

HIV/AIDS

Objective 6 To combat HIV/AIDS, malaria and other diseases

Goal 7 To have stopped and started to reduce the propagation of HIV/AIDS by the year 2015

Goal 8 To have stopped and started to reduce the incidence of malaria and other serious diseases by 2015

Performance Summary

Status of support conditions for attaining goal

Weak but improving

Will the goal be reached?

Very unlikely



Diagnosis and Trends

Guatemala reported its first case of AIDS in mid 1984. According to information provided by the National ETS/HIV/AIDS Prevention and Control Programme of the Ministry of Health, a total of 4,369 cases (74% are men) has been reported from 1984 to 2001. Twenty percent of these cases are of people between the ages of 15-24. According to the Ministry of Health (2001), the departments reporting the highest number of cases were Guatemala, Izabal and Retalhuleu. At present, reporting cases of AIDS is required, but due to diagnostic limitations and problems with the reporting system, it is estimated that the number of cases is higher than recorded.⁷² UNAIDS estimates that by the end of 2001 the number of adults (ages 15-49) infected with HIV was 67,000 in the whole country.⁷³

According to information provided by UNAIDS, HIV sero-prevalence studies have been systematically conducted since 1998 in certain departments of the country. This has enabled UNAIDS to get a better approximation of the number to characterize the HIV/AIDS epidemic in Guatemala. The serological samples collected from October 2000 to January 2001 in seven departments show that 57% of the HIV+ cases in women were of women between the ages of 16-25.⁷⁴ This same study concluded that the general HIV seroprevalence in the study groups was 1.10% (47/4259), and in low-risk groups (women who had recently given birth, applicants for health cards, and blood banks) a seroprevalence of 0.5% (IC 95%, 0.29-0.85%) was found, similar to the one seen in prior "Centinela" studies.⁷⁵ In high risk groups (sex workers and the military) seroprevalence was 2.42%.⁷⁶ There are some places such as Petén, Izabal and Escuintla that are undergoing a concentrated phase, and where seropositive conditions in the high-risk group are quite high.⁷⁷

In 1999 the Central American AIDS Action Project (PASCA) conducted an initial exercise to estimate the magnitude of the HIV epidemic in the country, using the Spectrum software. The estimated HIV prevalence in adults (ages 15-49) rose from 0.05% to 0.85% between 1990 and 2001, and it is estimated that if all things continue

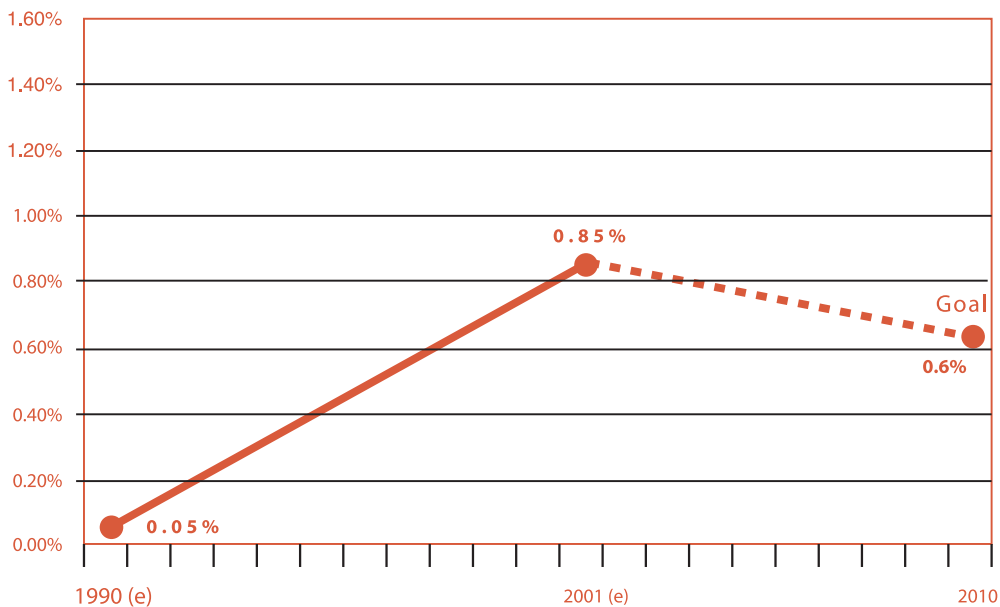
to be the same, by 2010 prevalence will be 1.56%, which means that some 111,087 people will be infected with AIDS.⁷⁸ According to these estimates, for the year 2001 the country had recorded a total of 44,754 people infected with HIV (this number could fluctuate between 33,565 and 55,942), of which 76% are in the high-risk groups (female sex workers, men who have sex with other men, and people with sexually-transmitted diseases). The highest percentage of this high-risk group is made up by a sub-group of men who have sex with men (35% of the total). Existing information has allowed us to establish that the HIV/AIDS epidemic has become entrenched in the high-risk groups studied, which is a characteristic of an epidemic of concentrated level.

The Action Plan of the International Conference on Population and Development set the following goals: to enable at least 90% of the population between the ages of 15-24 to have access to preventive methods by the year 2005; and to reduce the seroprevalence of this population by 25% by the year 2010. The challenge in the case of Guatemala, specifically as regards the population between the ages of 15-49, means that seroprevalence must be reduced to 0.6%.

GRAPH 13

To reduce the propagation of HIV/AIDS

**HIV prevalence in adults ages 15-49
(1990 and 2001 estimates, and 2010 goal)**



Source: Own estimates from PASCA (2002) information. "Guatemala: Estimates and Projections of HIV/AIDS Epidemic, 1980-2010 Period", preliminary version.

Until the end of 2001 the estimated number of orphaned children still alive (not yet 15 years of age) who had lost either father or mother, or both parents due to AIDS was 32,000.⁷⁹ However, the use of contraceptive methods by married women has increased. In 1987 the use of these methods reached 23%; 32% in 1995, and 38% in 1998.⁸⁰ However, in 1998 only 27% of women between the ages of 15-49 used some type of contraceptive method and only 1.6% used a condom (2.3% in the case of married women).⁸¹

Malaria

Based on information from the Gradual Elimination of DDT Project, it has been estimated that the incidence rate of confirmed malaria cases increased from 0.4 to 31 per 1000 inhabitants between 1990 and 2001. There is no information on the percentage of people in risk areas that apply efficient malaria prevention and treatment measures. According to information provided by PAHO, the country has been classified into high, medium and low-risk areas, with incidence rates of 25.9, 6.3 and 2.2 per 100,000 inhabitants, respectively, in the year 2001. Twenty-five percent of the people live in high-risk areas; 40% in medium-risk areas and 35% in low-risk areas. In total, there were 43,419 cases reported in 2001. Of this cases, 1,411 were infected by *P.falciparum* (the most dangerous) and the rest by *P.vivax*. There were no reports of deaths due to malaria. Sixty-six percent of malaria cases and 78% of cases by *P.falciparum* occurred in high-risk areas.

According to information provided by the Ministry of Public Health, in 2001 the number of people at high risk of contracting malaria was 3,945,988 and the main high-risk territories were Alta Verapaz (with 34% of the total number of cases in the country); the Ixcán (part of El Quiché, with 13% of total cases); the southwestern, southeastern, and northern Petén regions (with 19%, 11% and 3%, respectively, of total number of cases).

Tuberculosis

According to information provided by the National Tuberculosis Programme of the Ministry of Public Health, the registered incidence rate of tuberculosis dropped from 32 to 24 per 100,000 inhabitants between 1996 and 2000, more than 90% having been Bk+. WHO/PAHO estimated the incidence rate of tuberculosis to be 85 per 100,000 inhabitants for the year 2000, of which 45%, that is, 38 per 100,000 per year would be Bk+. In the year 2000 63% of the cases were incorporated into the directly observed treatment shortened (DOTS/TAES) strategy and 75% of patients were cured.

Policies and Programmes

The participation of the Government and civil society in the Global Fund initiative sponsored by United Nations is a fundamental step towards obtaining funding to support the actions being carried out in this country relative to HIV/AIDS, malaria and tuberculosis.

HIV/AIDS

Starting in 1991, the National Program for HIV/AIDS Prevention was implemented but without any legal support basis and not considered as a priority. It was not until the year 2000 when the National Program for Prevention and Control of STI/HIV/AIDS was legally established when the “General Law for Combating the Human Immunodeficiency Virus – HIV- and the Acquired Immunodeficiency Syndrome –AIDS- and for the Promotion, Protection, and Defense of Human Rights of people with HIV/AIDS” was approved by Decree No. 27-2000 of the Congress of the Republic. Additionally, a Multi-Sector Commission made up of organizations that oversee and work for the prevention of STI/HIV/AIDS was created, and the infection by HIV/AIDS was declared to be a national emergency. For the very first time, in 2001 a budgetary line item was allocated to the Ministry of Health specifically for combating AIDS. In August 2002 the President of the Republic publicly assumed the commitment to ensure universal access to treatment against retroviruses, in accordance with national protocols established by consensus. At present there is a 2000-2004 National Strategic Plan in place, and this plan specifies the work objectives of the National STI/HIV/AIDS Programme and the strategies to be followed in the coming years.

Malaria

In the decade of the ‘90s operations personnel of the former Malaria Division of the Ministry of Health was deployed to the departments, resulting in the creation of a coordinating body for Vector-borne Diseases. This section had the responsibility of providing technical assistance for implementing the standards of the vector programmes. During the first years goals were set for eradication through the use of insecticides and radical (mass) treatment for the cure of this disease. Subsequently, a two-stage process of technical re-adaptation and standardization (1997 and 1999) was implemented. In 2001 a process for strengthening diagnostic capacity was implemented, and in 2002 the National Plan for Promoting, Preventing and Controlling Malaria was designed. At present local plans have been completed for two of the high-risk areas (Ixcán and Sayaxché). The classification of high-risk areas has been prepared using the Annual Parasite Index (API), but starting in 2002 the plans will use other strategies besides de API. The strategy presently approved in the National Strategic Plan gives priority to epidemiological surveillance, early detection and adequate treatment of cases, community participation, and integral vector control.

As part of the initiative to “Reverse Malaria” measures are being applied for full vector control, and to adapt these measures to the local reality. The measures include: physical measures for controlling breeding grounds, the use of barriers (impregnated pavilions), biological control with *Bacillus Sphaericus*, larva-eating fish (*Poecilia reticulata* and *Gambusia* spp.), and a limited use of residual action insecticides (piretroids, carbamates, and larvicides). Recently the specific

plans for priority areas were completed. It is foreseen that work will start in 2003 in 341 locations in the country where malaria is present. Finally, the goal is to have reduced *P.vivax* by 40% and *P.falciparum* by 60%, with community participation (Social Action Groups), by 2008.

Tuberculosis

Supervision of treatment of tuberculosis is assessed by cohort studies of shortened treatment of confirmed pulmonary cases by positive bacilloscopy. It is known that the presence of HIV is one of the most important factors in increasing the number of cases of tuberculosis. The National Tuberculosis Programme has a standard rule (prior to counseling) to offer an evaluation to detect the presence of HIV to patients who are beginning treatment. Other important programmes are the DOTS/TAES Strategy applied at national level, the improvement of capacities and quality control of the laboratory network, and the preparatory work to conduct the first National Survey on Resistance. The medications and lab tests are free at specific centers open to the public.

Challenges and Priorities

On the basis of estimates made by the HIV/AIDS, malaria and tuberculosis programmes to enable them to request financial resources from the Global Fund, it is believed that at least some US\$100 million will be required during the 2003-2015 period to be able to achieve these goals. However, additional resources will be required from international cooperation and the Government to ensure that the goals that are not reached with Global Fund resources, are indeed reached.⁸²

The main challenges are to remove the stigma from groups that are at risk of HIV/SIDA, incorporate the different social actors into all actions to prevent malaria, beginning with high-risk locations, institutionalize inter-sector coordination, improve surveillance and control capacities, improve the targeting of the most vulnerable populations, do an epidemiological characterization of the disease, strengthen health areas, and promote decentralization.

Evaluation and Follow-up Capacity

Evaluation & follow-up capacity elements	Value		
	Very Good	Good	Poor
Amount and regularity of information from surveys		✓	
Data Collection Capacity		✓	
Quality of information from recent surveys		✓	
Statistical follow-up capacity		✓	
Statistical analysis capacity		✓	
Capacity to incorporate statistical analysis to policies, plans and mechanisms to allocate resources			✓
Monitoring and Assessment Mechanisms			✓
Reporting and information dissemination capacity			✓