

**FOLLOW-UP TO THE
DECLARATION OF COMMITMENT
ON HIV/AIDS (UNGASS)**

COUNTRY REPORT FORMAT

Reporting period: January-December 2002

PREAMBLE

The proposed generic reporting format is meant to assist National AIDS Councils (or equivalent) in drafting their national report to be submitted to the UN General Assembly on biennial basis as a follow-up to the Declaration of Commitment (DoC) signed in June 2001 at the UNGASS on HIV/AIDS

Countries should carefully review the *Guidelines on construction of core indicators – Monitoring the Declaration of Commitment on HIV/AIDS* (named hereinafter Guidelines) before embarking in any data collection exercise. As explained in the Guidelines, a total of 13 core indicators divided into three categories are supposed to be collected/reported on at national level to monitor the DoC on HIV/AIDS:

Category 1: Two indicators on national commitment and action

Category 2: Nine indicators on national programmes and behaviour trends

Category 3: Two indicators on impact.

The Guidelines provide countries with technical guidance on the definition of the core indicators, the measurement tools required for their construction and frequency of data collection. It is essential that countries follow those Guidelines to ensure quality of the reported information. Countries are also encouraged to report on additional nationally representative coverage indicators since this report will be used as baseline to monitor progress over time. While selecting data to be reported on, it is recommended to avoid anecdotal information.

For **2003** General Assembly Session, reporting is required for all three categories of indicators. In view of time constraints, the following is recommended to all countries:

Category 1: Collect information through desk reviews and survey on financial resource flows

Category 2: Compile existing data from (1) recent surveys such as DHS or MICS for those indicators requiring population-based information; (2) health facility, school-based, or workplace surveys for the other indicators. Countries are also encouraged to consult the following indicator database that contains data on some core indicators collected through household surveys: www.measuredhs.com/data.

Category 3: For HIV prevalence among young people, compile data from HIV sentinel surveillance (for countries with generalized epidemics) and recent specific surveys (for countries with concentrated or low epidemics). For HIV prevalence among infants, calculation of estimates needs to be done using programme coverage data.

2003 General Assembly Session
Target dates

End of data collection: 10 March 2003
Reporting to Geneva: 31 March 2003.

For 2004 General Assembly Session, no reporting on national indicators is required.

For 2005 General Assembly Session, reporting is required for all three categories of indicators. This means that countries that have not yet planned any surveys for collecting information on the second category of indicators need to do so as soon as possible and latest early 2003.

2005 General Assembly Session
Target dates

End of data collection: 30 September 2004
Reporting to Geneva: 28 February 2005

A total of four annexes should be attached to the national report: (1) the consultation/preparation process for the national report on monitoring the follow-up to the Declaration of Commitment on HIV/AIDS form; (2) the National Composite Policy Index Questionnaire; (3) the nine forms related to the National Programme and Behaviour Indicators; (4) the country M&E sheet.

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ANNEXES

ANNEX 1: Consultation/preparation process for the national report on monitoring the follow-up to the Declaration of Commitment on HIV/AIDS

ANNEX 2: National Composite Policy Index Questionnaire

ANNEX 3: Country M&E sheet

I. STATUS AT A GLANCE

NATIONAL COMMITMENT & ACTION

1. National Composite Policy Index - 53% (PASCA,2000)
2. Government funds spent on HIV/AIDS – \$8,000,000.00

NATIONAL PROGRAMME & BEHAVIOUR

Prevention

3. 7% of schools with teachers who have been trained in life-skills-based education and who taught it during the last academic year
4. % large enterprises/companies that have HIV/AIDS workplace policies and programmes – *Not Available*
5. 10% of HIV+ pregnant women receiving a complete course of ARV prophylaxis to reduce the risk of MTCT

Care/Treatment

6. % of patients with sexually transmitted infections at health care facilities who are appropriately diagnosed, treated and counselled
Not Available
7. 46% of people with advanced HIV infection receiving ARV combination (estimated)

Knowledge/Behaviour

8. %of respondents 15-24 years of age who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission or prevention
(Target: 90% by 2005; 95% by 2010) - Not Available
9. % of people aged 15-24 reporting the use of a condom during sexual intercourse with a non-regular sexual partner – *Not Available*
10. % of injecting drug users who have adopted behaviours that reduce transmission of HIV (*where applicable*) – *Not Applicable*

Impact alleviation

11. Ratio of orphaned to non-orphaned children 10-14 years of age who are currently attending school – *Not Available*

IMPACT

12. 0.5% young people aged 15-24 years of age who are HIV infected
(Target: 25% in most affected countries by 2005; 25% reduction globally by 2010)
13. 30% of infants born to HIV infected mothers who are infected
(Target: 20% reduction by 2005; 50% reduction by 2010)

II. Overview of the HIV/AIDS epidemic

HIV prevalence at a glance

0.5% young people 15-24 years of age who are HIV infected
30% of infants born to HIV infected mothers who are infected

Indicate Source: Proyecto Accion SIDA de Centro America (PASCA), Guatemala: Estimaciones y Proyecciones de la Epidemia de SIDA 1980-2010

The HIV/AIDS epidemic in Guatemala is still in concentrated phase, with prevalence rates of lower than 1% in pregnant women and higher than 5% in highly vulnerable population groups (CSW and MSM) in which 40% of all HIV/AIDS cases in the country are concentrated. Efforts are under way to strengthen the national epidemiological surveillance system with surveys conducted with high risk groups at various Health Districts (CSW, uniformed services, pregnant women and migrants).

The first systematic effort to reduce MTCT was initiated at Roosevelt National Hospital with assistance from UNICEF, the European Union and NAP. However, of the total of 400,000 annual births only 100,000 are attended by the public health system, posing a major challenge for effectively reducing MTCT in the country.

Ministry of Education has initiated training of future teachers and preparation of curriculum for HIV/AIDS prevention with children and adolescents at national schools across the country.

III. National response to the HIV/AIDS epidemic

1. National commitment and action

National commitment at a glance

National Composite Policy Index – 53% (2000)
Government funds spent on HIV/AIDS -
\$8,000,000.00

Indicate Source: PASCA; NAP

National authorities have demonstrated growing commitment by increasing allocation of financial resources to HIV/AIDS. New funds in 2002 include a \$62,500.00 emergency fund authorized by the Presidency for purchase of ARV medicines, and \$625,000.00 annual budget for Ministry of Education HIV/AIDS Commission for teacher training and sexual health education curriculum development. As for political commitment, Guatemala was elected focal point for Central America in the Horizontal Technical Co-operation Group and elected a member of UNAIDS Programme Co-ordinating Board.

At country level, Bylaws for the HIV/AIDS Law were approved, and a review of the National Strategic Plan 1999-2003 and preparation of National Operative Plan for 2003 were completed with participation of all relevant national stakeholders, including PWA associations. A highly representative, multisectoral Country Coordinating Mechanism (CCM) was created in February 2002 by Ministry of Health, and the Minister of Health was elected as President of CCM for its first term.

2. National programmes and behaviour

National programmes at a glance
<p>Prevention 7% of schools with teachers who have been trained in life-skills-based education and who taught it during the last academic year (urban high schools) % large enterprises/companies that have HIV/AIDS workplace policies and programmes – <i>Not Available</i> 10% of HIV+ pregnant women receiving a complete course of ARV prophylaxis to reduce the risk of MTCT</p>
<p>Care/Treatment % of patients with sexually transmitted infections at health care facilities who are appropriately diagnosed, treated and counselled – <i>Not Available</i> 46% (estimate) of people with advanced HIV infection receiving ARV combination therapy</p>
<p><i>Indicate Source: Ministry of Education; PASCA, Guatemala: Estimaciones y Proyecciones de la Epidemia de SIDA 1980-2010</i></p>

2002 was marked by intense efforts to increase access to ARV treatment, which resulted in an allocation of an emergency fund of \$62,500.00 by the Office of the President. Consequently, a multisectoral commission was created to study the best options for purchase of ARV medicines, with NGOs playing an important role in assisting the national authorities in the process. As a result, 40 new patients initiated their ARV treatment at Roosevelt National Hospital HIV/AIDS Clinic. (The estimation of 46% of AIDS patients with access to ARV treatment was calculated using the number of new AIDS cases minus AIDS deaths by end of 2002, versus number of AIDS patients in ARV treatment end of 2002.)

In prevention, Ministry of Education HIV/AIDS Commission trained future teachers who replicated the training through peer-to-peer education in their own high schools, covering 7% of all urban high schools. Access to condoms was significantly improved with the donation of 6,000,000 condoms by UNFPA (availability up from 1,2 million condoms in 2001), distributed through departmental Health Districts. This measure, together with new sexual health education curriculum at schools, is expected to produce favourable behaviour changes resulting in reduction of prevalence in years to come. In NGO sector, an important decentralization of actions to the interior of the country was produced at the high prevalence south-western coastal region where a network of 20 both governmental and non-governmental organizations was created to coordinate prevention efforts and improve access to care. In terms of workplace HIV/AIDS policies, only one NGO (Fundacion Preventiva del SIDA) works with

mid-size and large companies to sensitize workers. McDonald's and Central Distribuidora, the largest bottling company in the country, have established HIV/AIDS workplace policies with the assistance of the NGO.

National behaviours at a glance

% of respondents 15-24 years of age who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission or prevention – *Not Available*
% of people aged 15-24 reporting the use of a condom during sexual intercourse with a non-regular sexual partner – *Not Available*
% of injecting drug users who have adopted behaviours that reduce transmission of HIV (*where applicable*) – *Not Applicable*

Indicate Source

Recent qualitative studies by Pan-American Social Marketing Organization (PASMO) among young adults demonstrate that 16-20 years olds in urban sites are aware of HIV/AIDS and ways of transmission, but have low perception of risk of infection and very low level of use of condom with regular partners. Higher level of use of condom with CSW's is reported among adolescent boys. In rural, indigenous maya-indian communities, there is very little knowledge regarding sexuality in general, including sexually transmitted infections, HIV/AIDS and condoms.

Impact alleviation at a glance

Ratio of orphaned to non-orphaned children 10-14 years of age who are currently attending school – *Not Available*

Indicate Source

According to recent estimates (*PASCA, Guatemala: Estimaciones y Proyecciones de la Epidemia de SIDA 1980-2010*)), there were 5,700 orphans in the country due to HIV/AIDS in 2002. No specific strategy has been developed as of yet to address the specific needs of this population group, however, in 2002 Ministry of Health assisted with \$375,000.00 the only private, not-for-profit centre in the country attending this population group. The centre currently houses 24 children between the ages of 0 to 14.

IV. Major challenges faced and actions needed to achieve the goals/targets

Recent cuts in international funding for NGOs and insufficient funding in general at both governmental and civil society level are a major obstacle for achieving better results in prevention and care. Stigma and discrimination continue affecting not only those living with the virus, but also donor mentality. Although strong efforts are needed to work with the most vulnerable population groups, namely CSW and MSM, to contain the epidemic at its current concentrated level and gradually reduce prevalence rates, it is still difficult for NGOs attending these groups to obtain funding for their activities. At national level, a multisectoral prevention strategy needs to be developed based on the status of the epidemic in the country, together with co-ordinated monitoring effort to document its impact and a corresponding budget.

Data collection plan (2005 reporting)	2003	2004	2005
Household surveys			X
Health facility surveys	X		X
School-based surveys	X		X
Workplace surveys			X
Desk review			X

V. Support required from country's development partners

Development partners can play an important advocacy role with high level national authorities (Presidency, Finance sector, Human Rights Ombudsman and others) to increase awareness and commitment for combating HIV/AIDS in the country. Additional support is also needed for observation of implementation of legal framework. More effective resource mobilization and allocation of financial and technical resources for monitoring and evaluation effort is also required.

VI. Monitoring and evaluation environment

NSP includes a monitoring and evaluation component, but at the moment there is no national level monitoring unit dedicated to HIV/AIDS. Extended UN Theme Group on HIV/AIDS has a multisectoral Monitoring and Evaluation Committee, which has assisted NAP in co-ordinating revision of NSP and preparation of National Operative Plan. However, it is in the interest of the country to establish a M&E Unit linked to CCM, and to design a national strategy to monitor activities in order to obtain real data on national HIV/AIDS programmes and their impact on the epidemic. Technical assistance is needed in order to establish the M&E Unit and to design a national M&E strategy.

Additionally, technical assistance and capacity building are needed at Health Districts to train health personnel in implementing the national Norms for Epidemiological Surveillance established in 2002.