.
2. Avaliação externa do plano a médio termo, 1991-1993, MSES.
3. Boletim Epidemiológico. Serviço de Epidemiologia, Direcção Geral da Saúde. 2000.
4. Boletins Oficiais da República de Cabo Verde, do pós Independência.
5. Diagnóstico Sectorial da Saúde. GEP - MSES. 2001.
6. Human Rights and HIV/AIDS - Effective Community Responses. Human Rights Internet. 1998.
7. Guide pour le processus de planification stratégique de la réponse nationale contre le VIH/SIDA;1998, Collection meilleures pratiques de l' ONUSIDA- Outils fondamentaux.
8. Inquérito ao Sector Informal da Economia. IEFP. 1997.
9. Inquérito às forças de trabalho. IEFP. 1996.
10. Inquérito Demográfico e de Saúde Reprodutiva. 1998.
11. Legislação Cabo-Verdiana. Ministério da Justiça, Cabo Verde.
12. Legislação sobre DST & AIDS no Brasil. Edição Ministério da Saúde do Brasil. 1995.
13. Manual do Delegado da Saúde, Direcção Geral da Saúde.
14. Planos estratégicos nacionais de luta contra a Sida de Madagáscar, Mali, Portugal, Senegal e Uganda.

15. Programa Nacional de Luta contra a Droga; 1998, Ministério da Justiça e Administração Interna.
16. Programa Nacional de Luta Contra a Pobreza. Governo de Cabo Verde. 1998
17. Programa Nacional de Luta contra a Sida, Plano a Médio Termo, 1990-1992 e 1994-1998, MSES.
18. Recenseamento Geral da População e Habitação (resultados preliminares) INE. 2000.
19. Reformas Penais em Cabo Verde, Vol. I - Um Novo Código Penal para Cabo Verde. FONSECA, Jorge C. Praia - Cabo Verde. 2001.
20. Relatório Nacional de Desenvolvimento Humano em Cabo Verde. PNUD. 1999.
21. Relatórios anuais do PNLS.
22. Relatórios anuais de mortalidade, GEP, MSES.

<sup>1</sup>Annual Epidemic Bulletin of VIH/AIDS, PNLS, Ministry of the Health.