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# EL SALVADOR HIV/AIDS ASSESSMENT AND DESIGN

March 2010

This publication was produced for review by the United States Agency for International Development. It was prepared by Carlos Balcáceres, Hilary Hughes, Margarita de Monroy, and Rose Schneider through the Global Health Technical Assistance Project.



# EL SALVADOR HIV/AIDS ASSESSMENT AND DESIGN

RECOMMENDATIONS FOR USAID SUPPORT  
TO THE NATIONAL HIV/AIDS RESPONSE IN  
EL SALVADOR, 2010–2015

## **DISCLAIMER**

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This document was submitted by The QED Group, LLC, with CAMRIS International and Social & Scientific Systems, Inc., to the United States Agency for International Development under USAID Contract No. GHS-I-00-05-00005-00.

## ACRONYMS

AIDS	acquired immune deficiency syndrome
AOP	Annual Operational Plan
ART	antiretroviral therapy
ARV	antiretrovirus
BCC	behavior change communication
BCI	behavior change intervention
BSS	behavioral surveillance survey
CAM	Central America and Mexico
CCM	Country Coordinating Mechanism
CDC	Centers for Disease Control and Prevention
COMISCA	Council of Ministers of Health for Central America
CONASIDA	National AIDS Commission (Sp.)
DHS	demographic and health survey
DOD	Department of Defense
FBO	faith-based organization
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GH Tech	Global Health Technical Assistance Project
GOES	Government of El Salvador
GTZ	German Development Cooperation
HCW	health care worker
HIV	human immunodeficiency virus
HSS	health systems strengthening
IEC	information, education, and communication
IHAA	International HIV/AIDS Alliance
ISSS	Social Security Institute (Sp.)
KAP	knowledge, attitudes, and practices
M&E	monitoring and evaluation
MARP	most-at-risk populations
MCH	maternal and child health
MOE	Ministry of Education
MOH	Ministry of Health
MSM	men who have sex with men
MSPAS	Ministry of Public Health and Social Assistance
NAP	National AIDS Program
NSP	National Strategic Plan
OECD	Organization for Economic Co-operation and Development
OI	opportunistic infection
PAHO	Pan American Health Organization
PASCA	Program for Strengthening the Central American Response to HIV
PASMO	Pan American Social Marketing Organization

PC	Peace Corps
PLWHIV	people living with HIV
PMTCT	prevention of mother-to-child transmission
RCM	Regional Coordinating Mechanism
RH	reproductive health
S&D	stigma and discrimination
SICA	Central American Integration System
SISCA	Central American Secretary of Social Integration
STI	sexually transmitted infection
SUMEVE	Unified System of Monitoring, Evaluation, and Epidemiological Surveillance
SW	sex worker
UA	universal access
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
USAID	U.S. Agency for International Development
VCT	voluntary counseling and testing

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## EXECUTIVE SUMMARY

The El Salvador HIV/AIDS Assessment and Design was commissioned by the USAID/ES bilateral program and executed by GH Tech and the QED Group. The purpose of this assessment is to identify the most cost-effective, value-added strategy for USAID's continued support to El Salvador's national response over the next five years. Recommendations are based on evidence and prioritized in order to maximize aid effectiveness, in line with the Paris Declaration on Aid Effectiveness (2005) and the Accra Agenda for Action (2008), to which the U.S. and El Salvadoran Governments are signatory.<sup>1</sup>

USAID's bilateral and regional programs combined invest approximately US\$2 million per year in HIV/AIDS in El Salvador. These amounts are small compared to the tens of millions in grants awarded by the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) for HIV/AIDS, regionally and nationally, covering the next five years. Despite the modest financial investment involved, this assessment aims to provide a model for USAID bilateral support, demonstrating aid effectiveness and using Health as a Tracer Sector (HATS), as proposed by the Organisation for Economic Co-operation and Development (OECD).

The assessment team found that USAID has a comparative advantage when it comes to supporting national strategies and activities, with the potential to achieve relatively significant program results in return for small investment. The three main objectives for the assessment are as follows:

1. assess the HIV/AIDS situation and response in El Salvador, including identification of key actors and their contribution to this response (as well as their geographical focus areas, populations, and amount and duration of support).
2. identify the main needs existing in HIV/AIDS treatment and prevention, as well as intervention opportunities.
3. propose future USAID/El Salvador strategies, interventions, and corresponding activities to address those needs.

The methodology used included desk review of extensive documentation on the HIV/AIDS situation and national response (see Appendix D for references), as well as qualitative research conducted through individual interviews (see Appendix B for a list of persons interviewed) and focus group discussions among three distinct NGO groups (see Appendix C for full details).

This report covers advances, challenges, and recommendations for the following program areas: prevention, health systems strengthening, strategic information, and policy environment.

The assessment primarily focuses on prevention, given the nature of El Salvador's concentrated HIV/AIDS epidemic and the national response to date (see Section I below). While HIV prevalence in the general population is less than 1%, far higher rates are found in men who have sex with men (MSM) (17.75%), sex workers (SWs) (3.6%), and female crack cocaine users (8.5%).

Advances to date are largely clinical. The assessment recommends a paradigm shift in the national response toward prevention. This includes the need to expand behavior change communication (BCC) among most-at-risk populations (MARPs) such as SWs and MSM; to bridge populations such as clients of sex workers and female partners of MSM; and to reach vulnerable groups such as youth, drug users (cocaine), and prisoners. Rapid expansion of prevention education will require equally rapid expansion of technical assistance and funds to multiple civil society organizations working closely with MARPs and vulnerable populations at the provincial and community levels (see Prevention, Section II).

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<sup>1</sup> Available at [http://www.oecd.org/document/18/0,2340,en\\_2649\\_3236398\\_35401554\\_1\\_1\\_1\\_1,00.html](http://www.oecd.org/document/18/0,2340,en_2649_3236398_35401554_1_1_1_1,00.html).

Prevention also requires improving the quality of counseling in clinical settings and addressing the challenges in HIV/AIDS/sexually transmitted infection (STI) and tuberculosis (TB) testing and treatment which continue to fuel the spread of HIV (see Health Systems Strengthening, Section III). In order to ensure that the quality and coverage of prevention efforts are adequately monitored and evaluated, recommendations include the importance of involving civil society implementers in the country's Unified System of Monitoring, Evaluation, and Epidemiological Surveillance (known as its Spanish acronym SUMEVE) (see Strategic Information, Section IV).

Due to its limited funds, USAID's support to the national program should go beyond financial assistance; recommendations therefore target areas that require leverage and advocacy rather than funds. Table One below summarizes these findings, taking into consideration ongoing and planned support from other regional and national HIV/AIDS programs, such as those of SICA/SISCA and GFATM.

## RESUMEN EJECUTIVO

La evaluación y propuesta de acciones ante VIH/SIDA en El Salvador es una iniciativa solicitada por el programa bilateral de USAID/El Salvador y ejecutado por GH Tech y el QED Group. El propósito de esta evaluación es identificar las estrategias de apoyo más efectivas y de mayor valor agregado que USAID podría brindar a la respuesta nacional de El Salvador en los próximos cinco años. Las recomendaciones se fundamentan en la evidencia y son priorizadas en el contexto de la maximización de eficacia de este apoyo, de conformidad con la Declaración de París (2005) y el Programa de Acción de Accra (2008), al que los Estados Unidos y El Salvador son los gobiernos signatarios.<sup>2</sup>

Los programas bilateral y regional de USAID en conjunto invierten aproximadamente US \$2 millones por año al apoyo ante VIH/SIDA para El Salvador. Esta cantidad es modesta comparada con las decenas de millones en subvenciones a nivel de regional y nacional concedidas por el Fondo Mundial de Lucha contra el SIDA, la Tuberculosis y la Malaria (FMSTM) para los próximos cinco años. Tomando en cuenta lo moderado de dicha inversión, esta evaluación tiene por objeto proporcionar una propuesta de apoyo para USAID/El Salvador con un enfoque en la eficacia de la ayuda, desde la perspectiva de la salud como un eje trazador, según lo propuesto por la Organización para la Cooperación y el Desarrollo Económico (OCDE).

Los hallazgos de la evaluación identifican que la ventaja comparativa de USAID radica en lograr importantes resultados programáticos mediante el apoyo a la estrategia y las actividades nacionales, con una inversión modesta. Los tres objetivos principales para la evaluación incluyen:

1. evaluar la situación del VIH/SIDA y la respuesta en El Salvador, incluyendo la identificación de los actores claves y su contribución a esta respuesta (incluida su zona geográfica de atención, áreas de apoyo, las poblaciones, la cantidad y duración de la ayuda).
2. identificar las principales necesidades en cuanto al tratamiento y la prevención del VIH/SIDA y las oportunidades de intervención.
3. proponer a USAID / El Salvador futuras estrategias, intervenciones y actividades correspondientes para hacer frente a esas necesidades.

La metodología utilizada consistió en la revisión preliminar de una extensa documentación sobre la situación del VIH/SIDA y su respuesta nacional (véase el Apéndice D para referencias), así como la investigación cualitativa mediante entrevistas individuales (véase el Apéndice B para la lista de personas entrevistadas) y discusiones de grupos focales con tres aglomerados diferentes de organizaciones no gubernamentales (véase el Apéndice C para más detalles).

El presente informe abarca los avances, desafíos y recomendaciones para las siguientes áreas programáticas: la prevención, el fortalecimiento de los sistemas de salud, información estratégica y entorno político.

El enfoque global de la evaluación radica en la prevención, dada la naturaleza concentrada de la epidemia de VIH/SIDA en El Salvador y la respuesta nacional a la fecha (véase la Sección I). Si bien el predominio del VIH en la población general es inferior al 1%, se encuentran índices mucho más elevados en hombres que tienen sexo con hombres (HSH, 17,75%), trabajadores sexuales (TS 3,6%) y entre las mujeres que consumen cocaína/crack (8,5%).

Los avances hasta la fecha tienen en gran medida un enfoque clínico. Esta evaluación recomienda un cambio de paradigma en la respuesta nacional hacia la prevención. Esto incluye la necesidad de ampliar la comunicación para el cambio de comportamiento (CCC) entre las poblaciones en

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<sup>2</sup> [http://www.oecd.org/document/18/0,2340,en\\_2649\\_3236398\\_35401554\\_1\\_1\\_1\\_1,00.html](http://www.oecd.org/document/18/0,2340,en_2649_3236398_35401554_1_1_1_1,00.html).

condiciones de mayor riesgo como los TS y los HSH; poblaciones puente como la clientela de los trabajadores sexuales y las parejas femeninas de los HSH; y los grupos vulnerables como los jóvenes, consumidores de drogas (cocaína) y encarcelados. La rápida expansión de la educación en prevención requerirá igualmente rápida expansión de la asistencia técnica y fondos para varias organizaciones de la sociedad civil que trabajan en estrecha colaboración con la población en condiciones de mayor riesgo y las poblaciones vulnerables a nivel municipal y comunitario (véase Prevención, Sección II).

La prevención también requiere mejorar la calidad de la consejería en las clínicas y abordar los desafíos presentes en la evaluación y el tratamiento del VIH/SIDA, las infecciones de transmisión sexual (ITS) y la tuberculosis (TB) por su importancia crítica en la propagación del VIH (véase Fortalecimiento de Sistemas de Salud, Sección III). Con el fin de garantizar que la calidad y la cobertura de los esfuerzos de prevención estén adecuadamente supervisados y evaluados, dentro de las recomendaciones se incluye la importancia de la participación de la sociedad civil en el Sistema Único de Monitoreo, Evaluación y Vigilancia Epidemiológica (SUMEVE, ver Información Estratégica, Sección IV).

Debido a lo limitado de los fondos, el apoyo de USAID a la respuesta nacional debe ir más allá de la asistencia financiera y es por ello que en las recomendaciones se incluyen áreas que requieren de apalancamiento y abogacía. El cuadro de abajo resume estos hallazgos, teniendo en cuenta el apoyo en curso y previsto por otros programas nacionales y regionales de VIH/SIDA, tales como SICA/SISCA y el Fondo Mundial de Lucha contra el SIDA

**TABLE I. SELECTED ASSESSMENT FINDINGS: SUMMARY**

Program Area	Advances	Challenges	Recommendations	Time-frame	Budget Implications
Prevention (Community)–Section II	<ul style="list-style-type: none"> <li>Increasing number of local and international NGOs carrying out prevention and/or support activities at district level. PASMO is the major implementer with USAID support for BCC among MARP in selected cities.</li> <li>Large quantity of information, education, and communication (IEC) materials produced.</li> </ul>	<ul style="list-style-type: none"> <li>Need for expanded, focused behavior change communication (BCC) among MARP and vulnerable groups, to reduce high-risk behaviors and increase health-seeking behaviors.</li> <li>Need for targeted BCC among vulnerable groups, such as bridging populations, youth, drug users, and prisoners.</li> <li>Need for expanded social mobilization to implement prevention education, BCC, and advocacy.</li> <li>Need to address high levels of STIs in MARP and other vulnerable populations.</li> <li>Need for more effective distribution and use of IEC materials, especially materials related to health sector in service training.</li> <li>High levels of stigma and discrimination (S&amp;D) in health care settings affect access to services and prevention education.</li> </ul>	<ul style="list-style-type: none"> <li>Help create umbrella mechanism to channel expanded technical assistance (TA) and funds to multiple NGOs, and to expand community prevention among MARP, youth, drug users, and prisoners. Support proposals from civil society networks and develop a request for proposals (RFP) to identify umbrella organization.</li> <li>Support aggressive BCC efforts to increase STI awareness and behavior change in MARP and vulnerable groups; improve risk assessment counseling for vulnerable clients attending health facilities; and promote early diagnosis and treatment of STIs.</li> <li>Support design of a national BCC strategy, including an S&amp;D component, as part of revised National Strategic Plan (NSP).</li> <li>Promote multi-sectoral involvement in development of IEC materials, especially among youth and MARP.</li> </ul>	<p>2010–2011</p> <p>2010–2015</p> <p>2010–2011</p>	<p>High</p> <p>Medium</p> <p>Low</p>
Health Systems Strengthening–Section III	<ul style="list-style-type: none"> <li>Good coverage has been achieved for prevention of mother-to-child transmission (PMTCT), voluntary counseling and testing (VCT), and antiretroviral therapy (ART) services.</li> <li>The National AIDS Program (NAP) is restructuring itself to create a multidisciplinary team and integrate HIV/AIDS, TB, maternal and child health (MCH), adolescent health, and STI programs.</li> <li>Most norms and guidelines are now updated and ready for printing.</li> <li>HIV treatment among prisoners has been initiated.</li> <li>Most PLWHIV have access to TB prevention and treatment.</li> </ul>	<ul style="list-style-type: none"> <li>Missed opportunities in sexual health counseling in the clinic setting contribute to the spread of HIV, by failing to increase client awareness of risks or motivate behavior change.</li> <li>High levels of S&amp;D among health care workers (HCWs) decrease access to VCT, STI, and ART services.</li> <li>High levels of STIs among MARP and vulnerable populations need to be addressed through early diagnosis and treatment (see also Prevention, above).</li> <li>Early investigation and ongoing monitoring of antiretroviral (ARV) drug resistance are needed.</li> </ul>	<ul style="list-style-type: none"> <li>Regional SICA, USAID, and GFATM grants are providing support in most areas identified as challenged. USAID comparative advantage lies in advocacy at the appropriate levels: <ul style="list-style-type: none"> <li>validate norms and guidelines to global standards with MARP input, especially those for pre-test and post-test counseling.</li> <li>support quality assurance in service delivery for PMTCT, VCT, and ARV through improved in-service training and follow-up, focusing on confidentiality, human rights, and behavior change counseling. Monitor contribution to prevention.</li> <li>expand access to STI diagnosis &amp; treatment among MARP and vulnerable clients (see above).</li> <li>support early ARV drug resistance monitoring.</li> </ul> </li> </ul>	<p>2010–2015</p>	<p>Low</p> <p>Low</p>
Strategic Information–Section IV	<ul style="list-style-type: none"> <li>The country has a national monitoring &amp; evaluation (M&amp;E) plan with considerable baseline data developed.</li> <li>The National AIDS Commission (CONASIDA) has an M&amp;E subcommittee linked to the national HIV/AIDS/STI program.</li> </ul>	<ul style="list-style-type: none"> <li>CONASIDA’s M&amp;E sub-committee needs increased support to fulfill its mission.</li> <li>SUMEVE currently only houses surveillance data; added data components remain to be implemented as planned.</li> <li>Second-generation surveillance data, including behavioral surveillance survey</li> </ul>	<ul style="list-style-type: none"> <li>Work with the Joint United Nations Programme on HIV/AIDS (UNAIDS) to strengthen CONASIDA’s M&amp;E sub-committee, with focus on incorporating civil society into a unified national M&amp;E system and improving data use for decision-making in community-based prevention.</li> <li>Provide technical and financial support to involve</li> </ul>	<p>2010–2011</p>	<p>Medium</p>

	<ul style="list-style-type: none"> <li>A Unified System of Monitoring, Evaluation, and Epidemiological Surveillance (SUMEVE) has been initiated.</li> </ul>	<p>data (BSS and BSS+), need to be shared more swiftly for timelier use in decision-making.</p>	<p>civil society in a fully functional national M&amp;E system, possibly through Internet access to SUMEVE at provincial level.</p> <ul style="list-style-type: none"> <li>Support data use for decision-making in all program areas, involving all sectors.</li> </ul>	2010–2015	
Policy Environment–Section V	<ul style="list-style-type: none"> <li>NAP is governed by advisory body CONASIDA, with largely government-sector representation.</li> <li>A Country Coordinating Mechanism (CCM) was formed in 2003 following major GFATM investment in HIV and TB.</li> <li>Good baseline data exist for most intervention areas, as well as data relating to social determinants of HIV/AIDS, such as S&amp;D, within health and community settings.</li> </ul>	<ul style="list-style-type: none"> <li>National HIV/AIDS response is highly dependent on GFATM funds.</li> <li>Greater leadership in national response is needed; roles between CONASIDA and CCM need to be more clearly defined.</li> <li>S&amp;D remains major challenge to policy environment (see also HSS and Prevention, above).</li> <li>Limited civil society involvement in implementation of program limits quality and coverage of key services.</li> <li>The NSP 2005–2010 is due for revision.</li> </ul>	<ul style="list-style-type: none"> <li>Work with partners to support: <ul style="list-style-type: none"> <li>development of phase-out/phase-in GFATM proposal using National Strategy Application to ensure sustainability and integration of HIV/AIDS in health sector policies.</li> <li>strengthening CONASIDA to improve civil society, private-sector, and line ministry involvement.</li> <li>formation of civil society umbrella organization to strengthen NGO involvement in prevention (see above).</li> <li>participatory process for revision of NSP.</li> </ul> </li> </ul>	2010–2011 2010–2013 2010	Low

**CUADRO I. RESUMEN DE LOS HALLAZGOS CLAVES ENCONTRADOS EN LA EVALUACIÓN**

Área Programática	Avances	Desafíos	Recomendaciones	Temporalidad	Implicaciones Presupuestarias
Prevenición (Comunidad) - Sección II	<ul style="list-style-type: none"> <li>Incremento del número de ONG nacionales e internacionales en la realización de actividades de prevención y/o de apoyo a nivel local. PASMO, con el apoyo de USAID, es el mayor ejecutor de actividades para el CCC con poblaciones en condiciones de mayor vulnerabilidad en ciudades específicas.</li> <li>Hay gran cantidad de materiales producidos para la realización de actividades de información, educación y comunicación (IEC).</li> </ul>	<ul style="list-style-type: none"> <li>Hay necesidad de expandir las actividades de comunicación enfocadas al cambio de conducta (CCC) entre las poblaciones en condiciones de mayor vulnerabilidad para reducir los comportamientos de alto riesgo fomentar la demanda de servicios de salud.</li> <li>Hay necesidad de precisión de actividades de CCC entre grupos vulnerables, como las poblaciones puente, jóvenes, consumidores de drogas y encarcelados.</li> <li>Hay necesidad de ampliar la movilización social para implementar actividades educativas de prevención, CCC y abogacía.</li> <li>Hay necesidad de atender los altos índices de ITS en poblaciones en condiciones de mayor vulnerabilidad y otras.</li> <li>Hay necesidad de mejorar la eficacia en la distribución y el uso de materiales de IEC, en particular los materiales relacionados con la capacitación del sector salud.</li> <li>Los altos niveles de estigma y discriminación (E&amp;D) en los centros de atención de salud afectan el acceso a los servicios de educación y prevención.</li> </ul>	<ul style="list-style-type: none"> <li>Apoyar la formación de un mecanismo “sombriilla” tanto para canalizar la asistencia técnica y financiera para múltiples ONG, como para ampliar las actividades comunitarias de prevención entre poblaciones en condiciones de mayor vulnerabilidad, jóvenes, consumidores de drogas y encarcelados. Apoyar las propuestas de redes de la sociedad civil y llevar a cabo una solicitud de propuesta para identificar dicha organización sombrilla.</li> <li>Apoyar esfuerzos contundentes de CCC para aumentar la concienciación sobre las ITS y el cambio de comportamiento en las poblaciones en condiciones de mayor vulnerabilidad. Mejorar, en los centros de salud, la consejería sobre conductas de riesgo hacia las personas vulnerables y apoyar el diagnóstico precoz y el tratamiento oportuno de ITS.</li> <li>Apoyar en el proceso de actualización del Plan Estratégico Nacional (PEN) el diseño de un plan estratégico nacional de CCC que incluya un componente de E&amp;D.</li> <li>Apoyar participación multisectorial, principalmente de jóvenes y poblaciones en condiciones de mayor vulnerabilidad, en el diseño de materiales (IEC).</li> </ul>	<p>2010–2011</p> <p>2010–2015</p> <p>2010–2011</p>	<p>Alto</p> <p>Medio</p> <p>Bajo</p>

Fortalecimiento del Sistema de Salud - Sección III	<ul style="list-style-type: none"> <li>• Buena cobertura alcanzada en la prevención de la transmisión vertical, acceso a la Asesoría/consejería y Prueba Voluntaria del VIH (APV) y terapia antirretroviral (TAR).</li> <li>• El Programa Nacional de VIH / SIDA (PNS) se encuentra en proceso reestructuración para crear un equipo multidisciplinario integrando los programas de VIH / SIDA/ ITS, tuberculosis, salud materno-infantil y salud de los adolescentes.</li> <li>• La mayoría de las normas y protocolos están actualizados y listos para ser reproducidos.</li> <li>• Se ha iniciado el tratamiento de VIH para personas encarceladas.</li> <li>• La mayoría de las personas viviendo con VIH reciben orientación para la prevención y/o tratamiento contra la tuberculosis.</li> </ul>	<ul style="list-style-type: none"> <li>• La prevención del VIH no se aborda adecuadamente durante la consejería sobre de salud sexual y reproductiva en los establecimientos de salud, perdiendo así oportunidades claves para aumentar la conciencia del usuario sobre las conductas de riesgo y motivarle a realizar cambios de comportamiento.</li> <li>• Los altos niveles de E&amp;D en los trabajadores de salud disminuyen el acceso la APV y los servicios de ITS y TAR.</li> <li>• Los altos niveles de infecciones de transmisión sexual entre en las poblaciones en condiciones de mayor vulnerabilidad deben ser abordados a través de un diagnóstico precoz y el tratamiento oportuno. <i>(Véase también la sección previa de Prevención).</i></li> <li>• Es necesaria una pronta investigación y monitoreo permanente de farmacorresistencia a los antirretrovirales (ARV).</li> </ul>	<ul style="list-style-type: none"> <li>• Las subvenciones de SICA, USAID y Fondo Mundial están brindando apoyo a la mayoría de los desafíos identificados en esta evaluación. La ventaja comparativa de USAID reside en incidir en diferentes ámbitos para: <ul style="list-style-type: none"> <li>– Validar las normas y protocolos nacionales con los estándares mundiales, especialmente aquellas relacionadas con la pre-y post-consejería, tomando en cuenta aportes que brinden representantes de poblaciones en condiciones de mayor vulnerabilidad.</li> <li>– Apoyar el aseguramiento de la calidad en la prestación de servicios como la prevención de PTMI, APV y TAR mediante capacitaciones de perfeccionamiento al personal y su respectivo seguimiento, enfocándose temas como confidencialidad, derechos humanos, consejería para el cambio de conducta. Monitorear la contribución de estos servicios a la prevención.</li> <li>– Ampliar el acceso al diagnóstico y tratamiento de ITS en las poblaciones en condiciones de mayor vulnerabilidad <i>(véase la sección anterior).</i></li> <li>– Apoyar el monitoreo temprano de la farmacorresistencia a los ARV.</li> </ul> </li> </ul>	2010–2015	Bajo  Bajo
Información Estratégica - Sección IV	<ul style="list-style-type: none"> <li>• El país tiene un plan nacional de monitoreo y evaluación (M&amp;E) desarrollado con considerables datos de referencia.</li> <li>• CONASIDA cuenta con una sub-comisión de M&amp;E vinculado al Programa Nacional VIH/SIDA /ITS.</li> <li>• Se ha iniciado la implementación de un Sistema Único de Monitoreo, Evaluación y Vigilancia Epidemiológica (SUMEVE).</li> </ul>	<ul style="list-style-type: none"> <li>• La subcomisión de M&amp;E de CONASIDA necesita mayor apoyo para cumplir plenamente su función.</li> <li>• El SUMEVE actualmente sólo alberga datos de vigilancia epidemiológica; el resto de componentes previstos todavía no han sido implementados.</li> <li>• Los datos de vigilancia de segunda generación, incluyendo las encuestas conductuales de riesgos relacionadas con las ITS/VIH/SIDA, deben ser compartidas con mayor rapidez para una utilización más oportuna en la toma de decisiones.</li> </ul>	<ul style="list-style-type: none"> <li>• Trabajar conjuntamente con ONUSIDA para el fortalecimiento de la subcomisión de M&amp;E de CONASIDA, con especial atención en la incorporación de la sociedad civil en el SUMEVE y mejorar el uso de datos para la toma de decisiones en actividades de prevención.</li> <li>• Brindar apoyo técnico y financiero para que la sociedad civil participe en un sistema nacional de M&amp;E en pleno funcionamiento y facilitar el acceso desde el nivel municipal al SUMEVE a través de Internet.</li> <li>• Apoyar el uso de datos (provenientes de la información estratégica) para la toma de decisiones en todas las áreas programáticas, involucrando a todos los sectores.</li> </ul>	2010–2011  2010–2015	Medio

<p>Entorno Político - Sección V</p>	<ul style="list-style-type: none"> <li>• El Programa Nacional VIH/SIDA/ITS está regido por la CONASIDA como órgano asesor, el cual cuenta con gran representación del sector gubernamental.</li> <li>• El Mecanismo de Coordinación de País (MCP) se conformó en 2003 tras una importante inversión en VIH y la tuberculosis proveniente del Fondo Mundial (FMSTM).</li> <li>• Existe una importante base de datos para la mayoría de las áreas de intervención, así como datos relativos a los determinantes sociales del VIH / SIDA, tales como E&amp;D, dentro de los ámbitos comunitarios y del sector salud.</li> </ul>	<ul style="list-style-type: none"> <li>• La Respuesta Nacional al VIH / SIDA es altamente dependiente de los fondos del Fondo Mundial.</li> <li>• Hay necesidad de un liderazgo claro en la respuesta nacional, se necesita definir los roles de CONASIDA y MCP.</li> <li>• El E&amp;D siguen siendo un desafío importante para el entorno político del VIH/SIDA. <i>(Véase también la sección de Fortalecimiento del Sistema de Salud y Prevención arriba.)</i></li> <li>• La limitada participación de la sociedad civil en la implementación de programas limita la calidad y la cobertura de los servicios claves.</li> <li>• El PEN 2005-2010 tiene necesidad de revisión.</li> </ul>	<ul style="list-style-type: none"> <li>• Trabajar con los actores claves para apoyar: <ul style="list-style-type: none"> <li>– El desarrollo de una propuesta de transición ante el FMSTM mediante la aplicación de la estrategia nacional para asegurar la sostenibilidad y la integración del VIH / SIDA en las políticas del sector salud.</li> <li>– El fortalecimiento de CONASIDA para mejorar la participación de la sociedad civil, el sector privado y los ministerios operativos.</li> <li>– La formación de una organización sombrilla de la sociedad civil para fortalecer la participación de las ONG en la prevención. <i>(Véase secciones anteriores.)</i></li> <li>– Un proceso participativo para la revisión del PEN.</li> </ul> </li> </ul>	<p>2010–2011</p> <p>2010–2013</p> <p>2010</p>	<p>Bajo</p>
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# I. BACKGROUND AND CONTEXT

## EL SALVADOR



El Salvador is the smallest country in Central America, bordering the North Pacific Ocean, with Guatemala to the north and Honduras to the northeast and south. The country has a population of 6,122,413.<sup>3</sup> In terms of geographical area, El Salvador ranks 153 out of 249 countries in the world, which belies the magnitude and impact of past political and geological traumas. Known as the Land of Volcanoes, the country suffers frequent earth tremors, along with occasional destructive earthquakes, and is extremely susceptible to hurricanes. In addition, the country's most recent political history includes a 12-year civil war, which claimed the lives of 75,000 Salvadorans before finally being brought to a close in 1992, when the Government and leftist guerillas signed a treaty addressing military and political reforms.

Today El Salvador shares many of the problems seen throughout the Americas, such as a rapidly weakening economy and massive foreign debt, rising crime and violence, and environmental problems including deforestation, soil erosion, and contamination from disposal of toxic wastes. El Salvador has been identified as a transshipment point for cocaine, as well as a site of significant cocaine use within its borders.

At the time of this writing, the Salvadoran military, U.S. military support units, public-sector services, civil society, and international partners are fully engaged in emergency relief efforts following Hurricane Ida. A state of national calamity was declared after the country was hit with torrential rains over the weekend of November 6–7, 2009, causing deadly mud slides and flooding in seven out of 14 Salvadoran provinces, killing hundreds and rendering at least 15,000 people homeless.

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<sup>3</sup> Encuesta de Hogares de Propósitos Múltiples (EHPM) 2008, Dirección General de Estadística y Censos (DIGESTYC).



Coping with this latest national emergency is El Salvador's newly elected Government, led by President Mauricio Funes, of the ruling Frente Farabundo Martí para la Liberación Nacional (FMLN). Since taking office on June 1, 2009, Funes faces even more serious longer-term challenges. His task in confronting the worsening economy and rising violent crime will be complicated by the lack of a legislative majority, divisions within his own party, and strong opposition from the Alianza Republicana Nacionalista (ARENA).

## POST-ELECTORAL CHALLENGES

Against this backdrop, El Salvador is undergoing a major review and re-planning of the national response to HIV/AIDS—currently the highest-funded single-disease program in the health sector, along with TB. An evaluation and revision of the National Strategic Plan (NSP) for HIV/AIDS (2005–2010) is scheduled for early 2010, as well as development of multi-sectoral operational plans covering the next five years. This comes five years after major international funding was first awarded to the country by the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) for HIV and TB responses. Essentially, revision of the NSP forms a mid-term review of the national response and is pivotal to achieving longer-term outcomes, since a paradigm shift in strategic focus is now called for.

The past five years of the national HIV/AIDS response have seen some major achievements, recognized at the global level. El Salvador gained international acclaim for national roll-out of clinical services including antiretroviral therapy (ART) for people living with HIV/AIDS (PLWHIV), HIV testing, and prevention of mother-to-child transmission (PMTCT). Among countries receiving GFATM grants El Salvador also scored highest for rapid implementation and disbursement of funds. In some respects these pre-election achievements will be a tough act for the new Government to follow.

However, Funes' Government is arguably better placed to face the challenges now emerging, as assessments to date have revealed weaknesses in the response. Challenges include the need to emphasize prevention, increase involvement of civil society, and strengthen the quality and coverage of health promotion interventions. Improved interventions should be targeted to most-at-risk populations (MARP), bridging populations such as clients of sex workers, and heterosexual partners of men who have sex with men (MSM), and vulnerable groups such as youth, crack cocaine users, and prisoners. Of key relevance in this regard is that fact that new government appointees in the Ministry of Health (MOH) have strong backgrounds in health promotion, and a clear civil society mandate.

Another challenge in the national response is the issue of sustainability. The new strategic framework for the health sector, 2009–2014, launched by the newly appointed Minister of Health, Maria Isabel Rodriguez, lays emphasis on integrated health systems strengthening (HSS), rather than vertical programming, as seen in the HIV and TB responses over the past five years. Because the national AIDS response relies heavily on GFATM funding, the new Government's approach to HSS could prove to be crucial in steering a realistic phase-out (GFATM)–phase-in (public and private-sector) financing strategy, to ensure longer-term sustainability of HIV and TB responses.

## HIV/AIDS SITUATION

### KEY STATISTICS

(SUMEVE, November 2009)

- Concentrated epidemic. <1% general population; 3.6% in sex workers; 6% prisoners; >8% female crack cocaine users; 17.75% MSM.
- Newly emerging at-risk populations—crack cocaine users over 8% HIV infection, particularly among female SWs.
- 23,731 HIV cases and 8,644 AIDS cases (November 2009).
- Significant under-reporting.
- 5 to 6 new HIV cases daily.
- 99.5% of cases are from sexual transmission.
- Male:female ratio is 1.7:1.

El Salvador's epidemic is classified as concentrated, with HIV prevalence of 0.8% among the adult population (UNGASS Country Report 2008), but with significantly higher infection rates among most-at-risk populations such as men who have sex with men, sex workers, and crack cocaine users. El Salvador ranks 62 out of 170 countries worldwide in terms of adult HIV prevalence (2007).<sup>4</sup>

The latest data on the HIV epidemic in El Salvador can be found in the most recent SUMEVE report, disseminated on November 30, 2009, by the National AIDS Program. The report spans the period from the first registered case in 1984 through November 2009. The data states that by November 2009, 23,731 cases of HIV infection had been registered, of which 8,644 cases were diagnosed as AIDS. As vertical transmission from mother to child has been all but eliminated in the country (0.5% of total cases) due to a highly successful PMTCT program, sexual transmission now accounts for 99.5% of total cases registered. Men account for 14,890 cases, and women for 8,841 cases. The male-to-female ratio has hovered at roughly the same level since 2006, and by November 2009 was 1.7 to 1.

The number of new cases registered between January and November 2009 within the country's 14 departments was highest in San Salvador (668), followed by La Libertad (145), Sonsonate (139), and San Miguel (103), with Morazan (16), San Vicente (12), and Cabanas (10) showing the lowest number of new cases.

The AIDS mortality rate has been declining since 2003, and more markedly since 2007, due in large part to a highly successful program to scale up antiretroviral coverage. By the end of 2008, 95.8% of PLWHIV eligible for treatment were receiving antiretroviral therapy.

Increased HIV testing has provided the country with additional surveillance data. Of particular concern is the growing vulnerability of young people in El Salvador. Out of the HIV cases found between January and November 2009 (SUMEVE), 81.4% occurred in those aged 15–49, with the highest concentration (37.76%) in the 15–29 age group. Forty-nine percent of all cases described themselves as single, 31% described themselves as being in a relationship, and 14% were married. Sixty percent of cases occurred in people of the least educated sector (basic education),

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<sup>4</sup> Central Intelligence Agency. *The World Factbook*. Available at <https://www.cia.gov/library/publications/the-world-factbook/geos/es.html>.

17% occurred in those considered uneducated, and 17% occurred in those who had attained a high school diploma.

## NATIONAL HIV/AIDS RESPONSE

### HIGHLIGHTS

- 0.5% vertical transmission (mother-to-child) due to successful PMTCT program (SUMEVE, November 2009).
- Declining AIDS mortality rate since 2007 due to increased ARV treatment coverage.
- Increased HIV testing for the general population and among pregnant women (El Salvador *One Step Ahead*, MOH, 2008).

### CHALLENGES

- Continued stigma and discrimination among general population, as well as among service providers.
- Low coverage of targeted prevention programs within high-transmission settings, including MARP, bridging populations, youth, cocaine users, and prisoners:
  - Between January and November 2009, 37.76% of all new cases were found in young people 15-29 years (SUMEVE, November 2009).
  - Only 4.23% of schools carried out HIV and life skills education in the last academic year (UNGASS Country Report 2008).
  - Increased STIs were found among MARP, including MSM and SWs.

Ten years prior to the worldwide call by donors, developing countries, and UN agencies for the Three Ones<sup>5</sup> principle in national AIDS programming, El Salvador had developed and implemented a series of National Strategic Plans (NSPs) spanning 1995–1999, 1999–2001, and 2001–2004. In 2004 the country initiated a process of national consultations to revise achievements and evaluate obstacles encountered under previous national plans. On November 9, 2005, a new Strategic Plan was launched, largely with funds obtained from the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM). The Strategic Plan is, in effect, managed by the National AIDS Program under the Ministry of Health.

The GFATM grant (Phase 1 award totaled US\$32,987,036.00) marked a significant turning point in the national response. This was the first major grant awarded to El Salvador that was specifically earmarked for a single disease/epidemic, which enabled the mobilization of a major, health-sector–led response, including greater coverage of clinic-based ARV treatment and prevention services, such as voluntary counseling and testing (VCT) and PMTCT. Although the NSP (2005–2010) appears very comprehensive, covering eight key strategic objectives in prevention, treatment, strategic information, and policy reform, the actual programming and implementation emphasis to date has been markedly clinical in focus. There has been less emphasis on scaling up community-based prevention programs, such as behavior change interventions among MARP, bridging and vulnerable populations, and the general public.

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<sup>5</sup> • **One** agreed HIV/AIDS Action Framework that provides the basis for coordinating the work of all partners.

- **One** National AIDS Coordinating Authority, with a broad-based multi-sectoral mandate.
- **One** agreed country-level Monitoring and Evaluation System.

There have been a number of developments in terms of national governance. World AIDS Day, December 1, 2004, saw the formal establishment of the National AIDS Commission (CONASIDA), an advisory body to the National AIDS Program formed largely by professionals working in the health sector. CONASIDA has facilitated major advances with respect to legal and policy reforms, defense of human rights, training activities aimed at decreasing stigma and discrimination, and health policy issues such as universal access to treatment and care for PLWHIV, and coordination of key interventions with civil society.

Following the start of GFATM investment in 2003, a grant-related Country Coordinating Mechanism (CCM) was also formed. The CCM is a governance body overseeing grant-related activities and reporting to GFATM, in contrast with CONASIDA's advisory role to the national AIDS response.

The coexistence of CONASIDA and the CCM has affected governance issues at the national level. This is partly due to the dependency of the national response on GFATM funds and the CCM's role in overseeing the management of these funds, while CONASIDA has no budgetary or financing powers. Consequently, CONASIDA's national governance role in relation to the CCM has become somewhat ill-defined. See also Section V, Policy Environment, below.

### **Monitoring the National Strategic Plan**

El Salvador has developed a relatively impressive data warehouse, with the National AIDS Program, the Expanded UN Joint Team of HIV/AIDS, the GFATM County Coordinating Mechanism, and CONASIDA collectively able to provide baseline data, as well as some trend data, on globally recognized core indicators relevant to monitoring a national response. These data are collected within the framework of the National M&E Plan covering 2006–2010. Of particular note has been the country's ability to report to the United Nations on 19 out of 24 national indicators, with a country report successfully submitted to the UN General Assembly Special Session on HIV/AIDS (UNGASS) for the past two reporting rounds—the 2006 report covers 2004–2005 data; the latest 2008 report covers 2006–2007 data.

A major challenge to the national response has been the implementation of a functional Unified System of Monitoring, Evaluation, and Epidemiological Surveillance (known by its Spanish acronym SUMEVE). This system has been designed to provide key information for monitoring the national response and has been recognized as a model for the region. While the SUMEVE provides useful epidemiological data, its prevention component has not yet been implemented. Also, the system is not yet fully functional with regard to data analysis, data feedback, and data use for decision-making, in particular with respect to monitoring and evaluating behavior change communication (BCC) and other prevention activities implemented by civil society. See Section IV, Strategic Information, below.

UNGASS Country Report 2008 and additional survey data indicate the following achievements and challenges in the national response:

- The national program has received significant public-sector investment, to complement grants received from international donors, namely GFATM and, to a lesser extent, USAID regional and bilateral programs. The latest National AIDS Spending Assessment<sup>6</sup> (NASA) (2007) states that El Salvador invested a total of US\$43,769,460 in HIV/AIDS, with over 75% of all investment coming from the public sector, 16.83% from international funds, and 7.84% from the private sector. However, percentages quoted for public expenditure need to consider the related “bureaucratic” costs included in the calculations, such as public-sector salaries and overhead for all activities related to HIV/AIDS service delivery, whether or not staff are only partially involved in such activities.

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<sup>6</sup> R2 and R7 grant agreements, and the RCC proposal, are currently under negotiation and awaiting a first disbursement. R9 for TB includes activities complementary to the national HIV/AIDS response.

- The national response is heavily dependent on GFATM grants, which will expire in 2015, raising valid concerns around sustainability. This is a particular concern given the exponential costs incurred by clinical services committed to offering lifetime ARV treatment to an increasing number of PLWHIV.
- El Salvador has achieved very impressive coverage of ART, HIV-TB, and PMTCT clinic-based services. PMTCT and ARV access are two of the most outstanding clinical achievements in the national response. See Section III, Health Systems Strengthening, below.
- Another significant success has been the roll-out of HIV testing among women attending maternal and child health (MCH) clinics, and specific population groups, as well as increased VCT access for the general population. During 2008, 286,100 HIV tests were conducted in Ministry of Public Health and Social Assistance (MSPAS) service delivery points throughout the country. During January–November 2009, a further 260,706 tests were carried out, 66% in women and 34% in men. Tests were fairly well distributed in regions across the country; 24,782 were carried out through mobile clinics.
- HIV testing is high among self-identified MARP, such as sex workers (over 95%),<sup>7</sup> and to a lesser extent, MSM (55.26%). However, the quality of pre-test and post-test counseling, and the speed at which clients receive their results, remains a challenge (see Section II Prevention, below).
- Although the UNGASS indicator for drug users relates to intravenous drug use, which is deemed an insignificant practice in El Salvador, the national program does show relatively high levels of HIV infection among crack cocaine users. Prevention interventions have not yet been designed for this group, and no population size estimates have been undertaken. Significantly, crack cocaine users were not mentioned in the last UNGASS report.
- The percentage of MARP reached by prevention programs appears high among SW (88%) and MSM (62%). However, these figures may be misleading, since the denominator used to measure this indicator is the total number of respondents in a knowledge, attitudes, and practice (KAP) survey, rather than the total population size estimate. Coverage of total MARP to be reached at the national level is therefore not measured.<sup>8</sup>
- The percentage of schools which provided life-skills–based HIV education in the last academic year is extremely low (4.23%), and represents a major gap in the national response given the current vulnerability of young people to HIV infection.
- Data show alarmingly low levels of awareness among young people about HIV transmission. This is particularly alarming given the relatively high incidence of HIV infection in young people and their rate of sexual activity. For those under the age of 15, the infection rate is estimated at 26.81% (UNGASS Country Report, 2008).
- Several behavioral surveillance studies have been conducted among SW and MSM. However, data reveal a low level of awareness of HIV prevention messages among these target population groups. Data on condom use and level of STIs vary greatly depending on the study, the geographical area covered, and the sample size/profile. See Section II, Prevention, below.

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<sup>7</sup> UNGASS Country Report, 2008.

<sup>8</sup> *Guidelines on Construction of Core Indicators 2008 Reporting*. UNAIDS: 2007, p. 44.

- Impact indicators show HIV prevalence in the general population remains at less than 1%, with concentrated epidemics growing among MARP, particularly SW (3.6%) and MSM (17.75%). High rates also exist for crack cocaine users, especially female sex workers who are also drug users (8.5%).<sup>9</sup>

As mentioned above, the National Strategic Plan is due for evaluation and revision in early 2010, along with revision of the National Monitoring and Evaluation (M&E) Plan. This will include 2015 target-setting for key intervention areas. Baseline data are available for most program areas, but the country has yet to engage in a participatory process for setting nationally appropriate universal access (UA) targets in key service delivery areas, in particular those where UA targets have not already (apparently) been met. This includes social, not just clinical, support for PLWHIV and coverage of behavior change interventions, not only among MARP, but also among the “bridging” and vulnerable populations currently identified as:

- clients of SWs—a “bridging” population in terms of HIV transmission.
- men who have sex with men within hidden populations, i.e., those who do not identify as gay or bisexual, many of whom are married or otherwise engaged in heterosexual relationships (also an important bridging population).
- young people.
- drug users (i.e., cocaine).
- prisoners.

The assessment team hopes that findings from this assessment, covering **Prevention, Health Systems Strengthening, Strategic Information, and Policy Environment**, will be of use to a wide range of stakeholders in the national response, and will form part of a larger, country-owned process of mid-term review and re-planning, scheduled for early 2010.

## NATIONAL RESPONSE MAJOR IMPLICATIONS

- The national response is almost totally dependent upon GFATM grants, which raises sustainability, governance, and programmatic issues.
- New MOH authorities are keen on non-vertical programming.
- USAID/ES could support development of a bridging proposal to GFATM for a phase-out process under the new “National Strategy Application” funding track.
- New government has a tough act to follow on the clinical coverage front, but is well-placed to excel in expanding social mobilization for prevention education, given the skills, experiences, and policies of the new Minister for Health, Vice Ministers, and NAP Coordinator.
- ES Health Sector recently signed a bilateral TA agreement with Brazil. HIV/AIDS TA systems should be linked.

<sup>9</sup> *Riesgo de VIH/SIDA relacionado con el Uso de Crack*, FUNDASALVA, <http://www.fundasalva.org.sv/home/>

## USAID/EL SALVADOR HIV/AIDS ASSESSMENT AND DESIGN

### GLOBAL CONTEXT

- Health programming in Central America is not a top USAID priority at the global level. A relatively modest US\$2 million/year is invested in HIV/AIDS in El Salvador, through the bilateral and regional programs combined.
- Despite this modest investment, the current assessment aims to provide a valuable model for USAID bilateral support, demonstrating aid effectiveness, in line with the Accra Agenda for Action.
- Three of the eight Millennium Development Goals (MDGs) are directly related to health. Health is also an important component of all other MDG targets.
- The Organization for Economic Co-operation and Development (OECD) aims to track, promote, and report on progress on the Agenda for Action, using Health as a Tracer Sector (HATS).

The purpose of this assessment is to identify the most cost-effective, value-added strategy for USAID's continued support to El Salvador's national response over the next five years. Recommendations are based on evidence, prioritized within the context of maximizing aid effectiveness, in line with the Paris Declaration (2005) and the Accra Agenda for Action (2008), to which the U.S. and El Salvador Governments are signatory.<sup>10</sup>

The assessment team found that USAID has a comparative advantage when it comes to supporting national strategies and activities, with the potential to achieve relatively significant program results in return for modest financial investment. The USAID/ES budget for HIV is around US\$1 million per year in bilateral aid, and the USAID regional budget is also around US\$1 million per year, operated through the Central America and Mexico (CAM) Regional Strategy. These amounts are small compared to the tens of millions in grants awarded by GFATM for HIV/AIDS, regionally and nationally, covering the next five years.

Since the 1960s the U.S. Government has continuously supported various interventions in the public health sector in El Salvador. For approximately 15 years USAID has provided support to El Salvador to decrease transmission of HIV and mitigate the impact of AIDS. Along with the host country's National AIDS Program, other U.S. Government agencies (DOD, Peace Corps, CDC), the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), regional and country-specific grants in HIV and TB, UNAIDS, UN agencies, other bilateral donors, international and local NGOs, and civil society, USAID has been working collaboratively to build an effective national AIDS response. Interventions supported by these actors are identified in a diagnostic report<sup>11</sup> developed by the USAID-funded Program for Strengthening the Central American Response to HIV (PASCA) project.

The USAID/ES bilateral Strategic Objective Agreement (SOAG) for health and education with the Government of El Salvador (GOES) for the period 2004–2010 builds on past achievements and is aligned with USAID's CAM Regional Strategy. In turn, El Salvador's 2004–2011 Country Plan supports the three Strategic Objectives (SOs) of the CAM Regional Strategy:

**SO1:** Ruling Justly: More Responsive, Transparent Governance

**SO2:** Economic Freedom: Diversified and Expanding Economies

<sup>10</sup> Available at [http://www.oecd.org/document/18/0,2340,en\\_2649\\_3236398\\_35401554\\_1\\_1\\_1\\_1,00.html](http://www.oecd.org/document/18/0,2340,en_2649_3236398_35401554_1_1_1_1,00.html).

<sup>11</sup> *Diagnostico de Situacion y Respuesta al VIH y SIDA en El Salvador*. USAID: 2008.

### **SO3:** Investing in People: Healthier, Better-Educated People

CAM Strategy SO3 provides the framework for regional and country-specific programs in health and education. To address SO3, USAID/ES developed Activity No. 519-0463, Strengthening Health and Basic Education. This activity supports focus areas within SO3's health portfolio through the following Intermediate Results (IRs):

**IR 3.1:** Increased and improved social-sector investments and transparency

**IR 3.3:** Improved integrated management of reproductive and child health

**IR 3.4:** HIV/AIDS and other infectious diseases contained and impact mitigated.

USAID support for HIV/AIDS in El Salvador contributes to IR 3.4, specifically to sub-IR 3.4.1: ***Increased use of prevention practices and services to combat HIV/AIDS and other infectious diseases.***

USAID partners and contractors implementing these activities include: Population Services International (PSI), operating in Central America as the Pan American Social Marketing Organization (PASMO); Abt Associates; Institute for Reproductive Health (IRH/Georgetown University); the Health Policy Initiatives (HPI) project implemented by Futures Group International; the Centers for Disease Control and Prevention (CDC); and the Capacity Project implemented by IntraHealth International.

The scope of work for the current assessment and design (see Appendix A) includes the following three main objectives:

1. assess the HIV/AIDS situation and response in El Salvador, including identification of key actors and their contribution to this response (as well as their geographical focus areas, populations, and amount and duration of support).
2. identify the main needs existing in HIV/AIDS treatment and prevention, as well as intervention opportunities.
3. propose future USAID/El Salvador strategies, interventions, and corresponding activities to address those needs.

This report covers the first objective in Section I, Sections II–V under **Response to Date** and Appendix C. The second objective is covered in Sections II–V under **Challenges**. The final objective is covered in Sections II–V, under **Recommendations**.



## II. PREVENTION

### ADVANCES

- Almost all pregnant women receiving prenatal services are counseled and tested for HIV, as part of a country-wide PMTCT program.
- There is good public access to HIV testing, through 158 establishments in the public sector and two mobile laboratories. 286,100 HIV tests were carried out in 2008, promoted through efforts that included National Day for HIV Testing (held annually in June), and World AIDS Day.
- Voluntary counseling and testing (VCT) is offered every six months to all prisoners. Between February 2006–March 2008, 21,195 prisoners had received at least one counseling session, among a total prison population of 19,814 (as of December 31, 2008).
- NAP has produced a variety of HIV/AIDS IEC materials and diploma programs for multi-sectoral professionals, including health care workers (HCWs), teachers, NGOs, and community leaders.
- As of December 2007 eight educational campaigns had been launched, aimed at the general population. They included: “Win the AIDS Battle”; “Unite Against Discrimination”; National HIV Testing Day; and “Choose to Wait,” aimed at 12–19-year-olds.
- With USAID support, PASMO is the major implementer of behavior change communication (BCC) among SWs and MSM in selected cities in El Salvador, which has included promoting and improving access to condoms and lubricants.
- An increasing number of local and international NGOs are carrying out prevention and integrated support activities among vulnerable and most-at-risk populations. Activities include a national NGO-run AIDS hotline.

### ADVANCES

Over the past five years, the national AIDS response, including the majority of prevention activities, has been largely managed by the public health sector, through the National AIDS Program (NAP) under the Ministry of Health (MOH). Prevention education programs have not been extensive, and most education has been carried out as part of clinic-based programs, such as PMTCT and VCT. With GFATM funding the MOH has carried out a number of health promotion activities, including development of an extensive range of information, education, and communication (IEC) materials, as well as professional diploma programs targeted at multidisciplinary groups such as teachers, doctors, psychologists, community educators, and nurses.<sup>12</sup>

The Ministry of Education has also been involved in planning in-schools prevention education and is represented in decision-making bodies such as the GFATM County Coordinating Mechanism. The Ministry of Education is not yet represented in CONASIDA, which remains an advisory body made up largely of health professionals.

Plans to expand in-school education have benefited from coordination with civil society, including the larger NGOs such as Plan International and PASMO. Over the past five years, more than 1,000

<sup>12</sup> *The Fight Against AIDS in El Salvador, a National Commitment*. NAP: May 2007.

teachers have received training or sensitization, many of whom took the GFATM-funded diploma course. A recently approved GFATM proposal includes funds for research, training, and follow-up of teachers providing sexual health and life skills education, from pre-school through primary and secondary schools. During 2009 the Ministry of Education conducted a major knowledge, attitudes, and practices (KAP) survey among teachers and students,<sup>13</sup> which provided baseline data for launching sexual health/life skills education in schools. Curricula and methodologies have been developed, from pre-school through high school, but national roll-out of HIV/sexual health and life skills education in schools remains stalled.

A growing number of local and international NGOs have been carrying out prevention and integrated support activities among vulnerable and most-at-risk populations, largely with the support of small-scale, short-term funding from GFATM. A few local NGOs have received short-term GFATM and/or USAID funding to execute behavior change communication (BCC) programs, for example, in partnership with PASMO. However, PASMO remains the largest provider of BCC among SWs and MSM in selected cities.

Plan International has facilitated a number of broader, community-based education activities, with financial and technical support from the United Nations Population Fund (UNFPA), involving collaboration between local health centers, youth and street theatre groups, and PASMO educators, who teach the public about HIV transmission and the correct use of condoms. Nonetheless, involvement of civil society in prevention education remains limited.

Additional international support for prevention and related support services has been mobilized by civil society, for example, from the German Development Cooperation (GTZ), the International HIV/AIDS Alliance, CARE International, and faith-based organizations (FBOs) such as World Vision and Caritas. Local FBOs in particular provide an important range of community-based prevention and support services, including the Lutherans, Church Misericordia, ELIM Pentecostals, and more progressive elements within lay Catholic communities and Catholic Relief Services.

Civil society has also played an important part in raising awareness of stigma and discrimination (S&D) and developing responses to help address this (see also Section V, below). One important advance has been the PLWHIV Stigma and Discrimination Survey, funded by the United Nations Development Programme (UNDP), and conducted jointly by the Salvadoran Demographic Association and the National Association of PLWHIV Vida Nueva Positiva using a global tool developed by the International Planned Parenthood Federation and UNAIDS.<sup>14</sup> This survey will provide important baseline data in terms of S&D as experienced by PLWHIV respondents living in El Salvador. The survey will cover diverse topics including: experience of stigma expressed by others; access to work, health, and education services; internal stigma and fears; human rights; legal and policy issues; the role of respondents in terms of changing attitudes; taking the HIV test; sharing the test result with others and confidentiality; treatment; having children; and life problems and challenges.

Since stigma and discrimination are key pre-determinants to health-seeking and health-providing behaviors, this initiative could significantly assist El Salvador in planning more effective prevention and treatment programs alike.

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<sup>13</sup> Levantamiento de línea base de conocimientos, actitudes y practicas (CAP) de docentes de parvularia, básica y media, de adolescentes y jóvenes de 13 a 24 años acerca del VIH/AIDS en centros escolares. MINED, IUDOP, CCE.

<sup>14</sup> Estudio de Estigma y Discriminación en Personas con VIH, Informe de El Salvador, C.A. PNUD, ADS, ANP+, 2009.

## CHALLENGES

### CHALLENGES

- Significant weaknesses in both quality and coverage of HIV/STI counseling, prevention education, and BCC among MARP, bridging populations, and vulnerable groups.
- Limited involvement of civil society in prevention education and behavior change.
- Alarming low levels of awareness of HIV/AIDS among the general public, youth, and teachers.
- High levels of stigma and discrimination, even among health providers.
- Insufficient attention paid to increasingly vulnerable populations such as youth, crack cocaine users, and prisoners.
- Insufficient attention paid to high levels of STIs among MARP and other vulnerable population groups.

### Prevention Education and Role of Civil Society

Most of the NGOs (local and international) actively engaged in the national AIDS response were interviewed for this assessment within the context of focus group discussions (for details, see Appendix C).

Focus group discussions reveal an appreciation by NGO participants of the increase over the past three years in the involvement of civil society in the national response. Nonetheless, this involvement has been limited and has not been sufficiently supported in terms of reliable sources of funding, quality training, monitoring of coverage, or impact. NGO activities to date have largely relied on volunteerism and/or been supported through occasional limited funding contracts, administered by UNDP with GFATM funding.

Many of the smaller NGOs who are currently offering STI and VCT services at a local level (including referrals, pre-test and post-test counseling, and/or direct clinical services) have not benefited from earlier GFATM-funded trainings, or have lost trained staff through turnover.

Almost all NGOs working with MARP who were interviewed as part of this assessment described major gaps in prevention education. Most prevention education and behavior change communication programs have been carried out on a small scale by a few isolated NGOs. In addition, NGO representatives noted the rising demand in MARP communities for MARP-friendly pre-test and post-test counseling services, largely as a result of high levels of stigma and discrimination and low levels of HIV expertise experienced in many public health settings.<sup>15</sup>

Assessment findings clearly show that civil society throughout the country needs to become more involved in prevention education and HIV counseling. Representatives of NGOs working with MARP who attended the focus group discussions displayed high levels of awareness and training, and well articulated their role as educators and promoters, keen to reach out to other vulnerable sectors of the community such as youth and housewives (amas de casa). They did not define themselves solely as representatives of particular interest groups. However, their current role in the

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<sup>15</sup> Focus Group Discussion, MARP-based NGOs, December 2, 2009. See Appendix C.

national response has been limited, in part due to failure to recognize the potential in expanding coverage of prevention programs among targeted population groups.

According to PASMO (assessment interview November 20, 2009), financial resources are insufficient to train multiple NGOs to expand BCC interventions among MARP in order to scale up coverage. Given the estimated total population sizes of MSM (83,000) and SWs (27,434),<sup>16</sup> current PASMO coverage of BCC among MARP is very low. This is despite relatively high investment from USAID in PASMO prevention programs at the bilateral and regional levels. Clearly, a different type of mechanism to expand prevention coverage could be beneficial in increasing coverage (see Recommendations, below).

The limited involvement of civil society in expanding coverage of prevention education contributes to the alarmingly low levels of awareness of HIV/AIDS among the general public, youth, and teachers. In the FESAL 2008 study, 99% of women interviewed had heard about HIV/AIDS, but only one in every four women aged 15–49 could respond correctly to five questions relating to knowledge of HIV. While one in five women (20%) did perceive she was personally at risk from HIV, with the main risk being distrust of or infidelity on the part of her partner, only 8% who had had sex during the previous 12 months had used a condom. Four out of ten women aged 15–49 reported they had taken a test for HIV, but only 3 out of 10 reported that the test was voluntary and they had received the result.

### **Prevention Education Among Youth**

A particular weakness in prevention education is the low coverage of educational programs among youth. The latest epidemiological trends indicate that HIV incidence is rapidly increasing in the younger age groups in El Salvador. New cases registered from January–November 2009 show nearly 38% of cases are in youth aged 15–29 years. The FESAL 2008 study demonstrates that nearly four out of 10 single women aged 15–19 reported they had had sex during the last quarter prior to interview, but only 31% used a condom during their last sexual encounter (although this is a larger percentage than among the older age group).

The recent Ministry of Education study among pre-school, primary, and secondary teachers, and students aged 13–24,<sup>17</sup> shows alarming levels of lack of knowledge of HIV/AIDS. Only half the teachers and 30% of students knew two out of three ways of preventing HIV infection (use of condom, fidelity, or abstinence). In both groups, the main belief about the ways in which a person can become infected with HIV included “having sexual relations” (less than 30% of the responses) and “blood transfusions.” Disturbingly, the latter was perceived at almost the same level of risk, despite 100% blood safety achieved by the health sector.<sup>18</sup> Only 26.4% of teachers and 24.9% of students recognized condom use as one way of avoiding sexual transmission of HIV. “Don’t know” rated even higher, while fidelity and abstinence rated lower than either condom use or “don’t know.”

Over 60% of teachers and students could not state one way of preventing transmission of HIV from mother to child (despite the country’s highly successful PMTCT clinical services). However, over 50% of students were aware of four of the main STIs—syphilis, gonorrhea, hepatitis B, and genital herpes. While over 50% of respondents (students and teachers) did consider themselves to be personally at risk for HIV, a sense of efficacy for self-protection is very low, which is likely due to an underlying, somewhat resigned, attitude that “we are all at risk.”

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<sup>16</sup> UNAIDS El Salvador 2003.

<sup>17</sup> Levantamiento de línea base de conocimientos, actitudes y practicas (CAP) de docentes de parvularia, básica y media, de adolescentes y jóvenes de 13 a 24 años acerca del VIH/AIDS en centros escolares. MINED, IUDOP, CCE.

<sup>18</sup> UNGASS Country Report, 2008.

## Stigma and Discrimination

Low levels of awareness about HIV transmission and risk assessment among the general public and vulnerable groups partly explains the high levels of stigma and discrimination. Eighty-five percent of the women aged 15–49 who were interviewed in the same FESAL study mentioned above demonstrated attitudes of rejection or stigma toward PLWHIV. The Ministry of Education KAP survey<sup>19</sup> (also mentioned earlier) shows more complex attitudes. For example, among the 881 students aged 13–24, and 429 teachers, who were interviewed, over half the respondents stated that they would care for a family member with AIDS in their own home, and 77.6% of teachers agreed that HIV + colleagues should be allowed to continue teaching. But 31.9% of teachers and 11.9% of students stated that they would not buy food from an HIV+ vendor.

One of the greatest causes of stigma and discrimination is fear (in this case, fear of contagion).<sup>20</sup> Correct knowledge about how HIV is, or is not, spread can help decrease levels of this form of stigma. This is relatively easily addressed through effective prevention education, including mass media—a program area which remains weak in the national response. The other main cause of stigma is prejudice (e.g., against individuals seen to be “deviating” from sexual norms, or individuals struck by a deadly disease). This is less easy to address and requires interpersonal behavior change methodologies. See Recommendations, below.

Stigma and discrimination among health care workers is one of the most significant challenges in the national response, given the achievements in terms of increased coverage of clinic-based services such as VCT, ART, and PMTCT. Evaluation studies have shown that MARP clients occasionally feel driven away from public-sector services, despite high levels of investment in the sensitization and training of health care workers. Stigma and discrimination among health care providers is also an important underlying factor, behind inadequate and low-quality pre-test and post-test counseling services. The low-level quality of pre-test and post-test counseling represents a significant missed opportunity in terms of prevention education in the public health sector.

## Knowledge, Attitudes, and Practices Among Health Care Workers

A 2007 report on VCT and STI services,<sup>21</sup> covering 37 public health units and 14 NGOs working among MARP, found that a total of 2,777 professionals from MSPAS establishments had been trained between 2000 and 2006, as well as 215 staff and volunteers from 14 NGOs. However, the same report noted a high turnover and dropout rate of trained personnel in both the public and NGO sectors. Results also showed that current service providers were operating with outdated norms, and lacked access to algorithms and guidance materials. Despite the fact that the MOH has produced a considerable number of norms, protocols, and guidelines in its printed materials, their distribution and use have been limited. Many new staff had received no training at all in stigma and discrimination, STI counseling, or making effective referrals. NGO personnel in particular had low access to continuing education and in-service training opportunities with respect to pre- and post-test counseling—a role that civil society is well placed to carry out.

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<sup>19</sup> Levantamiento de línea base de conocimientos, actitudes y practicas (CAP) de docentes de parvularia, básica y media, de adolescentes y jóvenes de 13 a 24 años acerca del VIH/AIDS en centros escolares. MINED, IUDOP, CCE.

<sup>20</sup> Goffman, Erving. *Stigma: Notes on the Management of Spoiled Identity*. New York: Simon & Schuster, 1986.

<sup>21</sup> Diagnostico Situacional de los Servicios de Consejería y Prueba Voluntaria en Establecimientos del MSPAS y ONGs, USAID, PSI, PASMO e IRH, Ministerio de Salud Publica, El Salvador, Febrero, 2007.

Not surprisingly, this same survey reports high levels of prejudice, stigma, and discrimination demonstrated by public-sector health workers. Findings noted a high demand for in-service follow up of training programs; roll-out of new training approaches; and expanded training of health administrators, promoters, and staff/volunteers in new service-providing entities, especially those involved in HIV/STI counseling and referrals. These findings should be addressed through improved in-service training and follow up (see Section II, Health Systems Strengthening, below).

### **Reaching Increasingly Vulnerable Populations**

Insufficient attention is being paid to increasingly vulnerable populations such as youth, crack cocaine users, and prisoners (for additional data on HIV infection among these groups, see Section I above). Currently, coverage of programs among both in-school and out-of-school youth is very low. There are no prevention programs designed specifically to reach cocaine users as yet, despite evidence of higher rates of HIV among crack cocaine users. In a KAP study of 51 crack users in San Salvador (41 women and 10 men), 8.5% of those who had been tested pre-study revealed they were HIV+. The MOH Annual Operational Plan for 2009 does not include BCC among drug users or vulnerable youth.

Despite high rates of HIV in the prison population (6%),<sup>23</sup> the MOH expresses concern for the capacity of the national response to carry out systematic behavior change interventions (BCI) in prisons, including care and treatment of PLWHIV. Condom distribution and nutritional support in prisons is restricted by official policy and penal codes. Prevention education and other HIV activities in prisons is limited to HIV testing (conducted as part of pre- and post-test counseling), limited ARV treatment, and increasing links with the TB treatment program (see Health Systems Strengthening, below).

### **STI Among Key Populations**

In any HIV prevention program, intensive effort to decrease STI infections, especially among MARP and bridging populations, should be a priority. Despite thousands of staff trainings, development of STI norms and other treatment efforts (see Health Systems Strengthening, below), the 2009 *Estudio Multicentrico de Prevalencia de HIV/ITS Y Comportamientos* study revealed that 19.4% of PLWHIV reported they currently had one or more symptoms of a sexually transmitted infection. STI prevalence among SWs in the 2003 *Multicentrico* study was 24.7%, and syphilis prevalence among MSM was 15.1%. This implies that awareness of the importance of condom use, and of diagnosing and treating STIs, are equally low, even among MARP.

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<sup>22</sup> *Riesgo de VIH/SIDA relacionado con el Uso de Crack*, FUNDASALVA, <http://www.fundasalva.org.sv/home/>.

<sup>23</sup> Global Fund Round 7 HIV/AIDS El Salvador Proposal, 2007.

## RECOMMENDATIONS

### RECOMMENDATIONS

- Expand targeted prevention education, with increased involvement of civil society.
- Support a larger base of local organizations to implement activities through development of:
  - joint proposals from civil society networks
  - a national “umbrella” NGO, set up to provide technical assistance and channel small grants to multiple NGOs.
- Ensure that the umbrella mechanism complements other BCC efforts, funded by GFATM and/or managed by PASCA at the regional level.
- Support expansion of BCC among out-of-school youth and other bridging populations (e.g., through PASMO).
- Promote the design of an evidence-based BCC strategy as part of the revised National AIDS Strategic Plan, to decrease risk behaviors among MARP and vulnerable groups.
- Expand partnerships to develop activities targeted to neglected vulnerable groups, e.g., support FUNDASALVA to design BCC programs among crack cocaine users and advocate for implementation support from GFATM funds.
- Advocate for strengthened STI prevention education and treatment among MARP and bridging populations, within CONASIDA, the Expanded UN Joint Team, and the CCM.

### Expansion of Community-Based Prevention

During all three focus group discussions, it was noted that a joint proposal from a civil society network would help to unify the civil society response. Such a proposal would provide a comprehensive analysis of current capacity and future targets for increased coverage of prevention education programs among MARP and vulnerable groups.

NGOs recommended that technical assistance should be provided in this regard, since no institution to date had systematically worked with civil society to assess current capacity for prevention education, or the potential for expansion of activities. Since GFATM grants require reporting on numbers reached in prevention education programs, a collective response from the NGO sector and civil society could greatly help to reach existing targets.

A joint proposal from a civil society network could be implemented through an umbrella organization with specific experience in providing technical support and channeling small grants to multiple NGOs. Models and lessons learned already exist for umbrella organizations supporting national civil society responses—for example, through the global experience of the International HIV/AIDS Alliance (IHAA), which currently operates in neighboring countries such as Guatemala, and at the regional level.

The assessment team recommends that USAID/ES, along with CONASIDA, the CCM, and the USAID regional program, support the development of an umbrella institution. USAID should advocate for this to help ensure close collaboration with ongoing prevention education programs. A Request for Proposals (RFP) should be developed to identify the most appropriate umbrella institution to support expanded civil society involvement in prevention education and other

prevention activities. Building on the experiences of URC and/or IRH/Georgetown, USAID could consider expanding support to quality management in relation to activities supported through the umbrella organization.

Areas to be assessed before supporting the development of an umbrella organization include:

- activities, quality, and coverage of programs currently implemented by civil society.
- capacity for expansion based on current staffing/volunteer levels and training, and potential to handle small grants.
- financial and technical assistance needs, so that selected organizations can reach a critical mass of beneficiaries with quality services over the next three to five years.

### **Design of National BCC Strategy**

The assessment team recommends that USAID, through advocacy and TA, support the design of an evidence-based national BCC strategy during early 2010, as part of the revised National AIDS Strategic Plan, in order to decrease risk behaviors among vulnerable groups. This strategy would articulate the need for BCC, including definition of target populations and behaviors, communication channels, coverage, and monitoring tools. The BCC strategy should clearly define implementation plans, identifying specific civil society implementers supported by the recommended umbrella organization.

### **Improved Management of Stigma and Discrimination**

USAID should consider supporting formative research and appropriate intervention design to respond to the causes of stigma and discrimination among key population groups. S&D interventions should be based on sound theoretical and practical research.<sup>24</sup> This area is a key comparative advantage for USAID support, and is not being addressed by other stakeholders. Developing a sound BCC strategy for S&D involves relatively little financial investment for a quality product, which will affect the success of ongoing S&D interventions funded by GFATM and the USAID regional program.

S&D interventions should be targeted to:

1. employers and other groups affecting PLWHIV human rights and quality of life.
2. public, private, and non-government organizations influencing health-seeking behaviors among vulnerable clients. This includes health-seeking behaviors related to raising the demand for VCT, STIs, ART, TB, and PMTCT services.

As mentioned in the gaps section above, addressing S&D based on fear of contagion is easily resolved in BCC programs since it involves simply correcting fears and myths about the modes of HIV transmission, which can be accomplished via mass media or public education programs. However, interventions addressing S&D based on prejudice (for example, against sexual diversity) will require increased and improved interpersonal and experiential BCC among strategically targeted groups. Interactive sessions would preferably involve facilitators representing MARP, who have been trained to sensitize participants to sexual diversity and to the realities of living with HIV, using real-time, experiential learning.

Effective behavior change interventions designed to change S&D rely on evidence-based (tried and tested) theory and practice. Evidence demonstrates that experiential, interpersonal sensitization sessions among targeted participants can change lives—the lives of the participants and ultimately the lives of the program beneficiaries. A country's health outcomes cannot be changed without facilitating life-changing processes among the policymakers and decision makers involved.

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<sup>24</sup> Goffman, Erving. *Stigma: Notes on the Management of Spoiled Identity*. New York: Simon & Schuster, 1986.

### **III. HEALTH SYSTEMS STRENGTHENING**

#### **ADVANCES**

To strengthen health systems affecting HIV/AIDS services, the newly appointed National AIDS Program (NAP) Director is conducting a major internal review and restructuring in order to create a multidisciplinary team. The team will include specialists in gender, pharmaceuticals, infectious diseases, procurement, and logistics. Currently, the NAP is strengthening coordination and integration of HIV, TB, MCH, adolescent health, STI, and other divisions. At the same time, under the new Minister of Health a major reorganization is taking place which will result in four programs—nutrition, mental health, HIV/AIDS, and TB. Technical assistance for the restructuring is being sought largely from Brazil and Chile, but also from the UK, Netherlands, Taiwan, and Cuba.

The NAP Director reports that updated norms for nutrition, ART, PMTCT, STI, and HIV laboratory procedures are almost completed, with technical support from UNICEF, the Pan American Health Organization (PAHO), GTZ, USAID, and others.

#### **ART**

Cumulative antiretroviral therapy for adults and children was 5,683 PLWHIV of the 6,029 programmed, or 94%.<sup>25</sup> Treatment of opportunistic infections (OIs) for HIV+ clients for the same period was 93 of the 98 programmed, or 94.8%. ART has been decentralized to 16 MOH hospitals and two Instituto de Servicios de Seguro Social (ISSS) hospitals across the country. ART treatment, including CD4 counts, is free. The Rosales hospital in San Salvador serves as the referral hospital for more complex HIV care.

#### **Prevention of Mother-to-Child Transmission (PMTCT)**

PMTCT program implementation is recognized as a great success, with more than 97% of pregnant women tested for HIV; those who are found to be HIV+ are treated within the program. For the entire period 1984–2008, SUMEVE data show that only 6.2% of all HIV+ cases were caused by vertical transmission from mother to child. The number of infants infected through vertical transmission decreased 89% from 138 infants in 2002 to 15 in 2007. The Sistema Informativo Perinatal reports on required STI testing during prenatal care—HIV and Venereal Disease Research Laboratory (VDRL) tests in the first and third trimester, and required reporting on gonorrhea (complicated) and herpes simplex. STI tests, ART, and CD4 counts are provided free of charge. Substitute milk is provided free to infants until 18 months of age.

Between 2003 and 2008, approximately 4,000 staff from MOH, ISSS, and NGOs were trained in PMTCT norms and guidelines. Mass media and outreach by staff promote testing and treatment supported by USAID and GFATM.

The Director of Atención Integral en Salud a la Mujer reported that staff working groups are collaborating with the HIV division and are actively revising 2001 PMTCT guidelines. The new draft norms were developed and tested in USAID-supported Centros de Capacitacion en Habilidades. The Guía de Atención Pre Parto y Post Parto has been used to field-test the quality of MCH/PMTCT processes and has validated an evidence base for new norms. Staff have been trained and are adopting these approaches.

#### **Sexually Transmitted Infections (STIs)**

MOH training of staff in STI treatment and epidemiological surveillance has taken place. Advocacy activities have been carried out to reduce stigma and discrimination. Millions of condoms have been provided by PASMO and others with USAID support, and they are relatively easily accessible in pharmacies, NGOs, and some MOH facilities. Technical assistance to local NGOs, including faith-

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<sup>25</sup> NDP 2008–2009 Annual Report.

based organizations (FBOs), has expanded outreach to MSM and SWs. Mass media and interpersonal BCC interventions have addressed both at-risk and general populations. More than half of MSM interviewed in the 2009 ECVC study<sup>26</sup> attended an educational talk last year; 58.2% in San Salvador and 40.8% in San Miguel reported having taken an HIV test at some time.

### **TB-HIV Co-infection**

According to the UNGASS Country Report 2008, the co-administration of treatment for tuberculosis and HIV coverage is 100%. Of the 176 cases of HIV-TB co-infection detected, 100% of the 63 who required treatment received ART. The Plan Estrategico Nacional Para el Control de la Tuberculosis 2008–2015 reports the following achievements in MOH, ISSS, and 23 prison centers:

- the TB treatment success rate increased from 42.1% in 2000 to 68.7% in 2005.
- abandonment of treatment has dropped from 7.9% in 2000 to 4.8% in 2005.
- deaths reported from TB dropped from 47.4% in 2000 to 22.9% in 2005. (Source: El Salvador One Step Ahead.)

### **Correctional Centers**

In 2005 the MOH, working with the Directorate of Correction Facilities in the Ministry of Public Security and Justice, started a health intervention strategy, including HIV/AIDS/STI prevention and care in all correctional and youth remand centers. In the same year a health situation assessment led to the development of health teams and trained peer educators.

Authorities report providing voluntary HIV tests for inmates every six months in all penitentiaries, which resulted in 42,390 counseling sessions (pre and post-counseling) and 21,195 tests (first time and repeat) between February 2006 and March 2009. In 2007, 150 cases of HIV were detected.<sup>27</sup>

## **CHALLENGES**

### **CHALLENGES**

- Missed opportunities in quality counseling in the clinic setting contribute to the spread of HIV.
- Early diagnosis and treatment of STIs are needed to prevent the spread of HIV, especially among MARP.
- Norms and guidelines need piloting with MSM, SWs, and other vulnerable groups.
- Health care workers need sensitization and training to better address the needs of clients from MARP, and to decrease stigma and discrimination in health care settings.
- Quality care, including confidentiality, is crucial to HIV service delivery, and is not currently being monitored or addressed systematically.
- Monitoring of ARV drug resistance is needed.

<sup>26</sup> *Encuesta Centroamericana de Vigilancia de Comportamiento Sexual y Prevalencia de VIH/ITS en poblaciones Vulnerables (ECVC) para: HSH, TS, y PVVS.* 2009.

<sup>27</sup> *El Salvador un paso adelante en la respuesta al VIH/SIDA y Tuberculosis.* [Español/English](#). 2008.

To date, development of appropriate norms and guidelines, with associated in-service training, has been a considerable challenge. Limited input from PLWHIV and MARP-based NGOs has been sought during piloting or review of ART, PMTCT, OI, STI, or other norms and guidelines. Involvement of MARP-based clients in validating guidelines is a critical need.

Assessment findings underscore the challenge of sustaining systematic, competency-based in-service trainings, incorporating appropriate methodologies, and using up-to-date norms and guidelines. The draft UNDP Plan de Apoyo Tecnico December 2009 reports that 4,000 MOH staff have been trained in HIV; however, less than 10% of those trained were certified as competent in VCT counseling.

## **ART**

Given continuing stigma and discrimination by health staff, facilities must be developed to be “MARP-friendly,” i.e., with staff trained, sensitized, and competent to provide quality services to MARP clients. A few individual physicians at certain health facilities are known to treat SWs, MSM, and other MARP without discrimination and with quality care; unfortunately, coverage is very low. Some key MARP-based NGOs are known for non-discrimination and good-quality treatment and care, such as Atlacatl, Contrasida, and Entre Amigos. This situation seriously affects the access, acceptability, and quality of services to MARP and contributes to the spread of the epidemic.

In addition to these challenges, the relatively small (30) number of confirmed ARV drug-resistant cases must be treated. Recently, a purchase order of some \$171,000 for second-line drugs was signed by the MOH to treat 30 drug-resistant patients. The number of ARV drug-resistant cases could increase rapidly with astronomically higher costs. Ongoing adherence studies are also needed since the last study was carried out by Atlacatl four years ago. Recently the GFATM identified the need for a small study to address adherence issues, given the 30 drug-resistant cases.

## **Sexually Transmitted Infections (STIs)**

In a health system climate that contains stigma and discrimination, the effective identification and treatment of STIs, including HIV, to control the epidemic is a significant challenge for the MOH, for high-risk groups, and for the country.

The difficulty of preventing the sexual violence that fuels STIs is reflected in 2009 ECVC data, which show that 22.1% of MSM in San Salvador and 30.6% in San Miguel had had forced sex in the last 12 months, most with an unknown person. In San Salvador 11.9% of MSM reported that their initial sexual experience had been forced, typically by a partner or friend. Of the 15.9% of MSM in San Miguel who reported a forced initial sexual experience, the perpetrator was generally a parent or family member.

The challenges in coverage of STI treatment were also revealed in 2009 ECVC data. In a sample of 624 MSM from San Salvador and 200 in San Miguel, data showed that:

- 21% of MSM from San Salvador and 17.6% of MSM from San Miguel had some type of STI.
- 46.8% of MSM in San Salvador and 36% in San Miguel were sero-positive in the test for HSV-2, and 12.1% of MSM in San Salvador and 8.1% in San Miguel were positive for the Rapid Plasma Reagin test (used in syphilis screening). 4.4% of MSM in San Salvador and 8.1% in San Miguel were found to have active syphilis.
- 10% of MSM in San Salvador and 4.2% of MSM in San Miguel presented with symptoms of an STI in the past year.
- the prevalence of HIV among MSM was 4.6% in San Salvador and 7% in San Miguel.

- transvestites and transsexuals had the highest prevalence of HIV and HSV-2, while gay men had the highest prevalence of syphilis.

Challenges in coverage of STI treatment are also evident in the 2009 ECVC study of 663 sex workers in San Salvador and 185 sex workers in Sonsonate. The study reports unacceptably high levels of STIs, as well as a lack of access to services. Findings include:

- 54.6% of sex workers in San Salvador and 44% in Sonsonate had some type of STI.
- HIV prevalence was 5.7% among sex workers in San Salvador, and 2.5% in Sonsonate. HSV-2 among sex workers in San Salvador was 82.6%; in Sonsonate it was 76.2%.
- Sex workers without a fixed place to live showed the highest rates of STIs and HIV (45.4% in San Salvador and 56% in Sonsonate).
- 81.1% and 74.6% of all SW respondents had been tested for HIV at one time.
- More than 90% of sex workers in San Salvador used a condom when they last had sex; in Sonsonate 83.3% used a condom in their last sex with a regular client and 90% used one with a new client.

Challenges in the working conditions of sex workers and their access to health services in the same 2009 ECVC study limit control of HIV and other STIs. Data show that:

- 17% of sex workers in San Salvador and 13.4% in Sonsonate were forced to have sex during the past 12 months. Violence threatens the ability of sex workers to protect themselves from HIV and STIs. It also makes it difficult for health providers to provide adequate counseling and treatment.
- sex workers on the street present an additional challenge to reach with messages, condoms, and STI services.
- although condoms were provided in health facilities to 58.2% of sex workers in San Salvador and 84.9 % in Sonsonate, almost one quarter of SWs reported some abuse or maltreatment by health care providers in the past year.

Sexually diverse groups continue to face obstacles in gaining regular access to condoms as part of integrated care in health centers—often this apparently requires a long process of registration and multiple consultations simply to replenish condom supplies.

### **HIV-TB Co-infection**

Linkage between HIV and TB for the treatment of co-infections can present a challenge that requires strong collaboration and the merging of two different approaches to care.

Although there have been significant successes, the TB program relies heavily on daily direct observed therapy by already overworked health workers—adding other tasks could negatively affect the health services system.

### **Correctional Centers**

Although correctional centers are equipped with health units, physicians, and nurses, the units lack X-ray units and labs, and cannot provide ART, which threatens the continuity of HIV care for inmates.

Current MOH ART norms require that ART be administered only at hospitals. This creates a serious hurdle for integrating and consolidating TB and HIV norms/guidelines for integrated

testing, counseling, and treatment of TB, HIV, and co-infections in crowded and expanding prison populations.

### **Adolescent Services**

Developing youth-friendly health facilities and staff training for STI, VCT, and related services, and promoting access will be challenging, and service delivery staff will need to be reoriented and trained.

NGOs working with adolescents report stigmatizing and pejorative treatment by health staff, which reduces access to HIV/STI services. Adolescents report that staff do not keep information confidential, telling parents and others of adolescents' requests for condoms, HIV tests, and other services.

## **RECOMMENDATIONS**

### **RECOMMENDATIONS**

*Although the following recommendations are largely covered under the U.S. Government's Regional Partnership Framework, UNAIDS, and the GFATM projects, several could be complemented by USAID bilateral support.*

- Update and validate norms and provider guidelines to global standards, with MARP input.
- Support quality assurance for HIV/STI testing, treatment, and counseling services; monitor contribution to prevention.
- Advocate for more systematic training and sensitization of health care workers to address stigma and discrimination.
- Expand STI diagnosis and treatment among MARP and vulnerable groups.
- Strengthen advocacy to ensure human rights are protected in HIV services.
- Support early drug resistance monitoring.
- Advocate for improvement of procurement systems and supply chain management.

### **ART**

Advocacy is recommended to improve confidentiality, maintain respect for human rights, strengthen quality of services, and ensure increased access and adherence nationwide, which in turn will help address drug resistance. Quality management of services could be incorporated into ongoing regional and national programs supported by SICA and GAFM.

### **PMTCT**

Advocacy is recommended, in particular to protect the human rights of women who test HIV+ in MCH services, including the use of updated WHO norms.

### **STIs**

Support for, and/or advocacy, is recommended for rapid expansion of BCC to increase STI awareness and provide early diagnosis and treatment among MARP and vulnerable populations.

### **Adolescent Services**

Advocacy is recommended to establish youth-friendly services in key geographical areas. Youth-friendly services should be linked to ongoing community prevention programs.



## IV. STRATEGIC INFORMATION

### ADVANCES

There are currently about 72 governmental, nongovernmental, private, and other institutions involved in the national response to HIV/AIDS in El Salvador, working in one way or another to fulfill the objectives of the National Strategic Plan (NSP).<sup>28</sup> Each and every one of these institutions could generate valuable information to provide evidence on the progress of the NSP. Coordinating a unified, evidence-based national response to HIV/AIDS (or indeed any other national health or development issue) requires an M&E and strategic information system that will ensure accurate and timely reporting of use to the individuals who make programming and policy decisions.

Currently, El Salvador's successful strategies in medical intervention are built largely upon the availability of timely epidemiological and behavioral surveillance information. Signs of progress in data collection and use include the creation of the National Plan for Monitoring, Evaluation, and Epidemiological Surveillance of HIV/AIDS and STIs, 2006–2010—a framework in which impact and process indicators have been prioritized and harmonized at the global level, making use of such guidelines as one of the earlier UNAIDS manuals, *National AIDS Programs: Guidelines for Monitoring and Evaluation*, Geneva 2006. Methods of data processing are identified (sources, staff responsible for data collection, reporting frequency). This framework also highlights the importance of government organizations, NGOs, civil society, and others in joining this effort.

In addition to the development of the National M&E Plan, a National Sub-Commission for Monitoring and Evaluation was created, attached administratively to CONASIDA, with technical links to the STI/HIV/AIDS National Program. Among the institutions currently comprising the Sub-Commission are the National STI/HIV/AIDS Program, the UNAIDS country office, GFATM (AIDS-TB), local and regional WHO/PAHO offices, Prevensida, the Ministry of Education, ISSS, the Military Health Command, UNFPA, and the Central American Secretary of Social Integration (SISCA) Regional Project on HIV/AIDS.<sup>29</sup>

These efforts have enabled El Salvador to report efficiently to the United Nations over the past two reporting rounds, providing data on 19 of 24 UNGASS indicators in 2008, as well as annual generation of National AIDS Spending Assessments (NASA). In addition, the country has installed a national software platform and established a database for real-time recording of HIV and AIDS cases registered in the National System of Health.

Furthermore, El Salvador has produced several research studies related to HIV/AIDS, STIs, and sexual health service delivery, as a result of cooperation between government, civil society, academic institutions, the education sector, and international partners such as GTZ, UNAIDS, GFATM, and USAID.

In order to fulfill the basic functions of a national M&E system, the country has initiated development of a Unified System of Monitoring, Evaluation, and Epidemiological Surveillance (SUMEVE). The system is a web application, installed at the MOH central level, which can be accessed through an authorization procedure managed by the system administrator. Currently, SUMEVE only houses epidemiological data, registered from January 2009. No other data

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<sup>28</sup> Plan Nacional Monitoreo Evaluación VIH-sida/its, El Salvador, 2006–2010. Pg. 34.

<sup>29</sup> Plan Nacional Monitoreo Evaluación VIH-sida/its, El Salvador, 2006–2010. Pg. 32.

components are yet stored, with the exception of ARV prescriptions delivery. A number of SUMEVE database components remain in the planning phase, including:

- evaluation of clinic-based and community-based prevention activities.
- monitoring of patient records, including integrated clinical care for PLWHIV.
- monitoring of ARV patient adherence and drug resistance.
- implementation of legal reforms related to defense of human rights among PLWHIV.

SUMEVE is intended to handle second-generation surveillance data using sources from multiple studies, program reports, and behavioral studies. The system will track knowledge, attitudes, behaviors, age, gender, geographic areas, and risk factors in various communities, along with clinic-based information on modes of transmission and other data gained through the HIV/AIDS case registry system—all of which will provide information crucial to understanding the course of the epidemic.

Currently, HIV/AIDS case data are captured in real time by the following institutions: the MOH, ISSS, the Institute for Teachers' Welfare, and the Military Health Command (all of these organizations are part of the national health system of El Salvador). Data recorded in health facilities are sent to collection centers where typing personnel feed the system through the Internet or intranet. The information is received by the MOH's central server, providing a series of reports with a wide range of variables.

Other sources furnishing relevant and complementary data to those provided by SUMEVE include:

- the Department of Statistics and Census (DIGESTYC), which is responsible for reporting the country's vital statistics. The department's reports consolidate the total deaths reported by the 262 municipalities in El Salvador. This information remains available until one year after the close of the calendar year.
- the new online Morbidity and Mortality System of the MOH, which began functioning in 2005 in 30 MOH hospitals. Initially, only institutional hospitalizations and deaths were recorded, but as of 2006, records from outpatient services have been included.
- National AIDS Spending Assessment surveys (NASA).<sup>30</sup>

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<sup>30</sup> Plan Nacional Monitoreo Evaluación VIH-sida/its, El Salvador, 2006–2010. Pg 19.

## CHALLENGES

### CHALLENGES

- The National AIDS Commission (CONASIDA) does not fulfill its sub-commission M&E role.
- The M&E system (SUMEVE) currently only holds epidemiological data, and does not provide behavioral or programmatic data.
- Health facilities have no access to SUMEVE at the decentralized level.
- SUMEVE is not institutionalized (the only technician managing SUMEVE has recently left).
- Civil society does not participate in data entry or analysis.
- Data are not being used for decision-making, nor are second-generation surveillance data being used for evidence-based programming.

Although there has been progress, major gaps remain in El Salvador's Strategic Information and SUMEVE systems, some of which are covered under the GFATM R7 grant (Health System Strengthening, Objective 4). A major area left uncovered, however, is the inclusion of data on NGO sector programming, particularly the quality and coverage of prevention programs. This area in particular, involving the mobilization of civil society, will require additional sources of technical support, along with provision of hardware and software, particularly at decentralized levels.

Data from studies conducted by additional health programs and actors in the national response are not yet being systematically captured in such a way as to provide full understanding of the HIV epidemic, where it is going, and exactly where the high-transmission settings are. Existing studies include clinic-based studies carried out by the national STI and MCH programs; FESAL 2008; behavioral surveillance surveys (BSS) conducted with technical assistance from CDC; TRaC carried out among MARP reached by specific programs; service delivery studies carried out by PASMO, PASCA, and the Institute for Reproductive Health/Georgetown; URC quality management studies; and knowledge, attitudes, and practice studies conducted by the Ministry of Education and the University Institute for Public Opinion (IUDOP/UCA), among others.

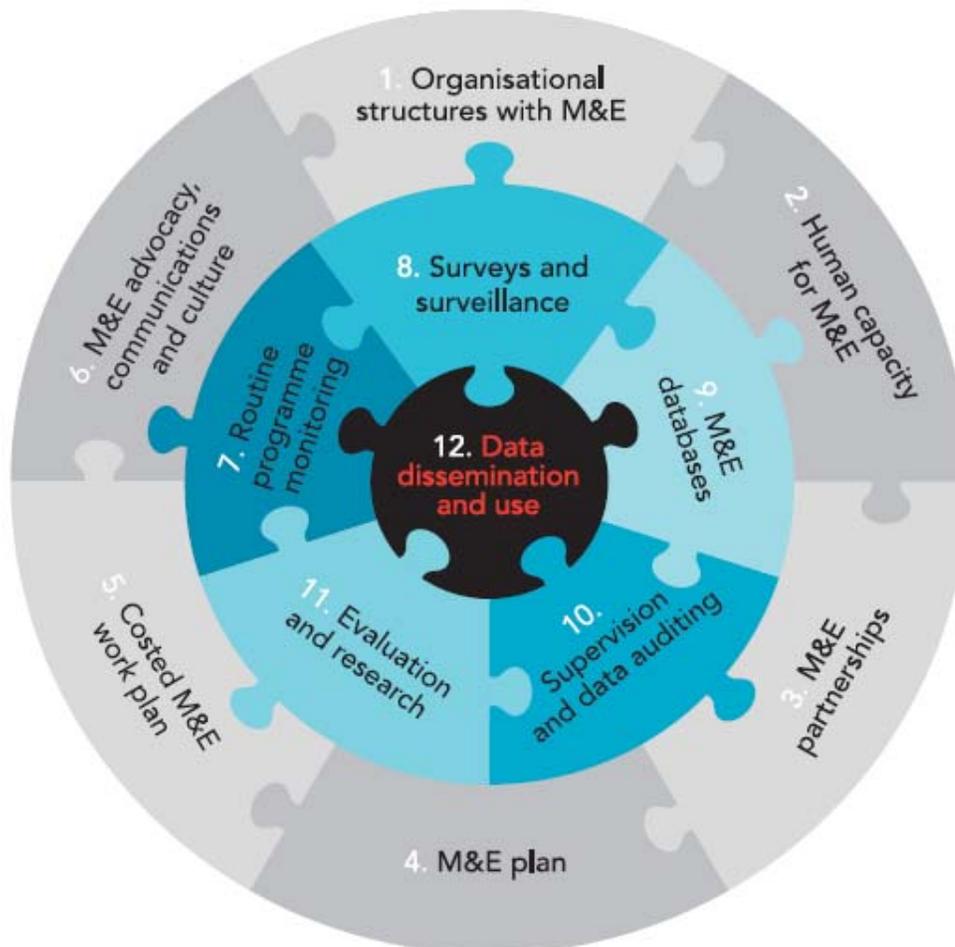
Lack of hardware and technical skills at NGO and MOH local-level facilities has resulted in the absence of a functional second-generation surveillance system—since the latter requires triangulation of data from multiple sources at multiple levels (including municipal, provincial, and central levels). Understanding an epidemic requires comparing information on HIV, TB, and STI prevalence, and on the behaviors that spread these infections (including drug use and sex industry trends), in order to build a picture of changes in the HIV epidemic over time.<sup>31</sup>

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<sup>31</sup> *Guidelines for Second Generation HIV Surveillance: The Next Decade*, Corp. Authors: World Health Organization WHO, Joint United Nations Programme on HIV/AIDS (UNAIDS), Division: WHO/CDS/CRS/EDC/2000.5. Geneva: WHO, 2000.

Ideally, there are 12 components in a functioning national M&E system, summarized in Figure 1, below.<sup>32</sup>

**Figure 1. Organizing Framework for a Functional National HIV M&E System—12 Components**



This “jigsaw puzzle” is not as complex as it looks—it is simply a systemic, dynamic approach to data generation and exchange that directly involves current actors in a national response. And once established, the system is much less confusing and much more effective than relying on empirical and subjective lines of communication among key implementers. The programming “universe” shown below, which depicts groups representing and delivering key services to MARP,<sup>33</sup> clearly illustrates this. (Similar results relating to the inadequacy of data flow systems have also been mapped out by national and international NGOs operating in El Salvador.)

<sup>32</sup> *Organizing Framework for a Functional National HIV Monitoring and Evaluation System*. UNAIDS: 2008.

<sup>33</sup> Focus group discussion organized by the current assessment consultants, San Salvador, December 2009.



- The delay in introducing the remaining sections of SUMEVE has created a medicalized focus to M&E, which has neglected social aspects of the epidemic, such as human rights, prevention education, and integrated care for people living with HIV.

## RECOMMENDATIONS

### RECOMMENDATIONS

*Although the following recommendations are largely covered under the U.S. Government's Regional Partnership Framework, UNAIDS, and the GFATM projects, several could be complemented by USAID bilateral support.*

- Work with UNAIDS to strengthen the functions of CONASIDA's M&E sub-commission.
- Define the division of labor among other partners involved in strategic information, such as UNAIDS, PASCA, PAHO, CCM, DOD, and CDC.
- Provide technical and financial support to involve civil society in a fully functional national M&E system, perhaps through Internet access at the provincial level.
- Support rapid assessments in high-transmission settings. Disseminate results for improved evidence-based programming.

The most cost-effective solution would be to establish data hubs in each of 14 provinces, with access provided to all HIV/AIDS implementers (controlled through passwords set by the administrator), using user-friendly interfaces. Data could thus be shared through a SQL server to a mainframe database (e.g., an expanded SUMEVE) housed at the National AIDS Program.

This would require developing an IT platform tailored to the needs of the national program, using cost-effective "off-the-shelf" software and providing minimal training of data input specialists. All users could generate their own reports using local, national, or regional data—in the same way that public users of GFATM's website can generate tailor-made grant progress reports without specialized training.

As noted earlier, most gaps described above relate to the government sector and are scheduled to be resolved through the Global Fund Round 7 proposal, which provides for acquisition of technology, staff training, development of SUMEVE regulations, and technical support, although largely relating to clinic-based data and behavioral surveillance.<sup>34</sup> The gaps relating to civil-society-generated data on prevention education remain unfulfilled, and this is specifically recommended for USAID support. This would also complement USAID's support for the expansion of prevention education among civil society, ensuring monitoring and evaluation of results, with evidence-based linkages to 2015 impact indicators.

<sup>34</sup> Global Fund Round 7 HIV/AIDS El Salvador Proposal, 2007.

Specific recommendations for USAID bilateral support include the following:

- Fund a cost-effective IT platform to support data flow among the 12 components of a functioning M&E system as shown in the figure above. Emphasis should be placed on the civil society component and on monitoring prevention education. For the other components, liaisons with the Pan American Health Organization (PAHO) and the Government of El Salvador (GOES) should be established.
- Coordinate with CDC to provide technical training on M&E and second-generation surveillance for key NGO staff and other users.
- Provide technical training on the use of provincial-level data hubs linked to SUMEVE, particularly for civil society and NGO staff.
- Advocate within NAP and CONASIDA, CCM, and the UN Joint Team for the strengthening of CONASIDA's M&E sub-commission, in order to carry out its strategic information functions and to ensure evidence-based programming within the national response.
- Promote more effective use of Global Fund Round 7 and Rolling Continuation Channel (RCC) second round resources to include NGOs in providing computers to strengthen M&E among civil society organizations.
- Work with PAHO and the MOH to ensure access for local health facilities to provincial data hubs. This will improve data use and decision-making in service delivery, which will benefit local clients in vulnerable population groups.



## V. POLICY ENVIRONMENT

### ADVANCES

Over the past five years, the national response has, in effect, been managed by the public health sector through the National AIDS Program (NAP) under the MOH, guided by the National Strategic Plan (NSP) for HIV/AIDS/STI, 2005–2010. The current NSP was launched in December 2005 with presidential and other high-level support. Consultations are currently underway with a number of stakeholders in preparation for the review and development of the NSP covering 2011–2015. Newly elected President Funes has written a letter of commitment to maintain HIV as a national concern at the highest political level.

The NAP is governed by an advisory body, CONASIDA, whose membership is made up primarily of governmental institutions (eight out of 12), with limited representation of civil society and the private sector (four out of 12). Current membership includes representatives from: (1) government—the Ministry of Health, the Ministry of Labor and Social Assistance, the Ministry of the Interior, the Ministry of Education, the National Family Secretariat, the National Social Security Institute, the Human Rights Ombudsman, and the armed services; and (2) the private sector and civil society—the media and communications sector, the business sector, the medical profession, and NGOs working in HIV prevention.

CONASIDA is thus well-positioned to spearhead more meaningful participation from non-health sectors represented in its membership, so long as challenges in implementing political commitment are resolved (see below).

To date, CONASIDA has facilitated major advances in legal and policy reforms and in human rights, such as development of new HIV laws and codes, and commitment to universal access of PLWHIV to treatment and care. Progress has also been made in providing sensitization and training to decrease stigma and discrimination, and coordination of key interventions with civil society. Implementation and monitoring of the legal framework remains weak, although CONASIDA has the capacity to monitor adherence to laws on HIV and human rights. This is an important future role for CONASIDA.

Following the start of GFATM investment in HIV/AIDS and TB in 2003, a grant-related Country Coordinating Mechanism (CCM) was also formed. The CCM is a governance body overseeing GFATM-funded activities and grant progress, in contrast with CONASIDA's national advisory role. To date, the CCM has acted as the strongest channel for voicing the concerns and needs of civil society. The CCM constitution is currently being revised and will include additional sector representation in its membership. The 2009 December meeting of the CCM included approval for changes in membership, voting rights, and roles and responsibilities of members.

In general, international support to the NAP, CONASIDA, and the CCM is strong, and focuses on assisting El Salvador to achieve globally approved core indicators, as reported regularly to the UN General Assembly Special Session on HIV/AIDS (UNGASS). The country has also gained global recognition for its achievements under the National Composite Policy Index (NCPI)<sup>35</sup> and the AIDS Program Index, 2009.<sup>36</sup>

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<sup>35</sup> UNGASS Country Report 2008.

<sup>36</sup> *El Salvador: Medición del Ambiente Político Asociado al SIDA*. USAID/PASCA: August 2009.

## CHALLENGES

### CHALLENGES

- The national HIV/AIDS response depends greatly on GFATM funds.
- Clearer leadership in the national response is needed.
- The roles of CONASIDA and the CCM should be clarified.
- The National Strategic Plan (NSP) 2005–2010 is due for revision.
- There is continued need for sensitization and training for front-line staff, especially in ministries and other sectors newly involved in HIV/AIDS.
- Advances in HIV law and policies must be monitored to ensure effective application.
- Stigma and discrimination remain major barriers to accessing services and improving policies (see also Section II, above).
- Civil society involvement as implementers of the national response remains limited.

### Governance

CONASIDA has a strongly medical focus, with limited multi-sectoral participation at the programming level on the part of other line ministries, the private sector, and civil society. Political will and increased advocacy will be necessary to expand the national response, especially within the private sector. Although the MOH 2009 Annual Operational Plan includes establishment of a Permanent Council of Private Enterprise, major advocacy and technical support will be required to ensure that this new body develops effective annual operational plans and budgets for HIV, and implements them over the next five years. In addition, new ministers, directors, staff, and focal points within CONASIDA's membership will need orientation and training on HIV, as well as technical support to enable the development of institutional plans and budgets within the overall framework of the revised NSP.

The coexistence of CONASIDA and the CCM has affected national governance. This is partly because the national response depends so heavily on GFATM funds, which are overseen by the CCM, and partly because CONASIDA has no budgetary influence over national stakeholders and implementers. In addition, civil society has a more powerful voice within the CCM than within CONASIDA. As a result, the respective roles of CONASIDA and the CCM as leaders in the national response have become blurred.

In focus group discussions, NGO participants discussed the current and potential roles of CONASIDA and the CCM as leading entities in the national response (see Appendix C), overwhelmingly expressing the need for improved leadership and coordination. In the visualization/mapping exercise, in which current programming “universes” were depicted, participants were unable to easily identify a leading institution or “planet” around which other players were “orbiting.” As far as governance, there was no obvious “sun” in any of the programming universes mapped out by the three groups of participating NGOs (MARP-based NGOs, local NGOs providing a range of services and activities, and international NGOs).

Participants in all three groups, including FBOs and representatives of health training institutions, oriented themselves away from the center of the national programming universe and showed little

relationship between either themselves or any one coordinating entity. In addition, the communications and media sector, the private sector, and other line ministries were invisible in all programming universes, as were the major cooperating agencies such as UNAIDS, GFATM (the CCM), and the Central American Integration System (SICA). Cooperating agencies were placed in distant orbits, with only temporary or incomplete significance, appearing as rapidly moving “comets” or as a waning moon, revealing only part of themselves to civil society actors. In the programming universes depicted by local NGOs, the larger international NGOs (such as PASMO) were also invisible.

In discussions following the mapping exercise, CONASIDA’s leadership was seen to be weaker because its legal framework could no longer support the implementation of its original objectives. Participants suggested that CONASIDA be placed outside the MOH, or at least operate more independently, in order to allow effective mobilization of a genuinely multi-sectoral response (see Recommendations, below).

### **Strategic Planning**

The National HIV Plan 2005–2010 is due for evaluation and revision by early 2010. Technical support is needed in evidence-based planning to ensure improved application of legal reforms and other policies aimed at improving the policy environment. This support is available at the regional level through USAID’s regional program, the Partnership Framework, implemented through PASCA using international standards and norms. At the national level, UNAIDS is tasked with providing technical support for M&E of the NSP, making reference to available baseline data and the most recent evidence of progress.

The revised NSP is the pivot around which the strategic plans of all other stakeholders should revolve. The NSP relates to broader strategic frameworks both at the national and regional levels, dovetailing with regional strategic parameters developed by the Council of Ministers of Health for Central America (COMISCA). Ideally, the revised NSP should also be linked to the National Health Strategy, as outlined by the new GOES prior to election.<sup>37</sup>

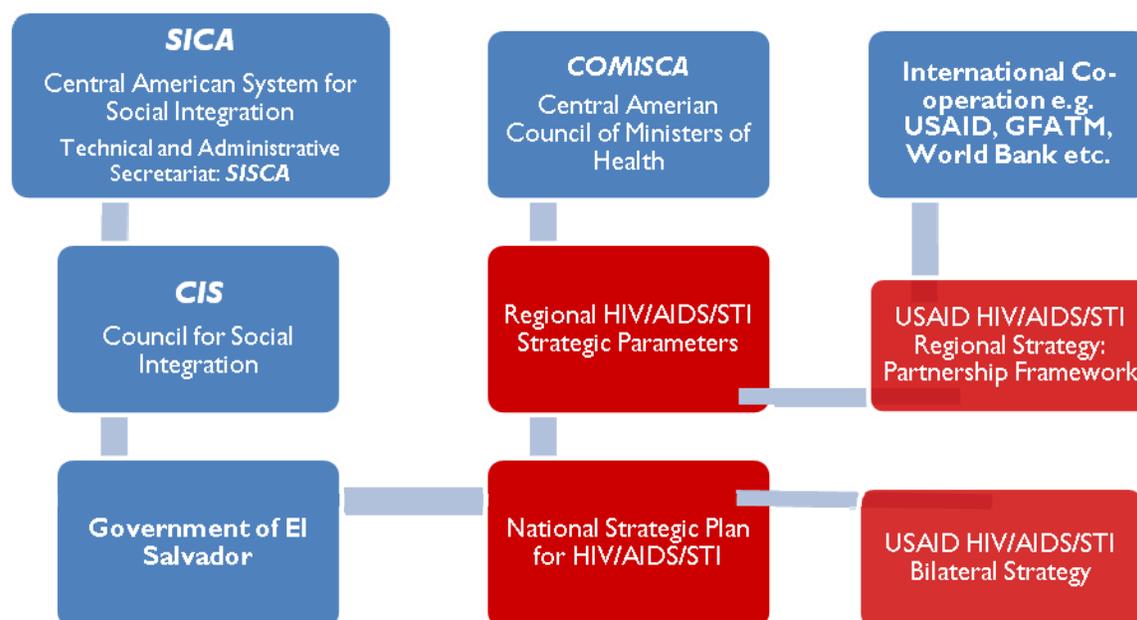
In turn, the strategic frameworks of key international cooperation agencies should also reflect the interrelationship between the NSP and broader national and regional frameworks. With USAID, this linkage is explicit, especially at the regional level.<sup>38</sup> Figure 1 below illustrates the interrelationship between key regional and national entities, and the respective strategies for HIV/AIDS/STI.

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<sup>37</sup> *Construyendo la esperanza: Estrategias y recomendaciones en salud 2009-2014*, Maria Isabel Rodriguez, Ministerio de Salud, El Salvador, May 2009.

<sup>38</sup> Cf. Partnership Framework Document, 2009, Annex 4, *Guiding Principles for the Relationship Between the Partnership Framework and the Strategic Parameters Defined by the Council of Ministers of Health (COMISCA)*.

**Figure 2. HIV/AIDS/STI strategic planning frameworks for El Salvador and Central America, showing links with USAID bilateral and regional strategies.**



A key challenge during early 2010 will be to support a nationally owned process that allows for iterative development of the revised NSP for 2011–2015 and the revised strategic plans of key cooperating agencies, in line with the GOES and regional policies for health and social integration.

### Supportive Environment

As mentioned in Section II, considerable baseline data exist on stigma and discrimination, and the ways in which these behaviors block access to key services, particularly prevention services. A major challenge over the next three to five years will be to ensure that the GOES has enough support in terms of advocacy and technical assistance to develop a national BCC strategy that will address stigma and discrimination, using the findings of existing surveys, as part of the revised NSP.

### Role of Civil Society

During the focus group discussions (see Appendix C) NGO participants expressed a lack of support from the national response for organizational development and training, and lack of coordination in civil society efforts. Results indicated a large vacuum in the relations between NGOs, as well as relations between civil society and the MOH. However, there were high expectations for a change in this situation under the new administration, given the civil society mandate of the newly appointed Director of the National AIDS Program.

Current scenarios presented by NGO participants in the discussions revealed interpersonal and inter-organizational conflict, competition for funding, and duplication of roles, which has led to a fragmented response within civil society that includes ineffective advocacy and under-utilization of resources. Participants attributed this to a lack of clear leadership in the national response.

NGOs working closely with MARP expressed concern over the lack of confidence demonstrated by international cooperation agencies in funding their activities.

A major challenge is the development of a funding and technical support mechanism that will maximize capacity of current actors in order to increase coverage of behavior change and

prevention programs among MARP and vulnerable groups, including drug users, prisoners, housewives, and youth.

As a result of insufficient institutional strengthening of MARP-based NGOs, behavior change interventions among MARP and vulnerable populations remain limited, in both quality and coverage, with little evidence of impact at the national level.

## RECOMMENDATIONS

### RECOMMENDATIONS

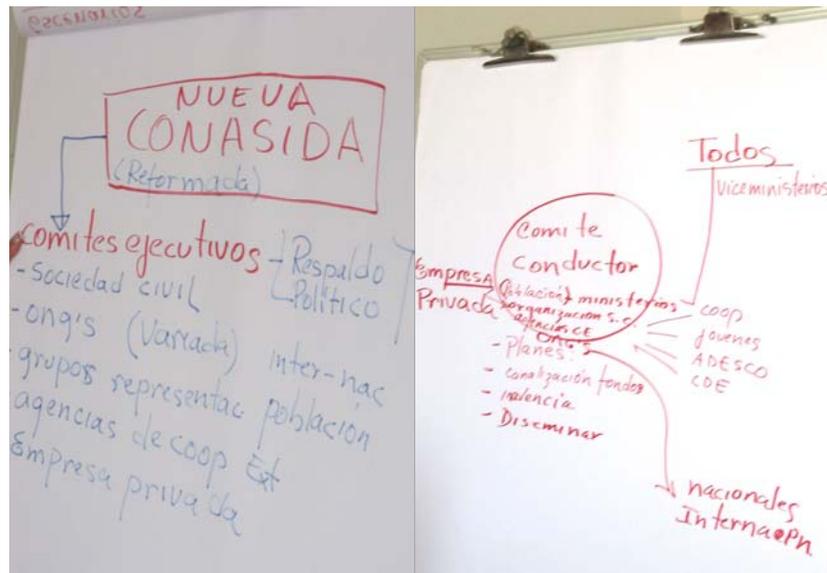
USAID should provide support for:

- Development of a phase-out/phase-in GFATM proposal using the National Strategy Application track, in order to ensure future sustainability of the national HIV/AIDS response.
- Strengthening CONASIDA to ensure a broader civil society and private-sector mandate, as well as advocating for a permanent member's seat to represent PLWHIV organizations.
- Clarifying CONASIDA's leadership role, especially in M&E of the national response, and improving the policy environment.
- Sensitization and training of government ministries, staff, and focal points involved in HIV/AIDS.
- Building a participatory process for revising the National Strategic Plan.
- Establishing an umbrella institution to provide technical assistance and funding to multiple NGOs, strengthening the civil society response as implementers of prevention programs and advocates for change.

## Governance

One of the major recommendations for resolving gaps in prevention relates to governance. The adjacent flip chart findings arose from a focus group discussion among five leading international NGOs, all of whom represent larger networks, including the following organizations: nine associations involved in training health-sector personnel; nine NGOs involved in prevention;

14 members of the Foro de ONGs; 23 church groups; and the Mesa



Recommendations for HIV/AIDS prevention governance resulting from the assessment team's focus group discussion with International NGOs.

Ciudadana, representing civil society as a voting member on the CCM. These findings epitomize recommendations arising from all three discussion groups.

The major recommendation was to restructure and strengthen CONASIDA to ensure the practical functioning of its leadership role and to give the organization a broader civil society and multi-sectoral mandate. Additional ministries, municipalities, private-sector, and civil society entities should be represented in a strengthened, “renewed” CONASIDA.

Key leadership roles for CONASIDA were identified as monitoring and evaluating the national response, ensuring the dissemination and use of strategic information (see also Section IV), and developing a supportive environment.

It was noted that new members of CONASIDA will need training and capacity development in HIV, support for appointing focal points and developing annual action plans and budgets.

### **Strategic Planning**

The assessment team recommends that the USAID bilateral program provide ongoing technical support to the GOES in the nationally owned process for revising the NSP during the first half of 2010, and for developing annual action plans and budgets to implement this revised NSP during the next five years. This support would complement that provided by UNAIDS, PASCA, and other cooperating agencies.

USAID’s future programming for HIV/AIDS/STI should support implementation of key objectives in the revised NSP (once these have been developed), which would complement activities supported by USAID’s regional program, GFATM, and other cooperating agencies.

### **Supportive Environment**

USAID’s main comparative advantage lies in supporting the design of a national stigma and discrimination strategy, not yet supported by other cooperating agencies. Detailed recommendations for this support are presented in Section II.

### **Role of Civil Society**

The USAID/El Salvador bilateral strategy should include advocating for, and supporting development of, a mechanism to ensure greater participation of civil society as implementers of prevention programs, within the national response. A model mechanism for providing technical assistance and channeling funds to multiple MARP-based and other NGOs is provided by the International HIV/AIDS Alliance (IHAA), which operates globally and in neighboring countries. A local NGO or private-sector organization could be identified to fulfill this role, acting as an umbrella institution for civil society programming. Support for development of this mechanism should be mobilized among relevant GOES institutions, as well as cooperating agencies such as GFATM and members of the expanded UN Joint Team. (See Recommendations, Section II, above.)

## **APPENDIX A. SCOPE OF WORK**

**GLOBAL HEALTH TECHNICAL ASSISTANCE PROJECT  
GH TECH  
CONTRACT NO. GHS-I-00-05-00005-00**

### **SCOPE OF WORK**

**El Salvador: HIV/AIDS Assessment and Design  
(Final 09/21/09)**

#### **I. TITLE**

Activity: USAID/El Salvador: **El Salvador: HIV/AIDS Assessment and Design**  
Contract: Global Health Technical Assistance Project (GH Tech), Task Order No. 01

#### **II. PERFORMANCE PERIOD**

O/a the last week in October 2009–o/a mid-December 2009

#### **III. OBJECTIVES AND PURPOSE OF THE ASSIGNMENT**

The objectives of this SOW are two-fold:

1. To conduct an assessment of HIV/AIDS in El Salvador.
2. To use the assessment to design strategic interventions to help prevent, contain, and mitigate the impact of HIV/AIDS in El Salvador.

The design of interventions will be a useful product for USAID/El Salvador in the development of its five-year strategic plan. In addition to providing guidance on USAID HIV/AIDS strategy, this assessment and design will also serve as an important outlet for HIV/AIDS stakeholders, including the new GOES authorities, to inform the process of identifying HIV/AIDS priorities and future directions.

#### **IV. BACKGROUND**

##### **A. Relationship to USAID Strategic Framework**

Since the 1960s the U.S. Government has continuously supported various interventions in the public health sector in El Salvador.

USAID/El Salvador's current bilateral Strategic Objective Agreement (SOAG) for health and education with the Government of El Salvador (GOES) for the period 2004–2010 builds on past achievements and aligns with USAID's Central American and Mexico (CAM) Regional Strategy (see annexes). El Salvador's 2004–2011 Country Plan supports the three Strategic Objectives (SOs) of the CAM Regional Strategy:

SO1: Ruling Justly: More Responsive, Transparent Governance

SO2: Economic Freedom: Diversified and Expanding Economies

SO3: Investing in People: Healthier, Better-Educated People

Under the CAM Strategy, Strategic Objective 3: “Investing in People: Healthier, Better-Educated People,” provides the framework for regional and country-specific programs in health and education. To address SO3, USAID/El Salvador developed Activity No. 519-0463, “Strengthening Health and Basic Education” (see annexes). USAID/El Salvador’s Human Investment Office (HIO) is responsible for implementing this activity providing support to the programs of the Ministries of Health and Education in El Salvador. This activity supports focus areas within SO3’s health portfolio, specifically through the following Intermediate Results (IR):

IR 3.1: Increased and improved social-sector investments and transparency

IR 3.3: Improved integrated management of reproductive and child health

IR 3.4: HIV/AIDS and other infectious diseases contained and impact mitigated

The USAID HIV/AIDS program in El Salvador contributes to IR 3.4, specifically to Sub-IR 3.4.1: Increased use of prevention practices and services to combat HIV/AIDS and other infectious diseases.

## **B. U.S. Government Support to HIV/AIDS in El Salvador**

El Salvador is characterized by a concentrated epidemic (i.e., HIV prevalence of less than 1% in the general population and greater than 5% among specific subgroups) seen in most-at-risk populations (MARP), specifically men who have sex with men (MSM), transgender, male and female sex workers (SWs), SW clients, individuals with sexually transmitted infection (STIs) and TB, and mobile populations. For more information on the HIV/AIDS situation in El Salvador, see the Ministry of Health (MOH) report Situación del VIH–SIDA en El Salvador, Abril 2009 (see annexes).

For approximately 15 years USAID has provided support to El Salvador to decrease the transmission of HIV/AIDS, through the Regional HIV/AIDS Central American Program and through bilateral interventions.

Currently, USAID regional interventions support El Salvador’s response to the HIV epidemic in prevention, policy reforms, and comprehensive care and treatment (see regional strategic framework in annexes section). In HIV prevention, USAID activities have focused on prevention among MARP, including behavior change to reduce the risk of sexual transmission; STIs; social marketing of condoms; expanding voluntary counseling and testing (VCT); and providing information, education, and communication (IEC) for those most vulnerable to infection. In policy reform, USAID activities have focused on development of national plans/monitoring and evaluation (M&E) plans; development of expenditure studies; support for strengthening surveillance; improving capacity for collecting, analyzing, and using information for decision-making; M&E; development and implementation of HIV/AIDS laws; the development of guidance and protocols; support for the development of GFATM proposals; and improving the capacity of the Country Coordinating Mechanism (CCM). In comprehensive care and treatment, the program has contributed to improving the skills of providers to care for HIV+ people,

establishing systems to ensure quality of services, and increasing the capacity of health personnel to carry out HIV/AIDS/STI testing.

With USAID bilateral HIV/AIDS funding, the Mission had been buying into the regional program. However, in November 2008 USAID/El Salvador started a two-year bilateral direct agreement to support country-specific needs in prevention. Interventions under this agreement are complementary to activities carried out by the regional program. However, USAID/El Salvador does not have an HIV/AIDS Strategic Plan where long-term goals and strategic interventions are identified. This is especially significant since USAID/El Salvador is starting the process of developing the overall 2010–2014 Strategic Plan in collaboration with the new GOES authorities.

USAID partners and contractors implementing these activities include: Population Services International (PSI); the Pan American Social Marketing Organization (PASMO); Abt Associates; the Institute of Reproductive Health (IRH)/Georgetown University; the Health Policy Initiatives (HPI) project implemented by the Futures Group; the Centers for Disease Control and Prevention (CDC); and the Capacity Project implemented by Intrahealth International.

In addition, the U.S. Government is in the process of developing a PEPFAR Partnership Framework (PF) for the Central American region (see annexes). This PF represents a five-year strategy to implement regional goals to reduce the transmission of HIV/AIDS jointly between the U.S. Government and the governments of seven Central American countries (Belize, Costa Rica, El Salvador, Guatemala, Honduras, Nicaragua, and Panama) through the Council of Ministries of Health for Central America (COMISCA). The development of this PF takes into consideration main needs and current interventions to address those needs in each of the countries. In September 2008 U.S. Government representatives met with stakeholders from all seven countries to identify current gaps in HIV/AIDS programming (see the results of this exercise in annexes). It is envisioned that the PF will harmonize the U.S. Government's response to the region, bringing additional resources. The PF plans to allocate an additional \$20–35 million to the region, bringing the total U.S. Government CA regional HIV/AIDS program to approximately \$60 million.

### **C. Work of Other Players**

El Salvador's National AIDS Program, USAID, other U.S. Government agencies (DOD, Peace Corps, CDC), GFATM (regional and country-specific projects), UNAIDS, other UN agencies, other donors, international and local NGOs, and civil society have been working collaboratively to create an effective national AIDS response in El Salvador. Interventions supported by these actors are identified in a diagnostic report developed by the USAID-funded PASCA project (see annexes).

### **D. Existing Studies and Plans**

El Salvador has a wide assortment of studies, documents, and plans related to HIV/AIDS, ranging from the National Strategic Plan to the study on prevalence and behavior change among MARP. See the list of studies and plans in Section XI.

## V. SCOPE OF WORK

In order to assist the Mission in determining the best approach to prevent transmission of HIV/AIDS and improve the national response, USAID commissions this HIV/AIDS assessment and design to identify HIV/AIDS needs that could be addressed by USAID/El Salvador in the next five-year strategy period. Specifically:

1. Assess the HIV/AIDS situation and response in El Salvador, including identification of key actors and their contribution to this response (including their geographical area of attention, areas of support, populations, and amount and duration of the support).
2. Identify HIV/AIDS main needs/gaps and intervention opportunities in country.
3. Propose future USAID/El Salvador strategies, interventions, and corresponding activities to address those needs, including estimated cost and estimated length for implementation; and a draft Results Framework and possible performance indicators to measure progress (see current Performance Management Plan/PMP for USAID/El Salvador Health Program in annexes).

The team will differentiate findings and recommend proposed interventions within at least four major categories, based on the program areas identified in the regional U.S. Government Partnership Framework:

- **Prevention:** including interventions in behavior change and communication, condom access, information, education, voluntary counseling and testing, sexually transmitted infections, and prevention of mother-to-child transmission.
- **System Strengthening:** including interventions in human resources, training, quality of services, norms, protocols, antiretroviral treatment, care for people living with HIV, community and care, information systems, logistics management.
- **Strategic Information:** including interventions in carrying out, analyzing, and using information from studies, research, assessments, and surveillance.
- **Policy Reform:** including interventions to improve policy and regulatory frameworks, human rights, strategic planning, and monitoring and evaluation.

These areas interrelate with each other and are key to the sustainability of the HIV/AIDS national response. The team should include other categories that need to be supported by the U.S. Government if they are not listed and/or included in the aforementioned major categorizations listed above, and if deemed appropriate. Any additional information that the team considers appropriate shall be included in the final report and discussed with USAID/El Salvador.

## VI. METHODOLOGY

The assessment team should consider a range of possible methods and approaches for collecting and analyzing the information required to carry out this scope of work. Data collection methodologies will be discussed with, and approved by, USAID at the start of the assessment. The team shall use facilitative methods and activities that will enhance collaboration and dialogue among counterparts, particularly partners. For instance, the team should consider meeting with and getting feedback from the MOH External Cooperation Unit, which provide guidance to the MOH in harmonizing donor cooperation. The Human Investment Office (HIO) team will

organize all internal USAID meetings and will arrange for initial meetings with appropriate stakeholders and partners at the outset of the process.

When appropriate, members of the HIO team may participate in meetings with relevant stakeholders and partners. A general list of relevant stakeholders and key partners will be provided to the assessment team by USAID before the time of their arrival, but the team will be responsible for expanding this list as appropriate and arranging all meetings and appointments needed to complete the required work.

### **Document Review**

- USAID/ES will provide the team with the key documents prior to the start of the in-country work (see list of annexes in Section XI). All team members will review these documents in preparation for the initial team planning meeting.
- Prior to conducting field work, the team will review existing literature and data, including program strategies, epidemiological information/DHS reports, studies, and reports, as well as documents of other donors' HIV/AIDS programs and the MOH National AIDS program.

### **Team Planning Meeting**

- A two-day team planning meeting will be held in El Salvador before the assessment/design begins. This meeting will allow the team to clarify the purpose, expectations, and agenda of the assignment. In addition, the team will:
  - clarify team members' roles and responsibilities;
  - establish a team atmosphere, share individual working styles, and agree on procedures for resolving differences of opinion;
  - review and finalize the assignment time line;
  - develop data collection methods, instruments, tools, and guidelines;
  - review and clarify any logistical and administrative procedures for the assignment;
  - develop a preliminary draft outline of the team's report; and
  - assign drafting responsibilities for the final report.

### **Internal USAID/ES Meetings**

Theses will include, at a minimum:

- Initial organizational/introductory meeting with the HIO, at which the team will present an outline and explanation of the proposed assessment/design, discussing the work plan to carry out this scope of work.
- An entry conference with Mission management will take place during the first week in country to delineate and summarize the work planned and expected results, as well as the proposed timeframe, and to obtain from management its feedback on the process and expected results.
- Mid-Assessment debrief—to provide an update on the status of the assessment and discuss performance and findings to date, and resolve any outstanding questions/issues.
- Final Assessment debrief—The team will debrief with USAID (and stakeholders if appropriate) prior to submission of the draft report and the team's departure from the

country. During the last week of the assignment, the contractor will provide an exit conference to include a summary of findings, conclusions, and recommendations in a PowerPoint presentation to Mission management. Comments generated during that presentation will also be incorporated into the final report.

### **Field Visits/Key Informant Interviews**

- The team shall arrange to visit selected sites in consultation with the HIO as appropriate. A list of proposed site visits is listed in Section XII, which can be modified by the team if necessary.
- The team may be accompanied by a member of staff from USAID/ES, as appropriate. The site visits will involve interviews with MOH officials, other donors, various implementing partners, civil society, etc.
- Key informant interviews will be conducted as required. The team will conduct interviews with donor organizations, selected NGOs, and other key respondents identified during the planning meeting.

### **Wrap Up and Debriefing on Field Visits and Key Informant Interviews**

- At the conclusion of the field visits/key informant interviews, there will be a debrief meeting at USAID/ES. The purpose of the meeting will be to share findings and get final inputs before preparing the draft assessment report.

## **VII. REPORTS AND DELIVERABLES**

- A. Work Plan/Schedule:** A detailed work plan (including a schedule) of how this scope of work will be carried out shall be submitted by the team at the conclusion of the team planning meeting. Work Plan/Schedule shall be in English.
- B. Weekly Reports:** The team shall provide to the HIO weekly verbal reports on progress, issues, special needs to accomplish the task, and plans for the following week.
- C. PowerPoint Presentation:** The team shall develop a PowerPoint presentation (in English and in Spanish) including the key findings, conclusions, and recommendations of this assessment and design, to be presented at the final debriefing.
- D. Final Report:** The team will submit the draft final report electronically to USAID/El Salvador before departure from El Salvador. USAID/El Salvador will provide comments and suggestions to the assessment team leader within 10 working days of submission of the report (USAID/ES is not planning to circulate the draft to any partner organizations for comments). A final revised version must be submitted by the team within five working days after receipt of USAID comments.

The final report must be organized by the three objectives listed in Section III of this scope of work. The report shall have a maximum length of 30 pages exclusive of appendices. The report shall contain an executive summary and will describe major findings, conclusions, and recommendations. The report shall also provide annexes including, but not limited to a summary of activities, list of individuals interviewed,

list of all reviewed/cited sources, summary of methodology used, and others as deemed necessary.

Five hard copies and an electronic version of the final report will be submitted to USAID/El Salvador in English. GH Tech shall also provide 10 hard copies of an executive summary report in Spanish to be shared with external partners. GH Tech will take approximately 3–4 weeks to complete the editing and formatting of the final report.

**E. Other Deliverables:**

Electronic versions of the approved final report must be submitted directly by the contractor to USAID Development Experience Clearinghouse (DEC) (<http://dec.usaid.gov>) and to the GH Tech Project website ([www.ghtechproject.com](http://www.ghtechproject.com)).

## **VIII. TEAM COMPOSITION**

The assessment to be carried out under this scope of work will be developed by a team of public health advisors with expertise in HIV/AIDS. The assessment team will include:

**A Team Leader/Senior Research Associate:** She/he will be responsible for providing: (a) the vision and overall leadership to the team; (b) overall contractor responsibility for the fulfillment of the assessment and acting as liaison with USAID/El Salvador's HIO.

The following qualifications are required for this position: (a) fluency in English and in Spanish at FSI 3/3 level; (b) graduate degree in health or related field; (c) at least ten years of experience in managing/assisting/assessing/designing similar HIV/AIDS programs in Latin America; (d) previous experience as COP of a similar multitask team in other Latin American country(ies); (e) experience in leading or participating in assessment teams for strategic planning purposes; and (f) demonstrated analytical and writing skills.

**Team Members:** All team members shall be senior-level health professionals with a master's degree in public health or other related field and at least five years of experience in similar programs in other Latin American countries. The experience shall be consistent with the area of expertise to which she/he is being proposed, and the team members should be experienced in the development of HIV/AIDS assessments for strategic planning purposes.

A minimum of three members is desired for the composition of the team (including the team leader). The following qualifications are desired for the team members (a) fluency in English and in Spanish at FSI 3/3 level; (b) graduate degree in health or related field; (c) at least five years of experience in managing/assisting/assessing/designing similar HIV/AIDS programs; and (d) demonstrated analytical and writing skills. It is also desired that among team members the following areas of expertise should be covered: expertise in assessing and developing interventions in HIV/AIDS prevention and care, systems strengthening, policy development, and strategic information.

## **IX. PLACE, PERIOD OF PERFORMANCE, AND LOE**

This activity will be performed in the consultants' home countries and in El Salvador for an estimated month and a half. It is estimated that work in the consultants' home countries will take approximately 10 working days to conduct preparatory work, research, and development of final report. Field work in El Salvador will take approximately 20 working days. Consultants

may be authorized a six-day workweek while in-country, with no premium pay. The assessment will begin in the last week of October 2009.

The following is an illustrative time line.

<b>Task/Deliverable</b>	<b>Duration</b>
1. Review background documents & offshore preparation work.	5 days
2. Travel to El Salvador.	1 day
3. Team Planning Meeting (Day 1) and meeting with USAID/ES HIO team (Day 2).	2 days
4. Information and data collection. Includes interviews with key informants (including partners and USAID staff) and site visits.	10 days
5. Discussion, analysis, and writing draft assessment report in country.	6 days
6. Debrief meetings with HIO team (preliminary draft report due to Mission before departure from country).	1 day
7. Finalize draft report based on feedback received during debriefing.	1 day
8. Depart El Salvador.	1 day
9. USAID provides comments on draft report (team out of country).	10 working days
10. Team reviews comments and revises report—final report.	5 days
11. USAID completes final review.	10 working days
12. GH Tech edits/formats report.	3–4 weeks

Total Estimated LOE = 32 days

## **X. OVERSIGHT AND MANAGEMENT**

The GH Tech team will work under the direction of USAID/ES HIO HIV/AIDS Specialist Maricarmen Estrada, with direct supervision and support from the Acting Director of the HIO, Dr. Raul Toledo. The team leader will report to the USAID HIV/AIDS Specialist.

## **XI. LIST OF ANNEXES AND OTHER SOURCES OF INFORMATION**

The following documents are attachments to this SOW:

1. Current USAID/El Salvador strategy for health
2. Activity Approval Document (AAD) for the Health Strengthening Project
3. Regional Strategic Framework
4. Performance Management Plan/PMP for USAID/El Salvador Health Program
5. Current Bilateral Cooperative Agreement with PSI
6. Current plans for each contractor/recipient of the USAID Regional Program
7. Proposed U.S. Government Partnership Framework
8. Regional Exercise of Gaps
9. HIV/AIDS Diagnostic in El Salvador (PASCA)
10. MOH documents on the web ([http://www.mspas.gob.sv/p\\_its\\_vih\\_sida\\_menu.asp](http://www.mspas.gob.sv/p_its_vih_sida_menu.asp)):
  - [Situación del VIH-SIDA en El Salvador, Abril 2009.](#)
  - El Salvador un paso adelante en la respuesta al VIH/SIDA y Tuberculosis (Noviembre 2008). [Español/English](#)
  - La Lucha Contra el SIDA en El Salvador, Un Compromiso de Nación (Mayo 2007). [Español/English](#)
  - [Plan Estratégico Nacional para la Prevención, Atención y Control del VIH-SIDA e ITS \(2005–2010\)](#)
  - [Plan Nacional de Monitoreo y Evaluación del VIH-SIDA e ITS, El Salvador \(2006–2010\)](#)
  - [Estrategia de País para la Prevención Materno Infantil del VIH.](#)
  - Medición del Gasto en SIDA 2007
  - [Compendio de Cifras VIH/SIDA 1999–2003](#)
  - [Red de Establecimientos de Salud que realizan la prueba de VIH.](#)
  - Estudios:
    - [Estudio multicéntrico de prevalencia de VIH-ITS en HSH en El Salvador](#)
    - [Estudio multicéntrico de prevalencia de VIH-ITS en TCS en El Salvador](#)

## **XII. LIST OF PROPOSED SITE VISITS**

1. Visit to behavior change interventions with MSMs
2. Visit to behavior change interventions with TCS
3. Visit to interventions with PLWHIV
4. Visit to educational activities with adolescents
5. Visit to VCT interventions with MARP
6. Visit to MOH clinics providing care for PLWHIV
7. Visits to GFATM projects



## **APPENDIX B. LIST OF PERSONS INTERVIEWED**

The persons listed below were interviewed individually; those interviewed as part of focus group discussions are listed in Appendix C.

### **EL SALVADOR**

#### **U.S. Agency for International Development/ES**

Larry Brady, Mission Director

Carl Derrick, Deputy Mission Director

Raul Toledo, Activity Manager, Human Investment Office

Maricarmen Estrada, Activity Manager, Human Investment Office

Dorita de Gutierrez, Manager, Education Projects

Sharlene Bagga-Taves, Human Investment Office

#### **Ministry of Health**

Dra. María Isabel Rodríguez, Minister of Health

Dra. Ana Isabel Nieto, Jefe de Programa Nacional de ITS/VIH/SIDA

Dra. María Elena Avalos, Gerente, Gerencia de Atención Integral al Adolescente

Dra. Guadalupe Flores, Unidad Ejecutora Fondo Global

Dra. Laura Nervi, Cooperación Externa, Ministerio de Salud

Dr. Jorge Alberto Ramirez Días, Asistente Ejecutivo Ministra de Salud

Dra. María Jose Herrera, Programa Nacional de ITS/VIH/SIDA

Dr. Jorge Cruz, Director, Atención Integral en Salud a la Mujer

Dr. Julio Garay, Director, Programa Nacional de Tuberculosis y Enfermedades Respiratorias

Jaquelin Sargasturm, Programa Nacional de ITS/HIV/SIDA

Ing. Rafael Avendaño, Director, Ejecutivo de ADS

#### **Ministerio de Educación**

Lic. Iris Idalia Carrillo de Reyes, Dirección Nacional de Planificación y la Gerencia de Proyectos.,

Dirección Nacional de Juventud–Gerente de Educación para la Vida

#### **CONASIDA**

Dr. Rodrigo Simán, Secretario Técnico de Comisión Nacional Contra el SIDA

#### **CCE–Comité Coordinador de El Salvador**

Licda. Isabel Villegas, Presidenta, MCC/CCE/Fondo Mundial (Presidenta) y Asociación Cristiana Femenina, Foro de ONGs

Licda Marta Alicia Magana, Secretaria Técnica CCE

#### **ONUSIDA**

Dr. Herbert Betancourt, Coordinador, ONUSIDA El Salvador

Dr. Reynaldo Flores, Consultante to ONUSIDA

#### **OPS/OMS/ELS**

Dra. Priscilla Rivas-Loría, Representante

**AECID, Cooperación Española**

Dra. Beatriz Yarza, Responsable de Programas de Acción Humanitaria, Agua y Salud

**Peace Corps**

David Hansen, Program and Training Officer, Deputy Country Director

**PASCA**

Lic. Alexia Alvarado, Representante para El Salvador, Proyecto Regional USAID/PASCA

**PASMO**

Lic. Gerardo Lara, Deputy Director, PASMO/PSI, El Salvador

Lic. Meg Galas, Representante Residente, PASMO/PSI, El Salvador

Susan Joania Padilla, Gerente Programa VIH “CCC”

**University Research Corporation**

Dra. Guadalupe Raseghi, QA/QI Advisor, URC El Salvador

**USAID GUATEMALA**

Brad Cronk, CTO, USAID/HIV/AIDS Regional Program and U.S. Government Partnership Framework

**USAID USA**

Karen Nurick, OGAC, USAID/Washington

Heidi Minh, OGAC, USAID/Washington

## **APPENDIX C. FOCUS GROUP DISCUSSIONS**

As part of the El Salvador HIV/AIDS Assessment and Design, three sessions of focus group discussions were carried out during December 2–4, 2009, involving representatives of 1) MARP-based NGOs; 2) national NGOs providing HIV/AIDS related services; and 3) international NGOs providing services and/or financial and technical support for HIV/AIDS at the country level. National and international NGOs included health training institutions and faith-based organizations (FBOs). In total, 21 participants were involved, representing 20 NGOs, nine training institutions, and 23 religious organizations. Each session lasted for approximately five hours.

### **OBJECTIVES**

1. key advances to date in the national HIV/AIDS response.
2. interrelationships between key actors in the national response, including roles, functions, and positioning within the national programming “universe.”
3. strengths, weaknesses, opportunities, and threats in the programming “universe.”
4. a vision for a more effective programming “universe” in the next five years.
5. USAID’s role, specifically in terms of the bilateral HIV/AIDS support program over the next five years.

### **METHODOLOGY**

To assist discussions, a participative visualization process was developed, tailored to achieving Objectives 2–4. Participants were asked to map out the HIV/AIDS programming “universe” as they saw it, both currently and as visualized in five years’ time. Participants depicted themselves and other key players in various “orbits” represented by planets, stars, or comets of different sizes, shapes, and colors, according to preference. The resulting “universes” depicted essentially form Venn diagrams, illustrating interrelationships between key actors according to the collective perception of the group. There were three separate group sessions with three sets of findings, summarized below, along with a photographic record of the three current and three future programming universes. The following is the focus group discussion guide (original Spanish version).

<b>8:00</b>	<p>Bienvenida</p> <p>Registro de participantes, introducción del equipo (Se sirve un café de bienvenida)</p>
<b>8:30</b>	<p>Explicación de los objetivos</p> <p>Preguntas introductorias</p> <ol style="list-style-type: none"> <li>1. ¿Qué avances se identifican en la Respuesta Nacional durante los últimos cinco años?</li> <li>2. ¿Qué ventajas o beneficios les ofrece para su trabajo el actual plan estratégico de VIH y Sida?</li> <li>3. ¿Qué limitantes identifican en el actual plan estratégico?</li> </ol>
<b>9:00</b>	<p><b>Presentación de la metodología de trabajo: Universo de la Respuesta</b></p> <ol style="list-style-type: none"> <li>1°. Se presenta al grupo una lámina con un universo dibujado, se muestra el sol al centro. En una mesa al frente se coloca una caja con diferentes figuras (planetas, estrellas, cometas, lunas, etc.)</li> <li>2°. Se solicita a cada participante que tome una de las diferentes figuras que están a disposición del grupo con la que más identifica el trabajo de su institución en la Respuesta Nacional de VIH y Sida. (puede ser en cobertura, actividades estratégicas, redes nacionales, regionales, impacto, apoyo político, etc.)</li> <li>3°. Se pide a los y las participantes que se tomen 5 minutos para hacer una reflexión individual sobre donde y como ubicarían su institución dentro del universo de la respuesta nacional del VIH en El Salvador.  Se sugiere que sea un ejercicio estrictamente personal (no se les sugiere ubicación pero si hay preguntas puede explicar que podría ser en las orbitas de planetas, alrededor de otros planetas, junto a otras estrellas, no aparecer, solitario, agrupado, etc. pero debe ser lo que ellos decidan por su propia iniciativa) Se entregará una libreta para que escriban sus ideas de la reflexión para discutir las posteriormente y al final entregarlas a la facilitadora.</li> <li>4°. Siguiendo paso, se les entrega una tarjeta en blanco y se les pide que individualmente identifiquen quien es el sol, además que identifiquen si hay otras lunas o estrellas que no están presentes pero que son importantes sus intervenciones en el universo de la respuesta, cuál es su papel y ubicarlas en el universo.</li> <li>5°. Cuando ya todos y todas han colocado sus figuras y ya están seguros de la ubicación de otros astros importantes en la respuesta, se les pide que con un marcador de color dibuje con líneas las interrelaciones que establece con los demás planetas y estrellas del universo.  Se pide que cada participante escriba en su libreta y explique cómo favorece la interrelación con el sol, las lunas u otras estrellas.</li> <li>6°. Se pide que en el grupo discutan y expliquen por qué se ubican en la posición seleccionada del universo y las interrelaciones con los demás astros. Nombran a un relator o relatora, toman 10 a 15 minutos para que exponer en plenaria ideas, opiniones y acuerdos y del grupo. ( si hay preguntas se dejan al final de la presentación en un parqueadero de preguntas por medio de la facilitadora)</li> <li>7°. Al terminar la exposición y discusión de preguntas se muestra a todo el grupo una lámina con el segundo universo, se les pide que tomen de nuevo una figura de la caja y la ubiquen en el sitio donde proyectan ver el trabajo de su institución en el universo de la respuesta en los próximos cinco años.  Se pide que cada participante escriba en su libreta y explique por qué se ven así en el futuro y cómo les favorece la interrelación con el sol, las lunas u otras estrellas que no están presentes.</li> <li>8°. Al finalizar esta discusión se les entregará una hoja individual para que anote ideas, preguntas, observaciones y comentarios que no alcanzaron a compartir en el grupo. Y las coloca sin nombre en una cartelera ya preparada por la facilitadora.</li> </ol>
<b>11:00</b>	<p>9th. Preguntas de cierre.</p> <ul style="list-style-type: none"> <li>- Que brechas identifican para mejorar la respuesta nacional</li> <li>- Que oportunidades y facilidades identifican para el futuro</li> </ul> <p>Que piensan del rol de USAID para poder dar una mejor respuesta y que ventajas competitivas encuentra en la asistencia técnica de USAID</p>
<b>12: 30</b>	<p>10th. Agradecimientos y Almuerzo</p>

## RESULTS

The following represents key findings, according to the perception of participants in all three group discussions:

### Advances in the National Response

Significant achievements have been made in the medical service field, resulting in wider access to VCT and antiretroviral therapy (ART).

- As a result of these interventions, vertical transmission has been reduced, and people have more confidence in rapid HIV testing and counseling.
- Interagency coordination and openness for greater involvement of MARP-based NGOs in the national response, as well as organizations representing uniformed services, migrant populations, and clients of sex workers, have increased over recent years.
- The religious sector and FBOs have shown openness to address HIV and have allowed the participation of leaders and pastors to carry out trainings and other activities aimed at the general population and MARP. This sector has also used their own radio and television stations to broadcast programs addressing HIV.
- International cooperation agencies have provided more support for training, mass media campaigns, and the development of IEC materials over recent years.
- Civil society has also achieved a social auditing function, provided to the Ministry of Health, and has created a national hotline, SIDATEL.
- Peer education among MARP and vulnerable communities, carried out by NGOs, has set standards for credibility, and has supported behavior change.

### Challenges

There is a lack of support from a clear coordinating entity within the national response, in particular for institutional strengthening and coordination. There is a huge vacuum in relations at all levels between NGOs and the Ministry of Health. As a result, NGOs are fragmented and weakened in their work.

- Coordination within MOH headquarters is described as chaotic and bureaucratic, partly because of the rivalry and poor coordination among programmatic divisions. Coordination is more effective at local and regional levels and much more efficient at the community level. Hopes were expressed for change under the new administration, post-election.
- Leadership of CONASIDA is weak and its legal framework is not suited for the objectives for which it was created. CONASIDA has in the past tended to respond to the interests of the former government political party.
- The national response and the role of CONASIDA have maintained a medical focus, and community prevention has been left aside. It was suggested that CONASIDA should be taken out of the Ministry of Health, administratively, physically, and technically, to achieve a more multi-sectoral response.
- There is no shared vision of the epidemic—every stakeholder has its own perspective. While the MOH reports official statistics, NGOs have a different perception of what is happening, based on findings seen in target populations.

- International cooperation agencies lack confidence in funding projects implemented by MARP-based NGOs. There is a perception that certain NGOs have monopolized international funding and technical assistance. As a result, there is little impact on behavior change among MARP and no institutional strengthening of MARP-based NGOs. The GFATM is seen as “a service contractor and trainer.”
- Despite increased training and diploma courses, the quality of content, methodology, and post-course impact have not been monitored.
- Voluntary counseling and testing (VCT) is an important way to promote behavior change with people requesting this service, but training and certification are lacking among counselors, especially in the NGO sector.
- Up-to-date data and statistics on the epidemic and the response are lacking, as well as access and training for the use of the Unified System of Monitoring, Evaluation, and Epidemiological Surveillance (SUMEVE).
- MARP-based NGO representatives in particular cited a lack of quality control in health research, with resulting manipulation of data and information. Representatives felt exploited by researchers during investigations because the representatives were used to identify MARP samples, but not included in the research process.
- NGO HIV programs lack reliable data for decision-making; activities are not evidence-based as a result.
- There is a dearth of integrated care and support for PLWHIV.
- The procedures for HIV testing in health units and hospitals are complicated, and there are significant levels of stigma and discrimination from health staff at local facilities.
- Health services for PLWHIV focus on ART and do not include prevention education, such as the importance of avoiding reinfection with HIV, opportunistic, and other sexually transmitted infections.
- There are no standardized BCC strategies and guidelines for targeted populations—each institution creates its own approach.
- Most activities and services are targeted to populations in urban and peri-urban settings; rural areas are neglected.

## **Recommendations**

Major recommendations are all included in the main body of the report.

## **Current and Future Programming Universes**

- Participants were not clear who is leading the national HIV response. For some NGOs, the programming universe revolves around base communities and civil society; to others, PLWHIV are the driving force. Leading institutions featured in the universes include the Atlacatl Association (the founding PLWHIV organization in El Salvador), the National HIV/AIDS Program (MOH), the GFATM, CONASIDA, and the Ministry of Health.

- In the current scenario, most NGO stakeholders located themselves away from the central entity, and without showing any relation between themselves. The universe-mapping and related discussion revealed that NGOs were aware of interpersonal and inter-institutional competition and some duplication of roles, leading to a fragmented response and underutilization of resources. This situation was attributed to a lack of clear leadership for civil society in the national response.
- External cooperation agencies such as UNAIDS, the GFATM, and the regional Central American Integration System (SICA) were placed in distant orbits and represented by comets, shining occasionally, or as a waning moon showing only part of itself. The GFATM CCM was identified as a large star near the center of the response. NGO networks are seen as solid planets in the first orbit, but outside of the leading entity.
- The media and communications sector and other line ministries (Education, Interior, Labor, and Security) are invisible in the national response, although represented in theory by CONASIDA. These sectors do not have a committed policy or program for addressing HIV.
- The center of the universe, visualized in five years' time, is represented by the sun-CONASIDA and Ministry of Health. The "renewed" CONASIDA will be more inclusive, representing broader government sectors and civil society.
- Organizations see themselves gathered together giving a joint response and being represented in functional networks, with clear mechanisms for interaction. NGO networks and civil society representatives are identified as solid big stars and planets included in the center of the conducting entity. This relates to the recommendation for a joint proposal from NGOs working in prevention, and the establishment of an umbrella institution, designed to channel technical support and funds to multiple NGOs.
- The GFATM and other international agencies are located in the sun's first orbit.

## Programming Universes–Current



**MARP-based NGOs**



**Local NGOs providing HIV/AIDS services**



**International NGOs**

## General Analysis

- Participants were not clear who is leading the national HIV response. For some NGOs, the programming universe revolves around base communities and civil society; to others, PLWHIV are the driving force. Leading institutions featured in the universes include the Atlacatl Association (the founding PLWHIV organization in El Salvador), the National HIV/AIDS Program (MOH), the GFATM, CONASIDA, and the Ministry of Health.
- In the current scenario, most NGO stakeholders located themselves away from the central entity, and without showing any relation between themselves. The universe-mapping and related discussion revealed that NGOs were aware of interpersonal and inter-institutional competition and some duplication of roles, leading to a fragmented response and underutilization of resources. This situation was attributed to a lack of clear leadership for civil society in the national response.
- External cooperation agencies such as UNAIDS, the GFATM, and the regional Central American Integration System (SICA) were placed in distant orbits and represented by comets, shining occasionally, or as a waning moon showing only part of itself. The GFATM CCM was identified as a large star near the center of the response. NGO networks are seen as solid planets in the first orbit, but outside of the leading entity.
- The media and communications sector and other line ministries (Education, Interior, Labor, and Security) are invisible in the national response, although represented in theory by CONASIDA. These sectors do not have a committed policy or program for addressing HIV.



## **PARTICIPANTS: FOCUS GROUP DISCUSSIONS**

### **Organizaciones Que Representan Intereses De Poblaciones Específicas**

#### **Organizations Representing Interest-Specific Populations**

##### **Asociación de Personas con VIH Vida Nueva**

Ing. Jaime Ernesto Argueta

##### **Asociación Entre Amigos**

Sr. William Hernández

##### **Movimiento de Mujeres Orquídeas del Mar**

Sra. Ana Dolores Henríquez

##### **Red Latinoamericana de Trabajadoras del Sexo–El Salvador**

Sra. Haydee Lainez

##### **Fraternidad Gay sin Fronteras**

Lic. Wilfredo Meza

Lic. Jaime Alexander Sánchez

##### **ICW Capítulo El Salvador**

Sra. Guadalupe de Castaneda

##### **Asociación Arco Iris–ASPIDH**

Srita. Lissa Alfaro

Srita. Noemí Lucero

## **LOCAL NGOS PROVIDING SERVICES**

### **FUNDASIDA**

Lic. Francisco Ortiz

### **Consejo de Formadores de Enfermería–CEFFAS**

Licda. Zoila Marina de Guadron

### **ACJ de El Salvador**

Licenciada Xiomara Rodríguez

Licenciada María Isabel Villegas

### **Iglesia Luterana**

Wendy Castillo

### **Iglesia La Misericordia**

Reverendo Luis Guzmán

### **Instituto de Profesionales de Salud–IEPROES**

Aminta de Zelaya

### **Asociación CONTRASIDA**

Dra. María Virginia Annel

## **INTERNATIONAL ORGANIZATIONS**

### **CARITAS El Salvador**

Licda. Meybel Flores

### **CARE–El Salvador**

Licda. Indira Escalante

### **Save the Children**

Licda. Ludin Caballero de Chávez

### **Cuerpos de Paz El Salvador**

Licda. Bryone Seoane

### **Plan–El Salvador**

Dra. Anabell Amaya

## **NGOS REPRESENTING LARGER NETWORKS**

- PREVENSIDA: 9 NGOs
- Foro de ONGs: 21 NGOs
- Sector Religioso en el VIH: 23 religious denominations
- Consejo de Formadores de Enfermería: 9 institutions
- Mesa Ciudadana: 7 International NGOs



## APPENDIX D. REFERENCES

### BY AUTHOR

Goffman, Erving. *Stigma: Notes on the Management of Spoiled Identity*. New York: Simon & Schuster, 1986.

Hughes, H. *Developing a Participatory M&E Plan: Case Study of an NGO Capacity Building Project in Mexico*. The Synergy Project, International HIV/AIDS Alliance, USAID: 2002.

Rodriguez, Maria Isabel. *Construyendo la esperanza: Estrategias y recomendaciones en salud 2009–2014*. El Salvador: Ministerio de Salud, 2009.

### BY ORGANIZATION

#### Ministry of Health, El Salvador

- “Base de Datos y Referencia para una Estrategia basada en Evidencia. Marco de Resultado y Costeo del Plan Estrategico Nacional (PEN).” 2009.
- “Compendio de Cifras VIH/SIDA, 1999–2003.”
- *El Salvador un paso adelante en la respuesta al VIH/SIDA y Tuberculosis*. 2008. (Español/English)
- *Encuesta Centroamericana de Vigilancia de Comportamiento Sexual y Prevalencia de VIH/ITS en Poblaciones Vulnerables*, 2009.
- *Encuesta Centroamericana de Vigilancia de Comportamiento Sexual y Prevalencia de VIH/ITS en Poblaciones Vulnerables (ECVC) para: HSH, TS, y PVVS*. 2009.
- *Encuesta Nacional de Salud Familiar, FESAL*, 2008.
- “Estimación de flujos de financiamiento y gastos en VIH-SIDA (MEGAS) 2007.”
- *Estrategia de País para la Prevención Materno Infantil del VIH 2007*.
- *Estudio Multicéntrico de Prevalencia de VIH/ITS y Comportamientos en HSH*. 2002.
- *Estudio Multicéntrico de Prevalencia de VIH/ITS y Comportamientos en TS*. 2002.
- “Informe de Labores 2007–2008. Metas alcanzadas.” 2007.
- “Informe nacional sobre los progresos realizados en la aplicación de los compromisos en la lucha contra el VIH-SIDA,” 2008.
- “Informe nacional sobre los progresos realizados en la aplicación de los compromisos en la lucha contra el VIH-SIDA, El Salvador, Enero de 2006–diciembre de 2007.”
- *La Lucha Contra el SIDA en El Salvador, Un Compromiso de Nación*. 2007. (Español/English)
- “Línea de Base de Mortalidad Materna en El Salvador.” 2007.
- “Medición del Gasto en SIDA.” 2007.
- “Plan Anual Operativo del Programa Nacional ITS/VIH-SIDA.” 2008–2009.
- “Plan Estratégico Nacional en ITS, VIH y SIDA 2005–2010, Avances y retos en su implementación.” 2008.
- *Plan Estratégico Nacional para la Prevención, Atención y Control del VIH-SIDA e ITS (2005–2010)*.
- *Plan Nacional de Monitoreo y Evaluación del VIH-SIDA e ITS, El Salvador (2006–2010)*.

- *Plan Estratégico Nacional para el control de la Tuberculosis 2008–2015*. 2008.
- “Política de Atención Integral a la Epidemia de VIH-SIDA. Comisión Nacional contra el SIDA (CONASIDA).” 2005.
- “Política Nacional de Salud. Presidencia de la República.” 2008.
- *Protocolos de Atención para Personas Viviendo con VIH/SIDA*. San Salvador. Ministerio de Salud Pública y Asistencia Social. Programa Nacional de ITS/VIH/SIDA. 2005.
- “Seroprevalencia de VIH, Sífilis y Comportamientos de Riesgo de Infección en Mujeres Embarazadas en El Salvador.” 2003.
- *Sistematización del Curso para el Abordaje de Enfermedades Oportunistas en Pacientes Viviendo con VIH/SIDA*. 2004.
- “Situación del VIH–SIDA en El Salvador.” 2009.

### **USAID/El Salvador**

- *Activity Approval Document (AAD), Health Strengthening Project*. 2005.
- *Bilateral Cooperative Agreement with PSI*. 2008.
- *Central America and Mexico (CAM) Regional Strategic Framework*. 2004
- *Diagnostico de situación y respuesta al VIH y sida en El Salvador. Avances y desafíos*. 2008.
- *El Salvador Country Plan for Public Release, July 1, 2004*.
- *Informe MAP Centroamérica*. 2008.
- *Performance Management Plan (PMP), USAID/El Salvador Human Investment Strategic Objective*. 2009.
- *PASCA Workplan: Year 1*.
- *PASCA Workplan: 2009*.
- *PSI Workplan: 2009*.
- *Regional Components of the HIV/AIDS Program in El Salvador*.

### **Other**

“AIDS Funding Proposals,” Round 2, Round 7, RCC (2009); “Grant Score Cards,” “Implementation Letters” *et alia*. Global Fund to Fight AIDS, TB and Malaria (GFATM): 2009.

*AIDS Policy Index, El Salvador*. USAID/PASCA: 2009.

“Compromisos Internacionales y Nacionales, Marco Jurídico vinculados a VIH SIDA en El Salvador.” USAID/PASCA: 2009.

“Country Reports El Salvador” 2007 and 2008. UNGASS: 2007, 2008.

*Diagnostico Situacional de los Servicios de Consejería y Prueba Voluntaria en Establecimientos del MASPAS y ONGs*. USAID, PSI, PASMO, IRH (Georgetown University), MOH El Salvador: February 2007.

*Encuesta de Hogares de Propósitos Múltiples (EHPM)*. DIGESTYC (Dirección General de Estadística y Censos): 2008.

“Encuesta de Opinión Pública en Centroamérica. Percepción sobre el sida en El Salvador 2003 y 2006.” Guatemala: USAID/PASCA/CID Gallup, 2006.

*Estudio de Estigma y Discriminación en Personas con VIH, Informe de El Salvador.* UNDP, Salvadoran Demographic Association, Association PLWHIV Vida Nueva: 2009.

Estudio TRaC de VIH/SIDA entre MSM y TS. PSI: 2007, 2008.

*Guidelines on Construction of Core Indicators.* UNAIDS: 2008.

*Guidelines for Second Generation Surveillance for HIV: The Next Decade.* WHO and UNAIDS: 2000.

*HIV/AIDS Diagnostic in El Salvador, Summary, Parts I, II III and Annexes 1–4.* USAID/PASCA: 2008.

*Human Rights Report, El Salvador.* Washington DC: U.S. State Department, December 2008.

*Informe sobre Desarrollo Humano El Salvador.* UNDP: 2007–2008.

*Levantamiento de línea base de conocimientos, actitudes y prácticas (CAP) de docentes de parvularia, básica y media, de adolescentes y jóvenes de 13 a 24 años acerca del VIH/AIDS en centros escolares.* El Salvador: Ministry of Education, 2009.

*Ley de Prevención y Control de la Infección Provocada por el Virus de Inmunodeficiencia Humana.* GOES: Legislative Assembly, 2001.

*Medición de la Cobertura y Acceso a Condones.* PSI: 2008.

*Organizing Framework for a Functional National HIV Monitoring and Evaluation System.* UNAIDS: 2008.

*Partnership Framework Document to Support Implementation of the Central American Regional HIV/AIDS Response Between the Government of the United States and the Governments of the Central American Region (Belize, Costa Rica, El Salvador, Guatemala, Honduras, Nicaragua and Panama), incl. annexes 1–6.* USAID/PASCA: 2009.

“Proyecto Regional VIH-sida. Seguimiento de los avances al cumplimiento de los acuerdos regionales presidenciales en VIH-sida.” Sistema de Integración Centroamericana SICA: 2007.

*Riesgo de VIH/SIDA relacionado con el Uso de Crack.* FUNDASILVA: 2009.

Universidad Centroamericana José Simeón Cañas. Cruz Roja Salvadoreña. *Resultados del Estudio de Línea Basal en jóvenes y adolescentes con problemas de drogadicción para el Diseño de la campaña de promoción de cambios conductuales en grupos con alta vulnerabilidad en la transmisión del VIH/SIDA.* 2005.

*VI Censo de Población y V de Vivienda.* DIGESTYC: 2007.



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