# HIV/AIDS POLICY IN Nicaragua

## A Civil Society Perspective

*A series of reports on HIV/AIDS policy in Nicaragua, Senegal, Ukraine, the United States, and Vietnam*

**PUBLIC HEALTH WATCH**

OPEN SOCIETY INSTITUTE
Public Health Program

# HIV/AIDS Policy in Nicaragua

## *A Civil Society Perspective*

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*Front cover (clockwise from left)* Luke Wolagiewicz, WPN: support group for people living with HIV/AIDS, Ukraine; Associated Press: a center caring for abandoned children living with HIV/AIDS, Vietnam; Donna DeCesare: 16-year-old living with HIV, and his mother, Central America.
*Back cover (top to bottom)* Associated Press: lab assistant tests blood for HIV, Senegal; Associated Press: coordinator with ACLU National Prison Project talks with people in the HIV/AIDS Housing Unit at Mississippi State Penitentiary.

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# Preface

In June 2001, at the United Nations General Assembly Special Session on HIV/AIDS (UNGASS), 189 national governments agreed to the Declaration of Commitment on HIV/AIDS (DoC). The document commits governments to improve their responses to their domestic AIDS epidemics and sets targets for AIDS-related financing, policy, and programming.

The DoC also stipulates that governments conduct periodic reviews to assess their progress toward meeting their UNGASS commitments. In recognition of the crucial role that civil society plays in the response to HIV/AIDS, the DoC calls on governments to include members of civil society, particularly people living with HIV/AIDS, in the review process.

Established by the Open Society Institute (OSI) in 2004, Public Health Watch supports the independent monitoring of governmental compliance with the UNGASS DoC and other regional and international commitments on HIV/AIDS. It aims to promote informed civil society engagement in policymaking on HIV/AIDS and tuberculosis (TB)—two closely linked diseases that lead to millions of preventable deaths annually. To this end, Public Health Watch also supports the monitoring of TB and TB/HIV policies by civil society, examining compliance with the Amsterdam Declaration to Stop TB and the World Health Organization's (WHO) Interim Policy on Collaborative TB/HIV Activities.

Public Health Watch's methodology incorporates multiple opportunities for dialogue and exchange among a broad range of policy actors. Researchers convene an advisory group of national HIV/AIDS and TB experts, activists, and policy actors. The researchers prepare draft reports based on input from the advisory group, desktop and field research, interviews, and site visits. They then organize in-country roundtable meetings to invite feedback and critique from policymakers, academics, government officials, representatives of affected communities, and other key stakeholders. Finally, Public Health Watch supports researchers in conducting targeted advocacy at the domestic and international levels in response to report findings and recommendations.

For the HIV/AIDS Monitoring Project, Public Health Watch's civil society partners in Nicaragua, Senegal, Ukraine, the United States, and Vietnam have prepared assessments of national HIV/AIDS policies based on a standardized questionnaire, which facilitates the structured review of governmental compliance with key elements of the UNGASS DoC.

To access the reports of the HIV/AIDS Monitoring Project and to learn more about Public Health Watch, including the TB Monitoring Project and the TB HIV Monitoring and Advocacy Project, please visit www.publichealthwatch.info.

# Acknowledgments

This report on HIV/AIDS policy in Nicaragua was researched and drafted by Miguel Orozco, the executive director of Centro de Investigaciones y Estudios de la Salud de la Universidad Nacional Autónoma de Nicaragua (CIES-UNAN) in Managua, Nicaragua, and Laura G. Pedraza Fariña, a student at the Harvard Law School in Cambridge, Massachusetts. The staff of Public Health Watch provided editing and administrative assistance. OSI's Communications Office provided additional editing and production assistance.

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## Public Health Program

The Open Society Institute's Public Health Program promotes health policies based on social inclusion, human rights, justice, and scientific evidence. The program works with local, national, and international civil society organizations to foster greater civil society engagement in public health policy and practice, to combat the social marginalization and stigma that lead to poor health, and to facilitate access to health information.

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## Open Society Institute

The Open Society Institute works to build vibrant and tolerant democracies whose governments are accountable to their citizens. To achieve its mission, OSI seeks to shape public policies that assure greater fairness in political, legal, and economic systems and safeguard fundamental rights. On a local level, OSI implements a range of initiatives to advance justice, education, public health, and independent media. At the same time, OSI builds alliances across borders and continents on issues such as corruption and freedom of information. OSI places a high priority on protecting and improving the lives of marginalized people and communities.

Investor and philanthropist George Soros in 1993 created OSI as a private operating and grantmaking foundation to support his foundations in Central and Eastern Europe and the former Soviet Union. Those foundations were established, starting in 1984, to help countries make the transition from communism. OSI has expanded the activities of the Soros foundations network to encompass the United States and more than 60 countries in Europe, Asia, Africa, and Latin America. Each Soros foundation relies on the expertise of boards composed of eminent citizens who determine individual agendas based on local priorities.

**www.soros.org**

# Abbreviations

| | |
|---|---|
| AIDS: | Acquired Immune Deficiency Syndrome |
| ARV: | Antiretroviral |
| ART: | Antiretroviral therapy |
| ASONVIHSIDA: | Nicaraguan Association for People Living with HIV/AIDS (Asociación de Nicaragüenses Viviendo con el VIH/SIDA) |
| CCM: | Country Coordinating Mechanism |
| CONCASIDA: | Central American Congress on STD/HIV/AIDS |
| CONISIDA: | Nicaraguan Commission to Fight AIDS |
| DoC: | UNGASS Declaration of Commitment on HIV/AIDS |
| HIV: | Human Immunodeficiency Virus |
| IEC: | Information, Education, and Communication |
| M&E: | Monitoring and Evaluation |
| MDGs: | Millennium Development Goals |
| NGO: | Nongovernmental Organization |
| OIs: | Opportunistic Infections |
| PCT: | National TB Program (Programa de Control de Tuberculosis) |
| RAAN: | North Atlantic Autonomous Region (Región Autónoma del Atlántico Norte) |
| RAAS: | South Atlantic Autonomous Region (Región Autónoma del Atlántico Sur) |
| STIs | Sexually Transmitted Infections |
| TB: | Tuberculosis |
| UNGASS: | United Nations General Assembly Special Session |

# Executive Summary

During the past five years, the HIV/AIDS epidemic has been spreading more rapidly in Nicaragua and is now on its way to creating a public health emergency. The Nicaraguan government initially downplayed the magnitude of the situation, however, demonstrating a significant lack of political commitment and leadership in implementing measures to prevent the spread of the disease and increase access to treatment.

The government agreed to the Declaration of Commitment on HIV/AIDS (DoC) at the 2001 United Nations General Assembly Special Session (UNGASS), but many of the commitments remain unfulfilled. For example, in the drafting of the national HIV/AIDS strategic plan, the government did not consistently seek or take into account input from civil society. It also never constituted a governmental committee for collecting and prosecuting HIV/AIDS-related discrimination cases (comité etico nacional), rendering the existing HIV/AIDS antidiscrimination law largely ineffective. Although the government has taken steps to develop prevention campaigns that target specific vulnerable groups, procure antiretroviral (ARV) drugs, decentralize access to health services, and train health care workers, these efforts have lacked the necessary continuity and depth.

In recent years, the government has started to demonstrate more concern over the spread of HIV/AIDS, for example, by collaborating closely with local and international nongovernmental organizations (NGOs) and by creating a multisectoral agency with the mandate to support HIV/AIDS control. The government of the newly elected president, Daniel Ortega, has likewise shown signs of its willingness to place HIV/AIDS in a more prominent position on the national agenda, as evidenced by the recent publication of the much-awaited 2006–2010 national strategic plan on HIV/AIDS and the national policy for prevention and control of sexually transmitted infections (STIs), HIV, and AIDS. Many of the individuals from civil society organizations who were interviewed for this report underscored the need for additional improvements—such as the development of a legal and regulatory process to address HIV/AIDS-related discrimination cases, increased financial resources, and the full participation of both governmental and nongovernmental entities in developing and implementing HIV/AIDS policies and programs, as had been stipulated in the national strategic plan for the period 1999–2004.

The government's recent shift in attitude is encouraging, but Nicaragua must also take more incisive, comprehensive, and systematic measures. It has not yet recognized the HIV/AIDS epidemic as a national priority. The 2006–2010 national strategic plan does not include a mechanism for monitoring and evaluating the country's progress toward preventing and controlling HIV/AIDS. It also does not include a centralized strategy or implementation guidelines to coordinate the multiple national and international efforts, including

those of civil society organizations. In addition, the government has yet to conduct a comprehensive national HIV-prevalence survey, which would provide reliable data on the extent of the spread of HIV.

The development of integrated treatment, care, and support services is also hindered by the country's centralized health care system and poor infrastructure. Hospitals frequently lack the capacity to properly care for people living with HIV/AIDS. Despite an initiative to decentralize health care in 2004—by providing specialized treatment centers in Managua, León, Chinandega, the South Atlantic Autonomous Region (Región Autónoma del Atlántico Sur, or RAAS), and the North Atlantic Autonomous Region (Región Autónoma del Atlántico Norte, or RAAN)—health care services remain highly concentrated in the urban center of Managua, with serious gaps in coverage in rural areas.

Furthermore, there is an insufficient number of health care professionals trained in HIV/AIDS care. In the public sector, rotation schedules often prevent the successful transmission of knowledge among staff, and training programs lack the necessary depth and sensitivity to have an impact on health care workers' attitudes toward people living with HIV/AIDS. These conditions, combined with the shortage of basic medical supplies (crucial for adherence to biosafety precautions), contribute to widespread discriminatory practices among health care providers.

Although there are newly drafted national HIV/AIDS diagnosis, treatment, and care protocols, there is not yet a clear implementation strategy that will translate these protocols into action that will positively impact the lives of people living with HIV/AIDS.

The range of available prevention services is limited by cultural norms, which hinders the development of programs that effectively target high-risk behaviors and marginalized groups at elevated risk for HIV, such as sex workers and men who have sex with men. As a result, prevention campaigns have not succeeded in reducing stigma and discrimination, increasing awareness of the individual's risk of infection, or effecting positive changes in behavior.

Funding for HIV/AIDS programming comes mainly from international donors, whose objectives are, at times, not well coordinated with national priorities. It is critical that coordination between international donors and national projects improve in order to develop an integrated, multisectoral national strategy that can deliver better outcomes for people living with HIV/AIDS and those at high risk of HIV infection.

Several local organizations have expressed concern about the sustainability of the ARV treatment program because of the heavy reliance on external donor support and, in particular, on financing from the Global Fund. Despite donor funding and support for Law 234 (Law on the Promotion, Protection and Defense of Human Rights in the Face of AIDS), which stipulates universal access to ARVs, only an estimated small percentage of those in

need of ARVs have access to them. HIV/AIDS activists believe that Nicaragua must formulate a national HIV/AIDS policy that includes a sound ARV-procurement plan.

Based on the research and consultations conducted for this report, the following recommended strategies specify ways in which the government of Nicaragua can improve the national response to HIV/AIDS:

- Strengthen the Nicaraguan Commission to Fight AIDS (CONISIDA) to effectively serve as a national coordinating and monitoring body and to allow the meaningful participation of civil society in policy processes.
- Improve the epidemiological surveillance system to identify high-risk groups and develop programs to effectively target those groups with prevention, treatment, and care services.
- Build the capacity of the health care sector to improve the delivery of HIV/AIDS-related services, including through the development of the infrastructure and the training of health care workers.
- Enhance the coordination of HIV and tuberculosis programming to address TB/HIV coinfection.
- Develop and implement comprehensive communication strategies to target key marginalized populations.
- Strengthen legal protection for people living with HIV/AIDS, including by establishing a committee to collect and prosecute HIV/AIDS-related discrimination cases.

# Background

The first case of HIV/AIDS in Nicaragua was not discovered until 1987, much later than the first cases appeared in most other Latin American countries. HIV/AIDS prevalence in Nicaragua is still relatively low, at 0.2 percent of the population.[1] In recent years, however, the number of people living with HIV/AIDS has increased at an accelerated pace, and the country is now at risk of succumbing to a full-scale HIV/AIDS epidemic, which will have devastating economic, social, and political consequences.

Young people ages 10 to 24 comprise 34 percent of Nicaragua's population. A high percentage of women (28 percent) give birth before the age of 18, indicating an early average age for first sexual intercourse.[2] The country also has high rates of illiteracy, unemployment, and underemployment, and nearly half the population lives below the poverty line.[3] In addition, Nicaragua is a multiethnic country with significant cultural diversity. These demographic and social factors, together with the government's failure to develop effective HIV/AIDS communication and prevention strategies, have had a profound influence on the HIV/AIDS epidemiological profile.[4] High-risk behaviors, such as unprotected heterosexual intercourse among adolescents, are widespread, and people often do not learn their HIV status until their conditions have advanced to AIDS, a situation that has contributed to exponential increases in HIV-incidence rates.

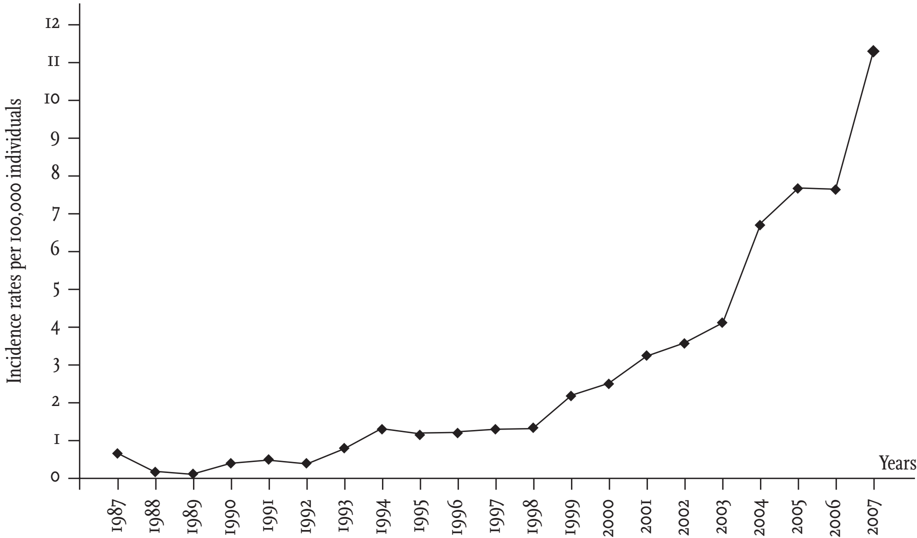
## Incidence and Prevalence of HIV/AIDS

Estimates of the impact of HIV/AIDS in Nicaragua vary greatly. According to official statistics, as of December 2006, the national prevalence rate was 29.35 per 100,000 people, and the national incidence rate was 7.64 per 100,000. The government has not conducted a national epidemiological survey, however, so this information is derived principally from a limited number of sites, which can mask broader epidemiological trends. The difference between the government's prevalence estimates and those of NGOs is significant. The National Program for the Prevention and Control of HIV/AIDS and Sexually Transmitted Infections (STI) registered a total of 2,450 people living with HIV/AIDS from 1987 to December 2006, compared to NGO estimates of more than 17,000 for the same period and an estimate of 7,300 from the Joint United Nations Program on HIV/AIDS (UNAIDS).[5, 6, 7]

HIV/AIDS has disproportionately affected people from 20 to 39 years of age—the most economically and sexually active sector of the population (Figure 2). As of 2006, the majority of diagnosed cases were among men, with a male to female ratio of 2.4:1. This recent finding indicates a dramatic increase in infections among women since 1987, when

the estimated ratio of male to female cases was 12.5:1. The gap between male and female infection rates has closed more rapidly within the adolescent population, which is now nearly 1:1 for the 15-to-19 age group (Figure 3). Despite the increasing risk of HIV infection for women and the efforts to address gender in public health policies and practices, the government has yet to effectively integrate gender issues and HIV/AIDS.

**Figure 1. HIV/AIDS Incidence Rates in Nicaragua, 1987–2007***



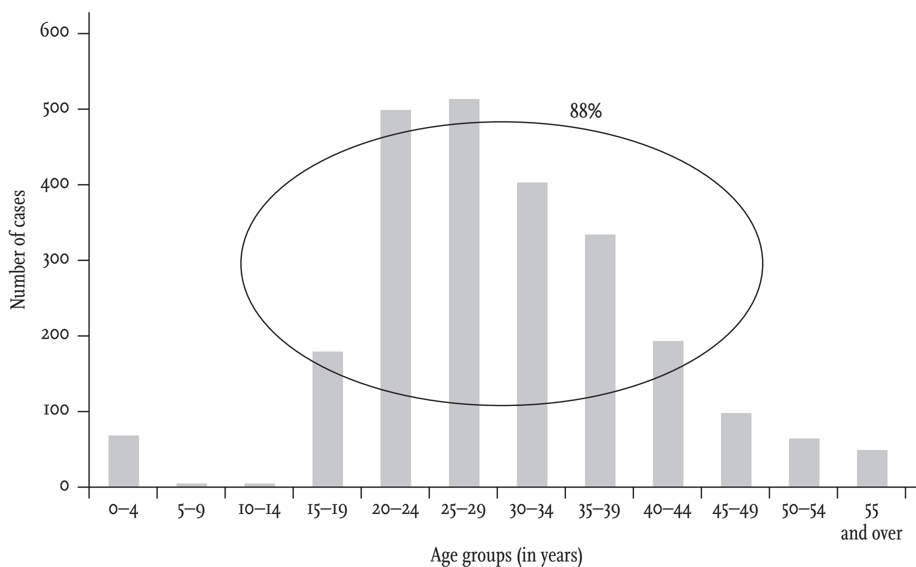

Note: * 2007 data are projected from first trimester incidence rates.

Source: National STI/HIV/AIDS surveillance data

Sexual intercourse is the primary mode of disease transmission, accounting for 94 percent of all new cases. Transmission through injecting-drug use results in 2.8 percent of cases. Mother-to-child transmission and transmission via contaminated blood products account for 3 and 0.2 percent of all diagnoses, respectively (Figure 4). Of all sexual transmissions, approximately 76 percent occur through heterosexual intercourse and 14 percent through homosexual intercourse. The transmission rate is 10 percent among those who engage in bisexual behavior.[8]

All of these factors—the accelerated spread of the disease, the principally heterosexual mode of transmission among the young and most economically active sector of the population, the increasing impact on women, and the large percentage of the population who live below the poverty line with little access to health care—create concern that the HIV/AIDS epidemic in Nicaragua may represent a public health time bomb.

**Figure 2. Cases of HIV/AIDS by Age Group, Nicaragua, 1987–2006**




Source: National STDs/HIV/AIDS surveillance data

**Figure 3. HIV/AIDS Cases by Age Group and Gender, Nicaragua, 1987–2006**

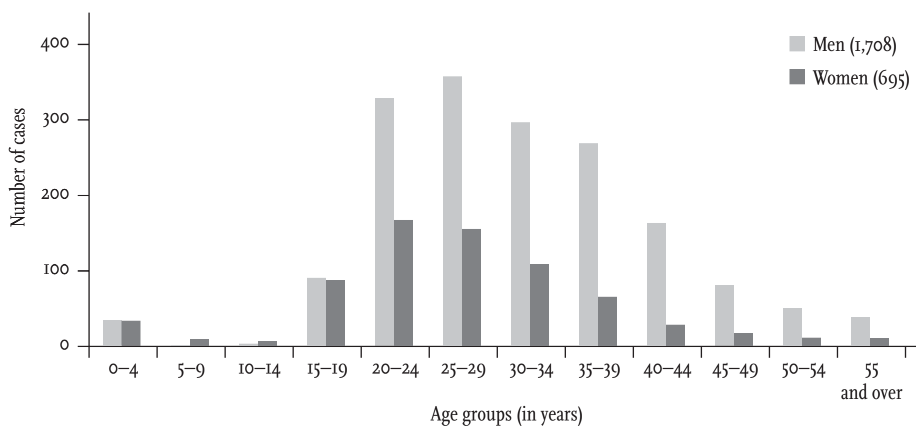
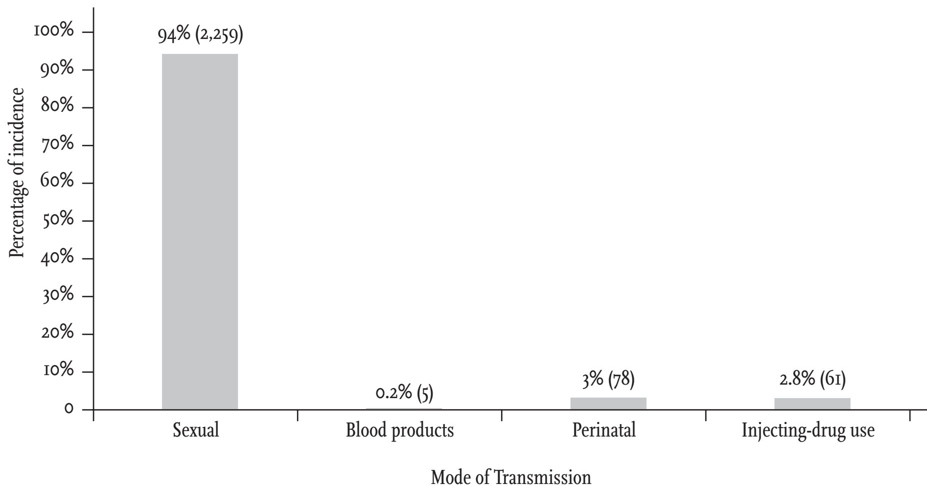


**Figure 4. Percentage of Distribution of HIV/AIDS Cases by Mode of Transmission, Nicaragua, 1987–2006**




## High-risk Populations

The available HIV/AIDS-prevalence data for high-risk populations—including sex workers, prison inmates, and men who have sex with men—are not comprehensive. Small-scale studies, however, have revealed increasing prevalence rates among men who have sex with men in Managua (from 1.3 percent in 1997 to 9 percent in 2003), signaling the emergence of a concentrated epidemic.[9] Similarly, in a recent interview published by the Nicaraguan newspaper *El Nuevo Diario*, prison ombudsperson María Auxiliadora Urbina warned that there was significant underreporting of HIV/AIDS-infection rates among inmates, which, combined with overcrowding, could soon lead to a widespread HIV/AIDS epidemic in the national prison system.[10] Studies in three urban centers revealed a 1.4 percent infection rate among migrant sex workers in the coastal town of Corinto. All sex workers surveyed had a high incidence rate of other STIs, and migrant sex workers had an 80 percent chance of presenting with two or more STIs, highlighting the heightened risk of HIV exposure for this specific subgroup and the need for policies that target them effectively.[11]

The 2006–2010 national strategic plan identifies several groups who should be targeted with HIV-prevention and communication efforts: women, sex workers, migrant populations, the prison population, uniformed personnel, adolescents and young people, and men who have sex with men. The lack of data quantifying their vulnerability and analyzing the contributing behavioral and cultural patterns has hindered the development of sound, targeted policies.

## TB and HIV/AIDS

The incidence rates of tuberculosis (TB) in Nicaragua have declined by 50 percent over the ten-year period from 1995 to 2005.[12] The accelerated spread of HIV/AIDS could lead to a resurgence of the disease, however, and to the development of drug-resistant strains. Although the government has taken some early steps in anticipation of this possibility, there is little coordination between the country's TB and HIV/AIDS programs, with recent studies indicating that most coinfection cases remain undetected.[13]

# The Health Care System

The country's total expenditure on health care measured as a percentage of gross domestic product (GDP) has been steadily increasing, climbing from 5.7 percent in 1996 to 8.6 percent in 2005.[14] The Ministry of Health's own expenditure on health care, however, has shown the opposite trend, declining from 5.4 percent in 1999 to 4.6 percent in 2002.[15]

According to a report published by the Center for Information and Advisory Services on Health (Centro de Información y Servicios de Asesoría en Salud, or CISAS), the decrease in the percentage of the national budget assigned to health care has resulted in increased out-of-pocket spending. As a result, an estimated 20 to 30 percent of the population is currently without access to health care. The decrease in funding for health care has also limited the ability of health care centers to buy basic medical supplies and reagents with which to perform HIV diagnostic tests.[16] The government has not earmarked a specific portion of the national budget for HIV/AIDS-related expenditures, and national budget reports do not include this information. Therefore, it is extremely difficult to determine the extent of governmental spending on the prevention and treatment of HIV/AIDS. The estimates provided by national HIV/AIDS accounts are approximate, at best.[17]

The Nicaraguan health care system is organized into three different levels of care, administered through a network of health centers and clinics. Basic health care services are provided at the primary level; specialized services at the secondary level; and clinical investigation and diagnosis at the tertiary level. The existing primary-care system is limited in the development and implementation of comprehensive treatment and care services for people living with HIV/AIDS by three major obstacles.

First, basic medical supplies—such as saline solution and sterile gloves—are in short supply, particularly in rural areas. Second, health care services are heavily centralized in large urban centers, so people in rural areas must travel long distances to receive diagnostic and maintenance tests (such as viral load and CD4 count tests). Given the financial burden associated with travel and the fact that private-sector laboratories are expensive, a

large portion of the rural population cannot afford reliable care. Finally, there is little communication and coordination among health care providers, and the quality of care varies widely from clinic to clinic. For example, José Manuel Espinoza, a medical doctor and the HIV/AIDS officer for the United Nation's Children's Fund (UNICEF), stressed that poor coordination is responsible for the fact that different HIV-detection techniques are employed across the country, some of which do meet the current scientific standards.[18]

## Socioeconomic Aspects of HIV/AIDS

In 1996, the government conducted a macroeconomic study on the socioeconomic impact of HIV/AIDS, including its projected impact through the year 2000. In the years since, there has been little follow-up to this study, and the analysis of the socioeconomic repercussions of HIV/AIDS in the 2006–2010 national strategic plan is based on this outdated assessment. In fact, based on the study's report of low infection rates, the 2001 Reinforced Economic Growth and Poverty Reduction Strategy (Estrategia Reforzada de Crecimiento Economico y Reduccion de la Pobreza, or ERCERP) places the HIV/AIDS epidemic in the category of "other less urgent problems." As a result, national poverty-reduction and development policies and programs currently do not include concrete action plans to address the socioeconomic impact of HIV/AIDS, beyond echoing the broad commitment to the prevention of the spread of HIV/AIDS and the reversal of infection rates by 2015, as declared in the United Nations Millennium Development Goals (MDGs).[19, 20]

The HIV/AIDS epidemic will likely have a disastrous effect on families in several ways—by increasing household expenditures for health care, by preventing the heads of households from continuing to work, and, ultimately, by leaving the children of infected parents orphaned. NGOs report, however, that scant attention and resources have been devoted to analyzing and mitigating the socioeconomic impact of the epidemic at a microeconomic level.[21] Without accurate knowledge of the socioeconomic impact of HIV/AIDS and, in particular, its impact on the most affected sectors of the population, the measures aimed at reducing such impact will likely remain inadequate and ineffective.

## Political Commitment

> *Strong leadership at all levels of society is essential for an effective response to the epidemic.*
>
> —*UNGASS Declaration of Commitment on HIV/AIDS, preamble to "Leadership"*

Following the inauguration of President Enrique Bolaños in 2001, there had been some positive signs of change in official attitudes toward HIV/AIDS. Previous governments had downplayed the impact of HIV/AIDS and even endorsed communication campaigns against condom use, which associated HIV with sinful behavior.[22] The Bolaños government—in part due to pressure from HIV/AIDS activists and international groups—slowly started to move away from these positions. For example, the government took a number of visible steps to recognize and address stigma and discrimination against people living with HIV/AIDS and also mandated sex education classes in public schools.[23]

Overall, however, the government failed to demonstrate the focused, sustained leadership and political vision required to prevent new infections and to provide comprehensive care and treatment to people living with HIV/AIDS. HIV-related political speeches and activities occurred primarily around World AIDS Day (December 1). Many governmental initiatives were never fully implemented, resulting in half-measures of limited efficacy and wasted resources. For example, the Ministry of Health failed to carry through on its plans to invest in building capacity for surveillance, monitoring, and evaluation by 2006. As a result, Nicaragua still lacks a national monitoring infrastructure, which would help the government evaluate the implementation of the national strategic plan and provide a guide for future policymaking.

Nicaragua has recently published a national policy for the prevention and control of STIs and HIV/AIDS, which articulates a long-term plan to control the diseases within a broader context of national health, development, and poverty-reduction strategies. Although this policy represents a significant step forward in developing a coordinated national response to HIV/AIDS, its impact has so far been constrained by a lack of political coherence. According to civil society groups, because the previous opposition government drafted the national policy, President Ortega's new government may be reluctant to disseminate or implement it.[24]

Similarly, although the development of two successive national strategic plans on HIV/AIDS (the first for the period 1999–2004 and the second for the period 2006–2010) represents progress, these plans only define broad objectives and do not set out the clear implementation guidelines required to mount a coordinated, comprehensive response to HIV/AIDS. The national strategic plans assign specific responsibilities to different govern-

mental agencies, but without a centralized mechanism for monitoring and evaluating their overall progress and for coordinating their various responsibilities, it is difficult to hold these agencies accountable.

Some NGOs assert that the government's principal preoccupation is attracting and maintaining international funding. According to these observers, the government spends more energy collecting quantitative data to meet the Global Fund's requirements and goals than it does developing a comprehensive national policy. A national policy with clear implementation plans and targets could, in fact, be monitored over time to draw additional donor support. According to Hazel Fonseca, the director of Fundación Xochiquetzal, "The [government's] commitment is almost nonexistent. The Global Fund is tracking the country's progress toward meeting certain quantitative goals, but this is not useful, as it is not generating political change."[25] A member of the NGO Fundación Nimehuatzin concurred that there is very little interest in HIV/AIDS policy on the part of National Assembly deputies.[26] In an interview with a German media agency, Niels-Arne Katsberg, the regional UNICEF director, described as "dangerous" the government's relaxed attitude toward the spread of HIV/AIDS and its refusal to prioritize HIV/AIDS in the country's political agenda.[27]

The NGO community believes it is still too early to determine whether the new Ortega government will show real commitment to the fight against HIV/AIDS. Some organizations maintain that the executive office's participation in the upcoming Central American Congress on STD/HIV/AIDS (CONCASIDA) will serve as an indicator of the importance assigned to HIV/AIDS within the government's agenda. The new government has taken some positive steps, for example, by posting current HIV/AIDS data, analysis, and policies on user-friendly websites to increase access to governmental health documents. Although improved access to information will likely facilitate civil society's scrutiny (which, in turn, could lead to greater political accountability), much more needs to be done to ensure the collection of accurate epidemiological data and the provision of integrated prevention, treatment, care, and support services.

## Legal Framework

> *[The law] is mainly administrative rather than coercive, as there are no repercussions for people that do not abide by it.*
>
> *—Member of Nicaraguan Association for People Living with HIV/AIDS (Asociación de Nicaragüenses Viviendo con el VIH/SIDA, or ASONVIHSIDA)*

In 1996, the government adopted Law 238 to protect, promote, and defend human rights in the context of the HIV/AIDS epidemic.[28] The law provides a progressive legal framework for the protection of the rights of people living with HIV/AIDS with regard to prevention, nondiscrimination, confidentiality, and access to health care.[29] Although the law promises much, it has so far delivered little in terms of increased legal protection or access to treatment for people living with HIV/AIDS. For example, Law 238 stipulates the establishment of a technical-ethical committee to ensure its proper implementation, but, more than 10 years after the law's adoption, the committee has not yet been formed.

In addition, there is very little awareness of the existence of Law 238. One lawyer, who works with people living with HIV/AIDS, maintained that the law is largely unknown, even among his colleagues in the legal profession. Moreover, he asserted that cases of discrimination that could be addressed under the law often go unreported, due to the lawyers' fear of breaching client confidentiality, the victims' fear of stigma associated with revealing one's positive HIV status, and the difficulty of finding witnesses willing to testify[30] Members of the Nicaraguan Association for People living with HIV/AIDS (Asociación de Nicaragüenses Viviendo con el VIH/SIDA, or ASONVIHSIDA) have remarked that, in practice, "Law 238 is mainly administrative rather than coercive, as there are no repercussions for people that do not abide by it."[31]

## Public Awareness

Among the general population, awareness of the risk of HIV is low. Some NGOs contend that this lack of knowledge is a consequence of earlier government policies, which downplayed the importance of condom use. Ana María Pizarro, director of the NGO Sí Mujer, explained during a local newspaper interview that the recent increase in the number of infections among women is due in part to the government's poor prevention efforts and to its ongoing negative attitude toward condom use. She also said that the Roman Catholic Church still exerts considerable influence over government policy, even though Nicaragua is a secular state.[32]

The government has also not widely publicized the commitments that it agreed to under the terms of the UNGASS DoC. As a result, public awareness of the DoC is low, even among NGOs working on the prevention and care of HIV/AIDS. Some NGO representatives believe that the government's failure to communicate its international commitments is deliberate. "In the long run," said Fonseca, "[making their commitments public] would be inconvenient for the government, since it would lead to increased demands from the population."[33]

## Participation of Civil Society

> *[People living with HIV/AIDS] are being used so the government can claim that it has consulted with civil society groups.*
>
> *—Member of ASONVIHSIDA*

Community participation in the development, implementation, and ongoing evaluation of the national response to HIV/AIDS is limited. There need to be enhanced opportunities and mechanisms to facilitate civil society participation in assessing and prioritizing the issues that need to be addressed, designing appropriate interventions, and monitoring progress.

Law 238 established the Nicaraguan Commission to Fight AIDS (CONISIDA) with the mandate to foster and facilitate coordination among government agencies, NGOs, and international organizations.[34] The Civil Society National Commission in the Fight against AIDS (Comisión Nacional de Lucha Contra el SIDA desde la Sociedad Civil, or CNLCSSC) represents civil society concerns within the CONISIDA. Despite this attempt by the CONISIDA to create space for civil society participation, several NGOs have indicated that, in practice, the participation is not meaningful. Although civil society representatives are often called upon to give their opinions regarding official HIV/AIDS policies and initiatives, their input is not taken into account or reflected in national policies.[35]

For example, the government invited several civil society groups to participate in the development of the 2006–2010 national strategic plan. Their participation occurred mainly during the initial planning stages, however, with little follow-up. The government did not seek broad civil society input on successive drafts of the plan, and the published version does not include any strategic goals that articulate the role of NGOs and community groups in the national response to HIV/AIDS.

As a result of these experiences, many civil society groups doubt whether there is sufficient political will to support substantive civil society participation in the HIV/AIDS policymaking processes. As a member of ASONVIHSIDA said, "People who live with HIV/

AIDS are convened to validate [the government's strategies], but in the end their recommendations are not taken into account. These people are being used so the government can claim that it has consulted with civil society groups."[36]

Effective civil society participation is further hampered by a lack of clear leadership. The Global Fund Country Coordinating Mechanism (CCM) and the CONISIDA have overlapping roles, which has led to conflict rather than cooperation. According to one observer, "The CCM controls all the funds. The CONISIDA has the political legitimacy. When it comes to leadership roles, this represents a problem."[37] Without strong central leadership to coordinate the various initiatives, projects initiated both by the government and the NGOs tend to be one-off efforts. There are few mechanisms to ensure complementarity with national policy and to avoid duplication. In an environment in which collaboration and the sharing of information are not encouraged or facilitated, there is considerable friction among NGOs as they compete for scarce resources and recognition.

## Stigma and Discrimination

> *Enact, strengthen or enforce, as appropriate, legislation, regulations and other measures to eliminate all forms of discrimination against and to ensure the full enjoyment of all human rights and fundamental freedoms by people living with HIV/AIDS and members of vulnerable groups…and develop strategies to combat stigma and social exclusion connected with the epidemic.*
>
> *—UNGASS Declaration of Commitment on HIV/AIDS, Article 58*

> *Surgeons kicked up a fuss when they realized that a patient they had just operated on had AIDS. Doctors were also highly alarmed when they found HIV-positive patients drinking coffee in the cafeteria commonly used by hospital staff.*
>
> *— Medical Doctor at a Regional Hospital*

The stigmatization of people living with HIV/AIDS is widespread, particularly of people in marginalized groups, such as sex workers and men who have sex with men. For example, 60 percent of respondents in a recent survey agreed that "prostitutes with HIV/AIDS asked for it because of their bad behavior" and 44 percent believed that "God punishes prostitutes and homosexuals for their lifestyle by giving them AIDS."[38] People living with HIV/AIDS report that these attitudes often result in discriminatory behaviors, such as breaches of confidentiality in hospital services and denial of medical treatment.[39]

Although individuals can report discrimination and the violation of other rights to the Nicaraguan Center for Human Rights (CENIDH) and the Ombudsman's Office for the Defense of Human Rights, few have actually filed reports.[40] The reasons are largely fear of retaliation and fear of facing yet more discrimination. These fears are not unfounded. The research for this report revealed several instances of discrimination, including discrimination on the part of relatives, the community, health care personnel, work colleagues, and supervisors, among others.

For example, Ricardo Taylor, MD, explained that "discrimination by health care personnel represents the principal source of breaches in patient confidentiality."[41] Another doctor said that, "In one case, surgeons kicked up a fuss when they realized that a patient they had just operated on had AIDS. Doctors were also highly alarmed when they found HIV-positive patients drinking coffee in the cafeteria commonly used by hospital staff. Several doctors also failed to attend HIV/AIDS-sensitivity training courses."[42]

Other examples of stigma and discrimination are illegal HIV testing requirements, forced disclosure of HIV-positive status in the workplace, and stigma from local communities. This treatment often leads HIV-positive individuals to remain secluded in their own homes for fear of being called *sidosos* (a derogatory term for people infected with HIV) and discourages other individuals from seeking HIV counseling and testing.

Educational institutions also often discriminate against children living with HIV. In a recent case, teachers agreed to parents' demands that a HIV-positive girl be forbidden to share the same classroom with uninfected children. Commenting on this case, Arelys Cano, president of ASONVIHSIDA, said, "Personnel working at public and private institutions are not provided with adequate education and sensitivity training on HIV/AIDS. We are extremely worried because, given the number of infected children, [this] is likely not an isolated case [of discrimination]." Rafael Ruiz, the municipal representative of the Ministry of Education, admitted that teacher training about HIV/AIDS is insufficient and said that this case "should serve as precedent to foster the development of initiatives to train teachers on HIV/AIDS issues."[43]

# HIV/AIDS Policy

> *Ensure the development and implementation of multisectoral national strategies and financing plans for combating HIV/AIDS that address the epidemic in forthright terms. ...*
>
> *—UNGASS Declaration of Commitment on HIV/AIDS, Article 37*

The CONISIDA was established in 1996 through Law 238 in order to facilitate multisectoral coordination on HIV/AIDS, including coordination with international organizations and civil society. To date, however, the CONISIDA has not been effective in its role, in part because the national strategic plan lacks specific guidelines for implementation and does not articulate reporting lines. Several NGO representatives have indicated that it is not clear to them what the CONISIDA is supposed to coordinate and what specific function it actually serves.

As a result of this lack of coordination, government and NGO HIV/AIDS activities are not effectively integrated into a cohesive national response. Interventions often cover the same territories and/or populations, which wastes resources and limits their efficacy. Similarly, the lack of a national coordination strategy means the initiatives of international donors are not always in line with the national priorities identified in the national strategic plan. Because the government relies heavily on donor funding, however, it has little leverage to negotiate for specific programs or the terms of disbursement.[44]

## Policy Administration

Experts have called repeatedly for better coordination of international programming with the national structures and policy priorities, which, in turn, should reflect UNGASS commitments and promote multisectoral participation. According to these experts, the establishment of a national forum for donor coordination on HIV/AIDS, with the support of the Secretariat for Social Integration of Central America (Secretaría de Integración Social de Centro América, or SISCA) and other regional entities, would facilitate this coordination of efforts.[45, 46] In addition, a stronger CONISIDA, with a clearly defined role and responsibilities for monitoring and evaluation, could play a key role in coordinating the now-diffuse civil society, governmental, and intergovernmental efforts and in ensuring the effective implementation of the objectives of the national strategic plan.

Information about the government's current allocation of the national health budget to HIV/AIDS—and the specific categories of HIV/AIDS spending—is not publicly

available.[47] Despite this lack of information, it is clear that the resources available for the control of HIV/AIDS in Nicaragua (and, in particular, for the purchase of ARVs) derive almost entirely from external sources.[48] As noted previously, these resources sometimes flow to projects that are not in line with the goals of the national strategic plan. They are also often distributed through parallel administrative structures that bypass rather than reinforce domestic decision making.[49] For example, the CCM, which was established to oversee the development of Global Fund proposals and to allocate those resources, has not worked in concert with the CONISIDA.

Representatives of several national NGOs have said that the availability of foreign aid, although crucial in generating greater governmental interest in the issue of HIV/AIDS, has paradoxically also allowed the national government to renege on its duties to guarantee universal medical care, as set forth in the constitution. The absence of standardized national protocols, the limited technical capacity for HIV/AIDS diagnosis and treatment, and the lack of a national strategy for training health care staff have also hindered the effective coordination of the HIV/AIDS-related activities of the Ministry of Health, NGOs, and private health providers.[50] Clinical capacity is highly centralized, and rural populations experience serious gaps in access to medical services. According to José Ramón Espinoza, MD, "[Hospitals] are working according to their own capacity to offer services and not taking into account whether this level of services meets demand."[51]

At the national level, only the Roberto Calderón and the Berta Calderón hospitals in Managua have an infectious disease team that is capable of monitoring patients' response to HIV/AIDS treatment. As a result, some patients must travel to the capital city to receive medical care. This condition not only places a great financial burden on those who can afford to make the trip, but also means that those who cannot afford it have no access to health care. The government recently began decentralizing health care services. Although it is still too early to assess the effectiveness of this process, data from select rural areas that have been targeted for decentralized access indicate that the impact has been minimal.

Like many other regional and local health facilities, San Juan de Dios Hospital, a local departmental hospital in Estelí in northern Nicaragua, does not have sufficient capacity to provide adequate care to people living with HIV/AIDS. As Gilma Rosa Juarez Quintero, MD, the chief of emergency medicine at the hospital, explained, "We are not set up to offer counseling services. For example [when people test HIV positive], I send them to the Roberto Calderón Hospital where they receive their ARV regimen. Then I monitor their treatment. However, all of this is not part of my job description, since I am the head of emergency medicine."

Quintero also pointed out a number of other limitations, including those created by the infrastructure. "[My] hospital does not have diagnostic tools, such as Elisa and Capilus. We have to borrow them from the epidemiologist. We also don't have the capacity to perform

diagnostic tests, which are usually sent to the Red Cross or to mobile health clinics." Health care workers find it difficult to comply with recommended best practices in treatment and care. Many facilities lack the necessary medicines (ARVs and medicines to prevent opportunistic infections, or OIs), proper ventilation, and lighting. Some hospitals do not have enough gloves for staff to comply with biosafety measures, and some local health clinics do not have the facilities to ensure the level of privacy necessary to maintain confidentiality.[52]

A 2004 study assessing the incidence of HIV exposure among health care workers in the workplace revealed that only 53.3 percent of hospitals complied with existing biosafety protocols. Moreover, 40 percent of all health care personnel interviewed had no knowledge of existing HIV/AIDS regulations. Only about half reported receiving HIV/AIDS training in the workplace. According to the study, most workplace accidents that carried a high-infection risk went unreported, and there was often no systematic institutional policy to control risk of exposure to HIV. Rather, individual workers were left to manage situations however they saw fit. These findings led the authors of the study to conclude that the "national outlook was grave."[53]

The lack of systematic and sustainable training programs for health care staff treating HIV/AIDS also hinders effective delivery of services. Current training efforts are sporadic, and there has been little evaluation of their impact on the adoption of best practices and transfer of knowledge. The Ministry of Health's training workshops for health care workers are not mandatory and lack continuity. As a result, they fail to reach and appropriately train all health care staff. Some NGO representatives contend that this lack of training, combined with inadequate hospital infrastructure and poor working conditions, is a major reason for the persistent discrimination against people living with HIV/AIDS among health care workers. Even the national reference hospital, Roberto Calderón, has failed to develop and implement training programs and workshops that would adequately sensitize its staff to provide quality HIV/AIDS care.[54]

High turnover rates within key governmental health care posts further hamper the provision of quality HIV/AIDS care. This lack of stability in the policymaking arena has had a negative impact on the government's ability to learn from experience and build upon policies and programs that show good results. One NGO representative noted, "Every five years, all of the health department heads are replaced, and everything starts from scratch. The Ministry of Health has not gained experience in these past fifteen years. The [HIV/AIDS and STI control programs] have not improved due to these high turnover rates, because new leadership is likely to establish new strategies and to view previous efforts [by different political parties] as useless."[55]

## Public–Private Partnerships

The 2006–2010 national strategic plan encourages public–private collaboration on HIV/AIDS. Although there is some evidence of increased activity, the level of coordination and information sharing between the public and private sectors is still poor.

Private health services have not been integrated effectively into the government's efforts to combat HIV/AIDS. For example, private providers do not send patient information to the Ministry of Health, citing concerns about patient privacy. As a result, national HIV statistics exclude these patients' information. Private providers also do not follow a standard national protocol or set of guidelines for treatment. In the autonomous regions—with the exception of the Central Bilwi Clinic in the RAAN—the government does not exercise quality control over the HIV/AIDS services offered by private health care providers.

Several recent instances of private sector participation in efforts to control HIV/AIDS provide encouraging signs of increased interest and willingness to collaborate with government efforts. For example, the Nicaraguan Private Enterprise Council (Consejo Superior de la Empresa Privada en Nicaragua, or COSEP) has begun to incorporate HIV/AIDS into their meeting agendas.[56] It is too soon, however, to determine whether these discussions will have an impact on implementation.

# Prevention

*Prevention must be the mainstay of our response.*
*—Declaration of Commitment on HIV/AIDS, preamble to "Prevention"*

The 2006–2010 National Strategic Plan on HIV/AIDS identifies 11 priority groups: adolescents, young people, sexually exploited children, child victims of violence, women of reproductive age, pregnant women, men who have sex with men, sex workers, mobile populations, prison inmates, and prison employees. To date, not all groups have been targeted with prevention efforts, however. The lack of targeted programs stems in part from the absence of reliable epidemiological and risk behavior data on specific populations. There is no such information available for mobile populations, and the data are incomplete for all other groups.

There are no government prevention campaigns designed for sex workers or for men who have sex with men, which is troubling given the relatively high prevalence rates among these groups.[57] Orphans and sexually exploited children have been similarly neglected. Prevention programs do not yet target mobile populations and prison inmates, although the government has conducted background research on these groups in order

to design effective interventions. The low levels of knowledge among mobile populations particularly illustrate the need to reach this group. A 2004 Ministry of State survey of this population revealed that only 23 percent of respondents were familiar with one or two forms of HIV/AIDS transmission.[58]

Existing prevention programs have generally not had real impact on the degree of knowledge about or attitudes toward HIV/AIDS. They also have not resulted in measurable behavior changes. In addition, HIV prevention efforts do not always follow protocols. For example, although HIV tests require informed consent, pretest counseling services are not comprehensive and are often either not available or not offered to the patient.

In 2003, two knowledge, attitude, and practice (KAP) surveys of sex workers and men who have sex with men indicated that familiarity with available HIV/AIDS prevention strategies had not translated into behavioral changes.[59] For example, although the majority of sex workers interviewed knew how to prevent HIV/AIDS transmission, only a small percent used condoms regularly, particularly in sexual relations with a stable (non-client) partner.[60] Among men who have sex with men, although more than 86 percent knew how to avoid infection (including correct condom usage), only about half reported using condoms in their last sexual relationship with an occasional partner.[61]

A similar study among the national prison population revealed that less than 50 percent of inmates knew how to prevent sexual transmission of HIV/AIDS and an even smaller percentage reported consistent condom use (19.4 percent of men and 16.9 percent of women). Almost one-third of those interviewed had never used a condom.[62] Promotion of condom use is now officially a part of the government's prevention strategy, but continuing opposition to condoms by religious authorities and lingering misconceptions resulting from earlier government campaigns that downplayed the magnitude and impact of HIV/AIDS still exercise a powerful influence on popular attitudes toward HIV/AIDS.

Local NGOs play an important role in implementing prevention programs, particularly by targeting marginalized populations. For example, ASONVIHSIDA works to promote condom use and positive behavior changes, to decrease stigma and discrimination, and to push for better care and treatment of people living with HIV/AIDS.[63] The lack of effective collaboration among NGOs, however, coupled with the government's ineffectiveness in coordinating the multiplicity of responses, leads to duplication of efforts in some areas and gaps in coverage elsewhere. In addition, the absence of an effective system for monitoring and for gathering data prevents the identification and scaling up of successful local strategies and the compilation of best practices that would improve current programs.

## Information, Education, and Communication

The 1999–2004 national strategic plan identified the development of an information, education, and communication (IEC) strategy as one of its eight strategic objectives. A national consensus on an IEC strategy is still missing from the 2006–2010 plan, however, highlighting the scant progress made in this area.[64]

An effective IEC strategy would provide targeted communication for marginalized groups at high risk of HIV infection—such as sex workers, prison inmates, youth, and men who have sex with men; other key segments of the population, such as health care workers and military and police officers; and socially influential groups, including religious leaders and politicians. A concrete strategy that establishes clear goals and benchmarks and identifies agencies responsible for its implementation has not been established, however.[65] In addition, there has been little attempt to systematically assess the impact of current HIV/AIDS communication efforts to improve their overall effectiveness.

There have been only a few isolated efforts to disseminate IEC messages targeting specific populations. For example, in 1997 a group of NGOs, working under an umbrella organization and in collaboration with the Ministry of Health, launched the Together We Decide When (Juntos Decidimos Cuándo) campaign. The primary objective of the campaign was to reduce unwanted adolescent pregnancies by increasing knowledge about reproductive health, postponing the first sexual encounter, and promoting child spacing.[66] The campaign also had an HIV component—promoting condom use as an effective means of protection against both unwanted pregnancies and HIV/AIDS and providing general information about HIV/AIDS and its prevention. The Ministry of Education and the Ministry of State, respectively, have launched two independent campaigns: Education for Life (Educación para la Vida), which targets teachers, students, and parents, and Together against AIDS (Juntos contra el SIDA), specifically for Ministry of State personnel.[67, 68, 69]

Studies evaluating the effectiveness of the Together We Decide When campaign revealed that it has had a positive impact. Of those exposed to its messages, 46 percent of the men and 33 percent of the women decided to take measures to avoid unwanted pregnancies. As a result, condom use among adolescents and youth has increased.[70]

With the noted exceptions, current communication efforts target the general population and largely fail to take into account the need for differentiated messages and strategies to reach high-risk groups. For example, there are no national campaigns currently in progress to target men who have sex with men, although studies indicate that the prevalence rate for this group may be as high as 9 percent. Ethnic minorities, such as migrant populations and the Miskito population (predominant in the RAAN), have also been neglected.

Prevention messages are also frequently out of touch with the realities of Nicaraguan society, often advocating abstinence and delay of first sexual relations, even though multiple studies and data show that sexual intercourse occurs at a very early age in Nicaragua.[71]

As a result, many youth who cannot or do not choose to practice abstinence remain at high risk for HIV infection. Moreover, IEC efforts most often target individual attitudes and behaviors, without adequately addressing the broader social context and the societal norms that influence those attitudes and behaviors, such as stigma, discrimination, and gender inequality.

Finally, there has been poor coordination of prevention messages among governmental departments. For example, the two autonomous regions (RAAN and RAAS) have different communication plans. Whereas the RAAS includes specific marginalized groups in its campaign, the RAAN has only implemented campaigns for the general public.[72, 73] This fact is particularly worrisome given the large ethnic diversity in the RAAN. In particular, individuals in the Miskito population may require targeted messages and materials in their own language.

## Coordinated Health Services

HIV-prevention efforts are not adequately coordinated with other health services, including diagnosis and treatment of STIs and TB, family planning, prenatal and neonatal care, drug use prevention and treatment, and efforts to address domestic and sexual violence. Major obstacles to greater coordination are the absence of national standards for disease diagnosis and the dearth of health care workers who can effectively refer patients to other pertinent services.

In order to improve coordination between services for HIV/AIDS and TB, the Ministry of Health has adopted protocols for the treatment of TB/HIV-coinfected patients.[74] In practice, it has not, however, been able to effectively coordinate TB and HIV/AIDS care, due to lack of a centralized coordinating mechanism to train medical staff on coinfection treatment protocols and to monitor their compliance. As a result, treatment of coinfected patients is not sufficiently responsive to the often complicated and difficult interactions between TB and ARV drugs.[75]

Poor coordination between the TB and HIV/AIDS programs also contributes to the low number of TB patients who undergo HIV testing and the insufficient data on coinfection rates (Table 1). For example, the staff of the national TB program (Programa de Control de Tuberculosis, or PCT) often do not know whether or not patients under their care have been tested for HIV.[76] Moreover, local TB control efforts do not always comply with national protocols.[77] Although the PCT specifies that TB patients between the ages of 15 and 65 should be routinely tested for HIV, subject to their informed consent, a recent study by the National Autonomous University of Nicaragua (Universidad Nacional Autónoma de Nicaragua, or UNAN) reported that only a small sample (16.7 percent) of TB patients in six municipalities were offered an HIV test.[78]

**Table 1. TB/HIV coinfection, 1998–2004[798]**

| Categories | 1998 | 1999 | 2000 | 2001 | 2002 | 2003 | 2004 | 2005 |
|---|---|---|---|---|---|---|---|---|
| All TB cases | 2,604 | 2,558 | 2,402 | 2,448 | 2,092 | 2,283 | 2,220 | 1,246 |
| HIV cases | 62 | 104 | 128 | 164 | 194 | 226 | 376 | ND |
| AIDS cases | 30 | 36 | 58 | 74 | 61 | 55 | ND | ND |
| % TB/HIV coinfection | 0.8%[80] | ND | ND | ND | 2%[81] | ND | 2.4 %[82] | ND |

ND: no data

The number of coinfections detected by the PCT may represent only a small fraction of the actual number of coinfected patients. In 2004, the PCT reported only nine coinfection cases. A study carried out by UNAN in 36 municipalities detected a coinfection rate of 3.7 percent (5 out of 138 HIV-positive patients also had TB), which, if extrapolated to the entire population, would total 82 coinfections. The fact that only a small proportion of TB patients are offered an HIV test undoubtedly further contributes to the statistical under-representation of coinfection rates.[83]

According to Guillermo González, MD, a consultant to the Ministry of Health in the drafting of the national strategic plan and currently the vice minister of health, "The two programs [HIV/AIDS and TB] are designed in a way that undermines cooperation. The country's epidemiological surveillance and monitoring systems are in an embryonic stage, and there is very little shared analysis [between the TB and HIV/AIDS programs]. The information [on coinfection rates] is there, but it is centralized and not inclusive of all segments [of society]. [The information we have] is not timely, not contextualized, and not comprehensive, due to our passive approach to case detection."[84]

In its latest annual report, the PCT proposed a number of steps that could be taken to improve cooperation with the HIV/AIDS program. Among them was the development of a TB/HIV national collaboration plan that would outline joint strategies for the treatment and care of coinfected patients.[85] The HIV/AIDS program does not appear to share a commitment to address TB/HIV, however. For example, the national strategic plan on HIV/AIDS does not include the development of a national TB/HIV national collaboration plan as an objective. This lack of a shared commitment to improve detection and treatment of coinfection cases is particularly troubling given the rise of multidrug-resistant strains of tuberculosis worldwide.

## Treatment

> *Make every effort to provide progressively and in a sustainable manner, the highest attainable standard of treatment for HIV/AIDS, including the prevention and treatment of OIs, and effective use of quality-controlled antiretroviral therapy in a careful and monitored manner to improve adherence and effectiveness and reduce the risk of developing resistance....*
>
> *—UNGASS Declaration of Commitment on HIV/AIDS, Article 55*

> *It is a big lie that Nicaragua has universal access to ART [antiretroviral therapy].*
>
> *—René Valverde, the Nicaraguan Red Cross, Chinandega*

Nicaragua's legislation guarantees access to health care—including prevention, treatment, and rehabilitation services—and the right to confidentiality, respect, and nondiscrimination. This guarantee includes the care and treatment for people living with HIV/AIDS, but taken alone, is insufficient in ensuring access to comprehensive, integrated care.

For example, despite legislation prohibiting discrimination based on HIV status, there are frequent violations in the health care sector. Members of ASONVIHSIDA have described several instances in which they were denied medical attention after tests revealed their HIV-positive status.[86] Likewise, national newspapers have published several accounts of discrimination in access to hospital treatment. For example, the Nicaraguan Red Cross denied emergency ambulatory transport to one young patient because he was HIV-positive and presented with blood loss.[87]

The limited capacity of the health sector, the lack of basic medical supplies, and the insufficient number of trained health care workers all represent challenges to widespread access to HIV/AIDS-related treatment and care.[88] The centralization of medical capacity further compounds the problem. As noted, rural populations must travel long distances for basic diagnostic and maintenance tests, such as viral load and CD4 count tests, and to access other services such as counseling. This circumstance may result in patients receiving ARVs without the necessary support and follow-up care to ensure treatment adherence.

With the purchase and installation of new technology in national laboratories, the government has taken some steps to improve access to diagnostic and maintenance tests. Increased capacity in national laboratories will not likely have an impact on rural communities, however. It remains to be seen whether these initial steps will be accompanied by a more comprehensive campaign to train the needed health care personnel and to ensure the availability of basic supplies.

## Antiretroviral Therapy

Although Nicaragua guarantees free access to antiretroviral therapy (ART), it is estimated that only 29 percent of all people living with HIV/AIDS currently receive it.[89] Despite an incipient decentralization process, antiretroviral (ARV) distribution is still centrally managed through the infectious disease department at the Roberto Calderón Hospital in Managua, which has negative implications for the rural population's access to ARVs.

As noted, the government relies heavily on donor funding to finance ARV treatment. According to Nicaragua's latest proposal to the Global Fund, Global Fund resources will subsidize approximately 70 percent of all necessary expenses for ARV treatment until 2012.[90] In addition, the Brazilian and Venezuelan governments have pledged to support treatment for 200 and 433 individuals, respectively, for the period 2007–2008.[91] Given the total number of registered cases of HIV and the large estimated number of undetected cases, these international contributions are insufficient to guarantee universal access to treatment. In the Global Fund proposal, the CCM estimates that current economic resources will leave 1,820 individuals without access to ARV treatment by the end of 2008 and 2,670 without access to treatment by 2012. It remains unclear whether the Nicaraguan government plans to earmark funds to ensure access to ARVs for individuals who are not covered by international funds.

A number of civil society organizations have echoed these concerns over lack of access to ARV therapy. In an interview with Fundación Agua Buena, a Central American human rights organization, René Valverde from the Nicaraguan Red Cross in Chinandega said, "It is a big lie that Nicaragua has universal access to ART. The Global Fund only [has plans to provide] access for one hundred people living with HIV/AIDS per year, a ridiculously low amount for Chinandega alone."[92] Other NGOs have had similar experiences regarding inadequate access to ART. Of the 143 HIV-positive patients who receive care at Fundación Xochiquetzal, only 53 receive ART. The Center for Justice and International Law (CEJIL) and the Fundación Agua Buena were forced to file a claim with the Inter-American Commission on Human Rights (IACHR) on behalf of 16 people living with HIV/AIDS who had been denied access to ART in violation of both national and international commitments.[93]

The Ministry of Health maintains that treatment for 25 percent of all patients has been subsidized directly by the government and that the remaining 75 percent has been paid for by the Global Fund. Several organizations interviewed for this report, however, question the veracity of this statement and maintain that the government's investment in ART is much lower—possibly nonexistent. The national health budget for 2006 does not include the use of national funds for the purchase of ARVs. Similarly, the proposal to the Global Fund does not specify the amount of government funding, if any, that has been earmarked for ARV procurement. Instead, the government funding allocated for the purchase of medi-

cines and reagents is combined with personnel salaries in a single figure for the entire 2008–2012 period, which makes it impossible to calculate the government's actual contribution to ARV treatment.[94] The lack of a clear, long-term plan to guarantee a sustainable national response is of concern, especially considering that current free trade agreements could restrict the government's ability to purchase generic ARVs in the future.[95]

## Care and Support

NGOs have spearheaded successful local initiatives in Nicaragua to expand access to care and support for people living with HIV/AIDS. The Ministry of Health has also launched Stepping Stones, a pilot project that focuses on diagnosing new HIV/AIDS cases and building and strengthening the care and support capacity of families.[96] These initiatives, although commendable, are isolated attempts and do not represent an effective national response. As is the case in the areas of prevention and treatment, the national response for the care and support for people living with HIV/AIDS remains fragmented and insufficient, in need of greater political will, better coordination, and additional resources.

In order to improve the quality of care for people living with HIV/AIDS and their families, the government must ramp up training for health care staff, decentralize specialized and interdisciplinary medical care, increase the availability of both ARV drugs and drugs for the treatment of OIs, and improve levels of social and community support for people living with HIV/AIDS, including the availability of home-based care when necessary. The lack of a comprehensive and accessible system of care and support can also interfere with patients' adherence to ART. To date, there have not been any studies to evaluate adherence to HIV/AIDS treatment. It is imperative to plan and conduct such studies, particularly given the minimal counseling and follow-up support that many people living with HIV/AIDS in rural areas receive.

During the past several years, social support for people living with HIV/AIDS has increased, due to the reinforcement and expansion of basic governmental food rations, greater availability of replacement feeding for children of HIV-positive mothers, and efforts to provide home-based care by community activists and local NGOs. The efforts of Atlantic Coast community activists are particularly noteworthy. The region's geographical isolation and the resultant lack of access to care has meant that these groups have had to redouble their efforts to provide home-based care for people living with HIV/AIDS.[97]

## Monitoring and Evaluation

A major obstacle to the effectiveness of efforts to control HIV/AIDS has been the absence of a monitoring and evaluation (M&E) system to assess the implementation and efficacy of programs. The HIV/AIDS strategic plan monitoring committee, founded in 1999, remained inactive until 2004. As a consequence, national performance was evaluated only as the 1999–2004 national strategic plan period drew to a close. Most of the plan's stated objectives were never achieved, and progress on implemented activities has not been properly documented and so remains largely unknown.

The national strategic plan for 2006–2010 calls for the development of yearly operational plans to implement its strategic objectives. The plan lacks, however, a core framework for the M&E system, a designated supervisory body, and a clear budget for monitoring and auditing activities. These omissions are likely to lead to disappointing outcomes once again. Without a centralized monitoring strategy, it will be difficult to hold implementing authorities accountable for progress. The absence of monitoring mechanisms hinders the collection and transmission of feedback on the performance of the various strategies and interventions, limiting the potential for learning lessons and for developing improvements over time.

The Global Fund has provided financial and technical resources to CONISIDA for the monitoring and evaluation of HIV/AIDS initiatives, which has allowed Nicaragua to expand M&E coverage to include an evaluation of NGO interventions. The committee that carries out civil society monitoring does not include representatives of people living with HIV/AIDS, however.[98]

Since the 1980s, Nicaragua has relied on a HIV/AIDS surveillance system that focuses mainly on the gathering of data on rates of infection. The government has recently begun to expand the system to include the monitoring of changes in risk behavior, in collaboration with international donors and United Nations (UN) agencies.

The country's epidemiological surveillance plan, however, still lacks clear guidelines to evaluate the success of initiatives to control HIV/AIDS and STIs. It also lacks a quality-control system to ensure the reliability of the collected data. Many experts believe that the official reports of the rates of HIV/AIDS incidence and prevalence grossly underestimate the true extent of the spread of the disease. In addition, the surveillance data are centralized in the Ministry of Health, and so are not easily accessible to the public. The data are also not fully analyzed to provide stratified data by groups, limiting their usefulness in guiding policies and new initiatives. Further, surveys by NGOs and academic institutions have not yet been compiled into a single database, which could serve as a reference tool.

During the past three years, Nicaragua has made an increased investment in building capacity for surveillance, monitoring and evaluation, and, in particular, the training of

Ministry of Health personnel.[99] The Country Response Information System (CRIS) developed by UNAIDS was not widely rolled out in 2006 as originally planned, however. The adoption and consistent use of the CRIS, which was developed specifically to assist with UNGASS reporting, could have supported national monitoring efforts. Similarly, plans to update the national HIV/AIDS database have been pending for several years.

# Recommendations

The following recommendations for the government of Nicaragua, based on research and consultations conducted for this report, specify strategies that will improve the national response to HIV/AIDS.

- Strengthen CONISIDA to effectively serve as a national coordinating body that promotes collaboration among international donors, government, and civil society; allows for meaningful civil society participation in policy processes; facilitates exchange of knowledge and best practices; and monitors implementation of national strategic objectives.
- Improve the collection and analysis of epidemiological surveillance data to identify high-risk groups in order to guide the development of interventions that effectively target these groups with prevention, treatment, and care services.
- Build the capacity of the health care sector to improve the delivery of HIV/AIDS-related services, including through the development of the infrastructure, training of health care workers, and more-effective decentralization of health services.
- Enhance coordination between HIV and TB programming to address TB/HIV coinfection, including by adopting and implementing the WHO's Interim Policy on Collaborative TB/HIV Activities, which stipulates the creation of a TB/HIV coordinating body, the joint planning of actions, and the increased monitoring of HIV/AIDS prevalence among TB patients.
- Develop and implement comprehensive communication strategies to target key marginalized populations and groups at high risk for HIV, including by addressing the underlying social and cultural factors that influence vulnerability.
- Strengthen legal protection for people living with HIV/AIDS, including by establishing a committee to collect and prosecute HIV/AIDS-related discrimination cases.

# Notes

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**[We] acknowledg[e] the particular role and significant contribution of people living with HIV/AIDS, young people and civil society actors in addressing the problem of HIV/AIDS in all its aspects, and recogniz[e] that their full involvement and participation in the design, planning, implementation and evaluation of programmes is crucial to the development of effective responses to the HIV/AIDS epidemic.**

**—UNGASS Declaration of Commitment on HIV/AIDS, Article 33**

Public Health Watch promotes informed civil society engagement in policymaking on tuberculosis and HIV/AIDS. The project's monitoring reports offer a civil society perspective on the extent to which government policies comply with international commitments such as the Amsterdam Declaration to Stop Tuberculosis and the Declaration of Commitment on HIV/AIDS—and on the extent to which those policies have been implemented. HIV/AIDS monitoring reports include assessments of policies in Nicaragua, Senegal, Ukraine, the United States, and Vietnam.

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