

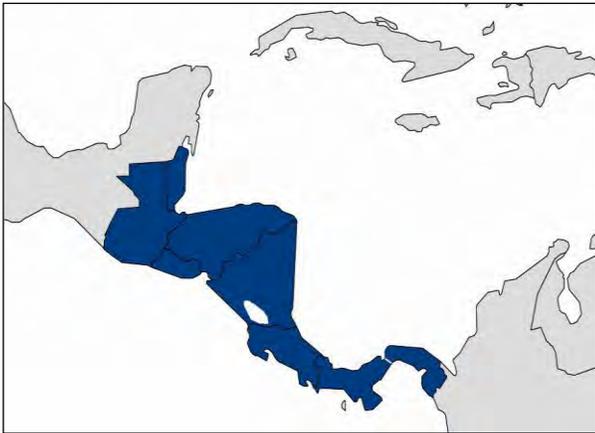


USAID
FROM THE AMERICAN PEOPLE



HIV/AIDS HEALTH PROFILE

Central America



Overall HIV Trends

According to limited available HIV surveillance data, Central America's HIV/AIDS epidemic is concentrated in large urban areas, with high prevalence rates in some areas along the Caribbean coast. The HIV/AIDS epidemic appears to be growing, with prevalence in select countries among the highest in Latin America; **Belize** is the only country in the region with an estimated adult HIV prevalence rate higher than 1 percent (2.3 percent), according to the Joint United Nations Program on HIV/AIDS (UNAIDS). Adult HIV prevalence in other countries in the region ranges from an estimated 0.2 to 0.9 percent. Approximately 163,000 people in Central America are HIV positive, with **El Salvador**, **Honduras**, and **Guatemala** accounting for the majority of the region's total. In most Central American countries, HIV

surveillance data on indigenous and other select populations or areas outside the capital are limited.

Unlike parts of South America, where injecting drug use plays a major role in the spread of HIV infection, most countries in the region are experiencing epidemics concentrated in and around networks of men who have sex with men (MSM), according to UNAIDS. While the United Nations General Assembly Special Session (UNGASS) *Country Progress* reports from around the region have documented the majority of reported new infections in Central America as being caused by heterosexual transmission, it is estimated that severe underreporting of HIV among MSM and high levels of testing among pregnant women bias these statistics.

Prevalence among MSM varies from country to country and has been reported to be as high as an estimated 12.7 percent in San José, **Costa Rica** – more than 40 times the prevalence in the general adult population. Men who have both male and female partners can also increase the risk of transmission to the general population. Condom use is inconsistent; data from a 2007 study by Soto, et al., found 39 percent of MSM surveyed reported they did not consistently use condoms with casual partners. The same study found less than one-third (29 percent) had been reached by HIV prevention programs. Other high-risk groups include commercial sex workers (CSWs), clients of sex workers, and prisoners. Estimated HIV prevalence among female sex workers (FSWs) has been documented at 4.1 percent in **Honduras**, 4.3 percent in **Guatemala**, and 5.7 percent in **El Salvador**.

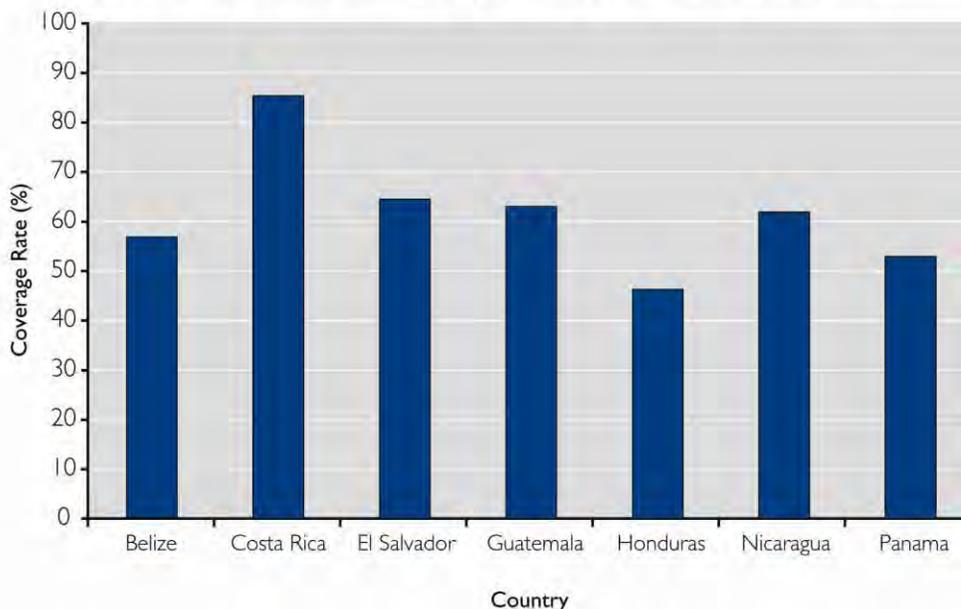
Unequal socioeconomic development and high levels of internal and cross-border population mobility – especially along the region's highways, commercial and industrial corridors, and the Caribbean coast – may contribute to the spread of HIV/AIDS throughout the region. Compounding these issues is the lack of reliable HIV-related data across the region. Without improved HIV surveillance, it will remain impossible to understand the true scope of the epidemic throughout the region. Accurate data inform program decisions, allowing for a more targeted response to the HIV epidemic, particularly among most-at-risk populations (MARPs). If this information is lacking, it becomes difficult for programs to identify priority target populations and develop effective messaging.

Regionally, scaling up antiretroviral therapy (ART) is a priority. However, only **Costa Rica** has surpassed the universal access target of 80 percent ART coverage, as shown in the figure on the following page. ART coverage in most other Central American countries is significantly lower – between 47 and 66 percent – according to the 2010 *Towards Universal Access* report of the World Health Organization (WHO), UNAIDS, and United Nations Children's Fund (UNICEF), abiding by the 2006 recommendations from WHO on when to initiate treatment. In

2010, WHO released revised recommendations to initiate ART when a person's CD4 count reaches or drops below 350 cells/mm³ rather than the previously recommended 200 cells/mm³. While this immediately increases the number of people living with HIV/AIDS (PLWHA) eligible for treatment, it is predicted that initiating treatment earlier will reduce HIV-related morbidity, hospitalization, and mortality in the long term.

HIV-tuberculosis (TB) co-infection is a major concern in Central America, as TB is endemic in the region. In five out of seven Central American countries, 12 to 20 percent of new TB patients are HIV positive. HIV-TB co-infection complicates the care and treatment of both diseases, and multidrug-resistant strains of TB are a growing concern.

HIV-Infected People Receiving Treatment in Central America, 2009



Source: WHO/UNAIDS/UNICEF *Towards Universal Access 2010* based on WHO 2006 guidelines (CD4 <=200)

While epidemics across Central America have many similarities, they also have unique attributes and challenges. With 0.8 percent of the total adult population estimated to be HIV positive, **Honduras** has a generalized epidemic on its north coast and concentrated HIV epidemics in other parts of the country. Sex is documented as the primary route of HIV transmission, accounting for 92 percent of reported cases, followed by mother-to-child transmission (6.1 percent) and tainted blood and blood products (0.64 percent) (MOH, 2009). Nearly 76 percent of Honduras' HIV infections have occurred among 20 to 39 year olds, one of the most economically active segments of the population (MOH, 2009). Preliminary findings from a 2006 study reported by UNAIDS indicate vulnerable populations include MSM (estimated prevalence of 4.8 to 9.9 percent, depending on the area surveyed), FSWs (prevalence as high as 5.5 percent), and the ethnic minority Garifuna community (4.5 percent prevalence). HIV-infected individuals have access to free ART, but coverage is low, with only an estimated 47 percent of HIV-infected people recommended for treatment receiving ART as of 2009.

Guatemala's 62,000 HIV-infected residents live primarily in urban areas along major transportation routes. According to the September 2010 report of the National Center of Epidemiology, 84.5 percent of all reported HIV/AIDS cases have occurred in only eight of Guatemala's 22 departments (Retalhuleu, Izabal, Escuintla, Suchitepéquez, Guatemala, Jutiapa, San Marcos, and Sacatepéquez). According to the 2008 UNGASS report, 20 to 34 year olds account for more than 51 percent of all cases and for 62.5 percent of cases reported in the last six years. Sex workers and MSM face the greatest risk of HIV infection. National HIV prevalence among FSWs was documented at 4.3 percent in 2007, although the prevalence is as high as 14.9 percent among groups of street-based FSWs. Migration and tourism both contribute to the epidemic in Guatemala. While in transit, migrants may participate in high-risk sexual behavior, increasing their chances of contracting HIV and other sexually transmitted infections (STIs). ART coverage has expanded over the years. Currently, an estimated 63 percent of people who need ART receive it.

With only 0.2 percent of the adult population estimated to be HIV positive, **Nicaragua** has the lowest HIV prevalence in Central America. While the 2010 UNGASS report indicates unprotected heterosexual intercourse accounts for 74 percent of new HIV infections, it is likely that heterosexual transmission is over reported and homosexual transmission underreported due to stigma and discrimination against MSM, compounded with a perception of low risk of contracting HIV. High HIV prevalence among MSM (4.2 percent in Managua in 2009) continues to be a major concern for those working to contain the epidemic, as MSM can act as a bridge to female partners. CSWs are also disproportionately affected, with prevalence of 1.1 to 1.9 percent – nearly five to 10 times greater than in the general population. Increasing numbers of new cases of HIV have been reported among women throughout the region, although increases in testing through prevention of mother-to-child transmission of HIV (PMTCT) programs may contribute to increased case detection. According to the national protocols, all people who need ART have access to it through 29 hospitals and health centers, which are located in every province. Estimated ART coverage (based on WHO 2006 guidelines) was 62 percent in 2009, up from 35 percent in 2006.

Although estimated adult HIV prevalence in **El Salvador** is relatively low at 0.8 percent, the number of PLWHA in the country is the third highest in Central America. In 2008, approximately 93 percent of infections were reported as sexually transmitted, of which 9 percent were cases of homosexual and bisexual transmission, according to the MOH. As in other countries in the region, transmission among MSM and their partners plays an important role in the epidemic and is most likely underreported. Mortality due to AIDS represented the second-leading cause of death in hospitals for 25 to 59 year olds and the third-leading cause among those 20 to 24 years old. HIV also remains a significant threat in groups who practice high-risk behaviors, including CSWs. National HIV prevalence is an estimated 5.7 percent among FSWs and an estimated 10.8 percent among MSM (2009 Central American Sexual Behavior Surveillance and STI/HIV Prevalence Survey, CDC/USAID/MOH/Guatemala Del Valle University). A 2007 study, reported by UNAIDS in 2009, demonstrated infection levels among MSM in El Salvador were 22 times higher than among the general population. Factors that may put El Salvador at risk of an expanded epidemic include early sexual initiation, limited knowledge of preventive practices among people engaging in high-risk behaviors, and the country's large mobile population. Although ART coverage is increasing, only an estimated 66 percent (based on 2006 WHO guidelines) of those people in need of treatment received it in 2009.

At an estimated 2.3 percent, **Belize** has the highest adult HIV prevalence rate in Central America. Data from the Belize MOH indicate prevalence among pregnant women (15 to 24 years old) was only 0.77 percent in 2009, far less than the overall prevalence estimates; as such, it is theorized that the country is experiencing an epidemic with HIV infections concentrated in pockets of the population, including MSM and CSWs. Sex between men is a major driving factor of the epidemic, according to UNAIDS. ART coverage has been increasing; as of December 2009, an estimated 57 percent of the people in need of treatment were receiving ART.

Panama, like much of the region, is experiencing a concentrated epidemic, with prevalence among MSM exponentially higher than in the general population. Adult prevalence has declined slightly to an estimated 0.9 percent, while prevalence among MSM was reported at an estimated 8.9 percent in 2007. According to UNAIDS, Panama is one of seven countries where condom use among MSM exceeds 80 percent, which is promising for reducing HIV prevalence in the future.

Costa Rica's epidemic follows a similar pattern. Adult prevalence is an estimated 0.3 percent and is dwarfed by 12.7 percent prevalence among MSM in the capital city, according to UNAIDS. In July 2008, the 2008–2010 National HIV/AIDS Response Monitoring and Evaluation Plan was introduced in order to better track the epidemic and estimate the impact of HIV prevention and treatment efforts.

Economic and Social Impact of HIV/AIDS in Central America

Since the beginning of the epidemic, HIV infections have increasingly affected the younger and more economically productive members of society. If unchecked, the epidemic has the power to have an impact on national economies, as seen throughout other parts of the world. The vast majority of the people infected by HIV in Central America are between the ages of 15 and 49, a demographic group filled with laborers supporting themselves and their families. In **Honduras**, nearly 76 percent of HIV cases reported as of December 2009 occurred among people aged 20 to 39. In **El Salvador**, AIDS has grown to be the leading cause of death among young and middle-aged adults, reducing the country's workforce.

Consequentially, HIV/AIDS could threaten the economic growth of countries in the region experiencing more pronounced epidemics due to the potential loss of productive labor. Although many Central American countries

currently have low prevalence rates, this could change due to cross-border migration of individuals from higher-prevalence neighboring countries. The cost of addressing HIV can also divert resources away from investments critical to economic development on a national level.

The heavy HIV burden among MSM, coupled with issues of stigma and discrimination against this population, creates a major challenge for those combating the epidemic in the region. Accurate national data on prevalence and incidence among MSM can be scarce due to the stigma associated both with HIV infection and behaviors within the MSM community. As such, concentrated epidemics among MSM have often been hidden. Stigma and discrimination toward PLWHA, especially toward those who belong to marginalized groups, can contribute to further spread of the virus when members of these groups are reluctant to access health services. Stigma may include a range of behaviors – from gossip and verbal abuse, to violence and physical abuse, to discrimination by employers – and creates a challenge to the success of HIV programs targeting MSM and other MARPs.

A persistent challenge in Central America is the hardship for families and individuals in purchasing antiretroviral drugs (ARVs). The high price of ARV cocktails can deplete family resources for those caring for an HIV-positive family member or deter PLWHA from seeking treatment. While prices were cut nearly in half in 2003 (five major pharmaceutical companies committed to reducing the cost of ARVs in **Costa Rica, Guatemala, Honduras, El Salvador, Nicaragua, and Panama**), treatment is often not affordable for PLWHA in the region. Social security systems and health insurance coverage are limited in many countries in the region, including **Guatemala, El Salvador, and Panama**. **Costa Rica** is one of the few Central American countries with a public social welfare system that covers health costs for ART. Even in those countries with stronger social welfare programs, the systems currently in place are not strong enough to manage the burden of the disease. The Global Fund to Fight AIDS, Tuberculosis and Malaria funds ART programs to increase coverage, fostering close collaboration between governments and civil society organizations to work toward sustainability of ART programs.

National/Regional Response

The U.S. Agency for International Development (USAID) works in close coordination with other donors and UNAIDS, particularly in promoting and implementing the “Three Ones” principle (one national coordinating authority, one national action framework/strategy, and one agreed-upon country-level monitoring and evaluation [M&E] system) for a coordinated response to address HIV/AIDS. UNAIDS plays a significant lead role in coordinating and galvanizing political commitment for a targeted response. All Central American countries, with the exception of **Costa Rica**, have national AIDS programs to guide the response to the epidemic. Each of the countries has also developed an HIV/AIDS national strategic plan, in conjunction with civil society and PLWHA. AIDS legislation addressing the human rights of those living with HIV/AIDS has been passed in all countries in the region, although full enforcement of those laws is often lacking.

The AIDS Program Effort Index is a tool used by USAID’s Program for Strengthening the Central American Response to HIV/AIDS; it was originally developed by UNAIDS, USAID, and the Policy Project to measure program effort in responding to the HIV/AIDS epidemic. According to data compiled with this instrument, political support in the Central American region has continued to improve. The region’s AIDS Program Effort Index scores have increased from 30 out of 100 in 1996, to 48 in 2000, 54 in 2003, and 56 in 2008–2009. Overall, the areas of greatest improvement were public support (**Guatemala, El Salvador, and Nicaragua**) and high-level political commitment (particularly in **El Salvador and Guatemala**). With the exception of **El Salvador**, the areas in need of the most improvement were organizational structure, human rights, and mitigation.

While the epidemic in Central America is less severe than in other parts of the world, such as sub-Saharan Africa, responding to the challenge of HIV on national and regional levels has been essential to stemming the spread of the virus. The Pan American Health Organization’s (PAHO’s) Regional HIV/STI Plan for the Health Sector for 2006–2015 is designed to help health services and systems in the Americas more effectively respond to the HIV epidemic and prevent and control STIs. As of July 2007, PAHO was supporting national HIV/AIDS programs across Central America in analyzing their national responses to the epidemic and in reaching a consensus on validating and approving strategic lines for regional cooperation in areas such as logistics and supplies for ARVs, and along themes of masculinity, sexual abuse, and sex education.

The Central America HIV/AIDS/STI Congress (CONCASIDA) is an additional regional-level initiative. Since 1997, high-level governmental and civil society representatives from Central American countries have attended the Congress, which takes place every two years. CONCASIDA provides a forum to formulate norms and policies, make public commitments to address HIV/AIDS, exchange technical best practices, and help ensure coordination of both country and regional initiatives.

Although Central American governments have taken on a substantial financial role in addressing HIV/AIDS, particularly in regard to treatment, the region still receives significant HIV/AIDS support from outside donors. In 2005, the World Bank approved an \$8 million regional grant to support Central American countries to manage and control the epidemic. The Inter-American Development Bank has supported health infrastructure, which has been important to HIV treatment and care programs in **Honduras, Guatemala, and Nicaragua**.

The Global Fund is a major contributor to containing the epidemic in Central America and supports several country programs. Project grants from the Global Fund support programs that target social protection for PLWHA, promote behavior change in high-risk populations, increase access to ART, improve evaluation and surveillance systems, and reduce mother-to-child transmission of HIV. To date, more than \$166.7 million in funding has been disbursed to support Global Fund programs throughout Central America. The U.S. Government (USG) provides nearly 30 percent of the Global Fund's total contributions worldwide.

USAID Regional Support

USAID's HIV/AIDS programs in Central America are implemented as part of the U.S. President's Emergency Plan for AIDS Relief (PEPFAR). Launched in 2003, PEPFAR is the USG initiative to support partner nations around the world in responding to HIV/AIDS. Through PEPFAR, the USG has committed approximately \$32 billion worldwide to bilateral HIV/AIDS programs and the Global Fund through fiscal year 2010. PEPFAR is the cornerstone of the President's Global Health Initiative (GHI), which supports partner countries in improving and expanding access to health services. Building on the successes of PEPFAR, GHI supports partner countries in improving health outcomes through strengthened health systems, with a particular focus on improving the health of women, newborns, and children.

HIV Estimates in Central America	
Belize	
Total Population	315,000
Estimated Number of Adults and Children Living with HIV/AIDS	4,800
Adult HIV Prevalence	2.3%
HIV in Most-at-Risk Populations	
Prisoners (2006)	4.6%
Costa Rica	
Total Population	4.5 million
Estimated Number of Adults and Children Living with HIV/AIDS	9,800
Adult HIV Prevalence	0.3%
HIV in Most-at-Risk Populations	
CSWs (national) (2004)	0.11%
MSM (San José) (2009)	12.7%
El Salvador	
Total Population	6.1 million
Estimated Number of Adults and Children Living with HIV/AIDS	34,000
Adult HIV Prevalence	0.8%
HIV in Most-at-Risk Populations	
FSWs (national) (2009)	5.7%
MSM (national) (2009)	10.8%
Guatemala	
Total Population	13.6 million
Estimated Number of Adults and Children Living with HIV/AIDS	62,000
Adult HIV Prevalence	0.8%
HIV in Most-at-Risk Populations	
FSWs (national) (2007)	4.3%
MSM (national) (2007)	11.5–18.3%
Honduras	
Total Population	7.9 million
Estimated Number of Adults and Children Living with HIV/AIDS	39,000
Adult HIV Prevalence	0.8%
HIV in Most-at-Risk Populations	
FSWs (national) (2006)	4.1%
MSM (national) (2006)	9.9%
Nicaragua	
Total Population	6.0 million
Estimated Number of Adults and Children Living with HIV/AIDS	6,900
Adult HIV Prevalence	0.2%
HIV in Most-at-Risk Populations	
CSWs (national) (2004)	1.1–1.9%
MSM (Managua) (2009)	4.2%
Panama	
Total Population	3.4 million
Estimated Number of Adults and Children Living with HIV/AIDS	20,000
Adult HIV Prevalence	0.9%
HIV in Most-at-Risk Populations	
CSWs (2007)	0.2%
MSM (2007)	8.9%

Sources: U.S. Census Bureau, UNAIDS 2010 Report on the Global HIV/AIDS Epidemic, 2009 Central American Sexual Behavior Surveillance and STI/HIV Prevalence Survey, Honduras National Institute of Statistics, 2006 Honduras Behavioral Surveillance Survey, and Nicaragua 2009 Global Fund study

In March 2010, the USG and the Council of Ministers of Health of Central America (COMISCA) met in San José, Costa Rica, to sign a Partnership Framework that outlines a jointly developed strategy to support the Central American regional response to HIV/AIDS. The Partnership Framework provides a five-year strategic plan that is being implemented by the USG, the governments, and civil society in the seven countries in the region. The Framework describes the coordination and contribution of key regional stakeholders and donors to support the goals of Central America's regional and national HIV/AIDS programs and contribute to PEPFAR goals.

USAID's Central America program is designed to help contain the epidemic and mitigate its impact through increasing healthy behaviors among MARPs, other vulnerable populations, and PLWHA; improved health systems to reach MARPs and PLWHA more effectively; increased availability and use of strategic information to support national and regional HIV/AIDS response; and an improved policy environment for achieving universal access to HIV/AIDS services in the region. The program features a multisectoral approach with public, private, faith-based, and secular partners working together under the framework of participatory national strategic planning processes. The program emphasizes the participation and strengthening of local organizations to respond to the epidemic's threat to sustainable development in the region, particularly through strategic use of information for advocacy, policymaking, and M&E of program efforts. USAID seeks to improve the delivery and use of effective prevention practices by reducing stigma and discrimination toward HIV-infected and -affected individuals.

USAID regional support also focuses on private sector involvement. In **Panama**, for example, USAID has supported the Panamanian Business Council in HIV/AIDS prevention activities in the workplace since 1999. The Council distributes its HIV/AIDS management manual to human resource managers and provides corresponding training. A similar council was formed in **Guatemala** in December 2007 to develop and improve HIV/AIDS workplace policies and promote voluntary counseling and testing (VCT). In **Guatemala**, USAID is assisting in establishing a public-private HIV commission, bringing together private sector providers with public sector programs, such as the National AIDS Program. The commission integrates reporting on private sector services into the reporting requirements of the public sector. Utilizing best practices developed in Mexico and **Guatemala**, USAID supported the creation of additional public-private alliances for HIV workplace policies and education in 2009–2010.

USAID's HIV/AIDS regional program is part of the Agency's global effort to improve health through increased access to HIV prevention, care, and treatment services. The Agency has both a regional presence facilitated by the Central American Regional Office, which is based in **Guatemala**, as well as bilateral Missions in **El Salvador**, **Guatemala**, **Honduras**, and **Nicaragua**. The Regional Office works with local partners to conduct HIV/AIDS activities in **Belize**, **Costa Rica**, and **Panama**, while also supporting bilateral Mission offices in their respective countries.

A number of activities took place in 2009–2010 to improve comprehensive care in Central America, including an expanded initiative to work with national social security health services programs on performance improvement and supervision to improve HIV/AIDS services within hospital systems. Thirty-five hospitals (up from 19) showed improvement from baseline to follow-up measurements, and 3,543 medical personnel (up from 1,367) were trained in biosecurity, quality improvement of HIV/AIDS services, HIV stigma and discrimination, and gender issues.

Regional activities strive to achieve a number of goals through direct programming and other support. Activities are aligned with the tenets outlined in the Partnership Framework signed with the USG. Specific USAID regional activities in Central America include, but are not limited to:

- Implementing combination prevention interventions for MARPs
- Conducting behavior change interventions that target high-prevalence groups, complemented by a condom distribution program; these interventions had 635,000 contacts with at-risk persons in 2009
- Presenting data collected from behavior surveys to monitor and evaluate national HIV/AIDS strategic plans to leverage policy support and resources and guide future strategies
- Expanding a model of mobile counseling and testing clinics pioneered in **El Salvador** and **Nicaragua**, where the regional program coordinated with bilateral efforts to train 37 percent more individuals in counseling and testing than initially anticipated
- Developing a regional VCT strategy

Much emphasis is put on combination prevention interventions, particularly among MARPs. Special activities include improving the availability of condoms and lubricants; creating an enabling environment for prevention activities for MARPs, free from stigma and discrimination; improving the professional skills of health providers in the quality of services provided to MARPs, PLWHA, and others; improving the political environment surrounding HIV/AIDS issues; supporting policy implementation and monitoring; and strengthening use of the continuum of care model at the community level.

USAID successes in Central America for 2009–2010 included significant progress in strengthening national responses to address HIV/AIDS. With USAID technical assistance, six USAID-supported countries now have national strategic plans in place. USAID worked closely with COMISCA to develop the Partnership Framework aligned with the Regional Strategic Framework. The Regional Country Mechanism (RCM) serves as the technical arm of COMISCA, advising and leading the HIV/AIDS response in the region. The RCM includes MOH representatives, donors, civil society, and others. In 2009, there were 10 documented positive HIV policy changes in the region. In 2010, the RCM also published the regional strategic plan.

Global Fund projects received substantial technical assistance in 2009–2010, resulting in strengthened Country Coordinating Mechanisms, better implemented projects, and the development of four grant proposals. To deepen country commitments, USAID supported the relaunch of advocacy alliances and social audit groups in four countries (**Belize, Costa Rica, El Salvador, and Guatemala**) to demand better coverage and quality of services for PLWHA.

USAID Country Support

In Central America, USAID provides direct technical support to and implements HIV/AIDS bilateral programs in **El Salvador, Guatemala, Honduras, and Nicaragua**. Examples of USAID country support include:

- Conducting behavior change interventions in **El Salvador** to reduce and prevent the transmission of HIV in MARPs, including CSWs, MSM, migrants, and clients of sex workers. These activities included several spots to promote National HIV Testing Day and messages against stigma and discrimination.
- Reaching 165,000 prevention contacts and increasing targeted condom service outlets in **Guatemala** to 23 percent above the goal, demonstrating the commitment to provide condoms to at-risk groups.
- Scaling up rapid HIV testing through six nongovernmental organizations in **Honduras** with brigades for mobile testing in hard-to-reach communities. Project surveys showed the percentage of MSM receiving counseling and testing and their corresponding results increased, from 68 percent in 2004 to 98 percent in 2009. Among FSWs, there was an increase in HIV testing, from 53 percent in 2004 to 99 percent in 2009.
- Improving the quality and availability of public HIV/AIDS services in **Nicaragua** (counseling and testing, ART, monitoring of standards and quality indicators for service provision, increased patient adherence to clinical therapy, and reduction of stigma and discrimination by health service providers).
- Strengthening the capacity of MOH personnel and other key stakeholders in **El Salvador** to provide HIV/AIDS prevention and treatment services, including training 633 nurses working in the health network and 3,000 community health promoters. Fifty MOH health units were accredited as providing quality VCT.
- Reaching 201,645 members of MARPs through a condom social marketing campaign in **Honduras**, resulting in significant behavior change among beneficiaries. Condom use with an occasional partner rose from 32 percent in 2004 to 98 percent in 2009 in the Garifuna population, and from 79 to 86 percent among PLWHA during the same time period.
- Strengthening the national HIV/AIDS response in **Guatemala** by launching the national M&E plan and creating a National AIDS Account process for reporting on HIV/AIDS spending.

Important Links

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USAID's HIV/AIDS Web site for the Central America Region:

http://www.usaid.gov/our_work/global_health/aids/Countries/lac/caregion.html.

For more information, see USAID's HIV/AIDS Web site: http://www.usaid.gov/our_work/global_health/aids
and the Latin American and Caribbean HIV/AIDS Initiative Web site:

http://www.usaid.gov/our_work/global_health/aids/Countries/lacin.html.

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