USAID | **GUATEMALA**

FROM THE AMERICAN PEOPLE

HIV/AIDS HEALTH PROFILE

HIV and AIDS Estimates	
Total Population*	13.6 million (mid-2010)
Estimated Population Living with HIV/AIDS**	59,000 [41,000–84,000] (end 2007)
Adult HIV Prevalence**	0.8% [0.5–1.1%] (end 2007)
HIV Prevalence in Most-at-Risk Populations**	Sex Workers: 4.3% (2007) MSM: 11.5–18.3% (2007)
Percentage of HIV-Infected People Receiving Antiretroviral Therapy***	37% (end 2007)

*U.S. Census Bureau **UNAIDS ***WHO/UNAIDS/UNICEF *Towards Universal Access*, 2008

With less than 1 percent of the adult population estimated to be HIV positive, Guatemala is considered to have a concentrated epidemic. However, as Central America's largest country, it accounts for nearly one-sixth of Central America's HIV-infected population. Since the country's first case of HIV was reported in 1984, infections have occurred primarily among men who have sex with men (MSM) and commercial sex workers (CSWs). According to the National AIDS Program (NAP) in the Ministry of Health (MOH), as of June 2009, Guatemala had 19,856 officially reported cases of HIV/AIDS (National Center of Epidemiology [NCE]). The Joint United Nations Program on HIV/AIDS (UNAIDS) estimates 59,000 people in Guatemala are living with HIV and 3,900 deaths occurred due to AIDS in 2007.

Guatemala's HIV-infected population lives primarily in urban areas along major commercial routes. According to the March 2010 report of the NCE, 80 percent of all reported HIV/AIDS cases have occurred in only eight of Guatemala's 22 departments (Retalhuleu, Izabal, Escuintla, Suchitepéquez, Guatemala, Petén, San Marcos, and Quetzaltenango). Many of these eight departments border neighboring countries. According to the 2008 United Nations General Assembly Special Session (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. National HIV prevalence among sex workers is 4.3 percent; among street-based female sex workers (FSWs), prevalence as high as 14.9 percent has been reported. Recent evidence suggests HIV prevention efforts may be having an impact among sex workers. A 2009 study found a multilevel intervention focused on FSWs resulted in more than a fourfold decline in HIV incidence in the study population and a significant increase in consistent condom use (UNAIDS, 2009). National HIV prevalence among MSM was 11.5 to 18.3 percent in 2007, according to UNAIDS and the NCE. A 2002 study published by UNAIDS in 2007 indicated infection levels among MSM in Guatemala were 10 times higher than in the general population. According to the MOH, no cases of infection have been reported through injection drug use or through blood or blood products. Available data indicate HIV has affected mainly Ladino (persons of mixed Amerindian-Spanish descent) and urban populations; however, preliminary data indicate the indigenous population (primarily Mayans) could be experiencing increasing HIV infections. The data are insufficient, however, to determine the extent of the epidemic within this population.

Several risk factors contribute to Guatemala's epidemic, including migration and tourism. While in transit, migrants may participate in high-risk sexual behavior, increasing their chances of contracting HIV and other sexually transmitted infections (STIs). The Garifuna population, which shares cultural and ethnic characteristics with people in the Caribbean countries, is more at risk than the general population. The overall effects of HIV/AIDS are exacerbated by high levels of poverty and limited access to health care, particularly among rural populations.

The rate of HIV co-infection with tuberculosis (TB) is growing. The current rate of new TB infections is 63 cases per 100,000 population. According to the World Health Organization's (WHO's) 2009 TB report, an estimated 19 percent of adult-incident TB patients were also HIV positive in 2008. According to the 2010 UNGASS report, only 10.1 percent of patients in Guatemala co-infected with TB and HIV receive treatment for both diseases. TB is the most frequent opportunistic infection associated with HIV/AIDS in Guatemala, and co-infection complicates the care and treatment of both diseases.

National Response

The NAP and the NCE have been responsible for surveillance of the epidemic since 1984. However, sentinel surveillance was not established until 1998. Over the past several years, the Guatemalan Government has taken concrete steps to address the HIV/AIDS epidemic. A national strategic plan was produced for 1999–2003. At the end of 2005, Guatemala adopted a new national HIV/AIDS policy, along with its Strategic Plan for 2006–2010. Currently, a process is in place to develop a new national Strategic Plan for the next five years. The current Plan charges the NAP with coordinating national responses, including those from civil society. In 2007, the MOH established a National Monitoring and Evaluation Plan for Preventing STDs and HIV/AIDS for 2006–2010. However, the information system is still weak, with only 60 percent of health centers reporting data (UNGASS, 2008). In 2005, the Ministry of Education incorporated HIV/AIDS prevention into the curriculum in primary and secondary schools, though implementation is not universal. In 2007, a national information, education, and communication strategy was launched. UNAIDS works with the NAP, and the U.S. Agency for International Development (USAID) provides technical assistance to implement the national Strategic Plan and establish key universal access targets. Decentralization of HIV/AIDS care and prevention services has been initiated throughout the country, but a gap in implementation remains.

In recent years, the NAP has improved communication with civil society and other institutions to coordinate national efforts. This has resulted in the establishment of NAP-led technical committees with multisectoral participation to address such issues as standardizing diagnosis, treatment, and care. Although legislation has established a national AIDS commission to coordinate all activities in country, this commission is not currently functional, and efforts are required to institutionalize and strengthen the body. As a result, the UNAIDS Theme Group and the Country Coordination Mechanism of the Global Fund to Fight AIDS, Tuberculosis and Malaria serve as the two inter-institutional coordinating bodies. Guatemala is also implementing the Pan American Health Organization Regional HIV/STI Plan for the Health Sector 2006–2015. The Plan is designed to assist health services and systems in the Americas to more effectively respond to the HIV epidemic and prevent STIs.

Antiretroviral therapy (ART) coverage has expanded over the years. Currently, 59 percent of estimated HIV-infected men and women who need treatment receive ART, according to the 2010 UNGASS report. The 2008 WHO/UNAIDS/UNICEF report *Towards Universal Access* estimated 37 percent of HIV-infected people who needed treatment in Guatemala in 2007 received ART. However, because the expansion and decentralization of services have been slow, people living with HIV/AIDS (PLWHA) must travel long distances to obtain treatment, imposing cost burdens on them. There are major challenges in extending both prevention and care coverage outside the capital and other main cities. Although there is a law to protect PLWHA in general, there is no legislation to specifically protect the rights of those most vulnerable to the epidemic, including MSM and CSWs, and discrimination against these groups poses a significant barrier to a more effective AIDS response. A few years ago, USAID supported a national campaign focusing on the diversity of PLWHA to help break down barriers of stigma and discrimination and promote respect for human rights related to HIV/AIDS.

The Global Fund has made significant investments in HIV prevention in Guatemala since 2004. It has disbursed a total of $42 million for HIV care and prevention activities. Guatemala is now in phase two of a third-round grant designed to expand prevention activities and integrated care for vulnerable groups (CSWs, MSM, street children, and gang members) to regions with the highest HIV incidence. Other objectives include improving coordination among civil society organizations working in HIV/AIDS and reducing mother-to-child HIV transmission by expanding voluntary screening and counseling for pregnant women. The U.S. Government (USG) provides nearly 30 percent of the Global Fund's contributions worldwide. Bilateral donors, including USAID and European countries, also provide support for prevention, treatment, care, and health system improvement initiatives.

USAID Support

Through USAID, Guatemala received approximately $3.5 million in fiscal year (FY) 2009 for essential HIV/AIDS programs and services. USAID's HIV/AIDS programs in Guatemala 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 to bilateral HIV/AIDS programs and the Global Fund through FY 2010. PEPFAR is the cornerstone of the President's Global Health Initiative (GHI), which commits $63 billion over six years to support 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.

In March 2010, the USG and the Council of Ministers of Health of Central America 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 to be implemented by the USG and the Governments of the seven countries in the region (Belize, Costa Rica, El Salvador, Guatemala, Honduras, Nicaragua, and Panama). The Framework describes the coordination of key regional stakeholders to support the goals of the countries' regional and national HIV/AIDS programs, in addition to contributing to the goals of PEPFAR.

USAID/Guatemala has a relatively short history of bilateral involvement in HIV/AIDS. The Mission began bilateral support in July 2001, obligating funds to strengthen the MOH surveillance system for HIV/AIDS and to include a male module on sexual behaviors in the 2002 National Maternal/Child Health Survey. Currently, USAID is increasing the number of prevention activities in its current and new geographic areas. In 2009, USAID reached 165,000 prevention contacts. The number of targeted condom service outlets was 23 percent above the goal and reflects commitment to provide access to condoms for high-risk groups. Gender remains a significant component of all USAID-supported HIV/AIDS activities. USAID also implemented a number of behavior change communication methodologies for small group and individual interventions to address different "types" of men based on core beliefs and attitudes identified in innovative research undertaken in 2008.

USAID also assists the MOH in extending services for people with STIs and those needing voluntary HIV/AIDS counseling and testing (VCT). The number of individuals trained in counseling and testing was 2.6 times above target in fiscal year 2008, and the number of individuals receiving VCT was nearly double the target. Additionally, 70 private labs have introduced quality controls for HIV testing and counseling, and in the public sector, 34 VCT centers have been established, including three STI sentinel surveillance clinics for most-at-risk populations (MARPs).

Together with the MOH, civil society, and the private sector, USAID is strengthening the national response to HIV/AIDS. With USAID technical assistance, a national monitoring and evaluation (M&E) plan was launched and the national M&E committee strengthened; a National AIDS Account process was established for reporting HIV/AIDS spending; and a National Strategic Plan is in place. In 2009, USAID provided critical technical assistance and leadership to update the National AIDS Account. USAID also supported the relaunch of advocacy alliances and social audit groups to demand better coverage and quality of services for PLWHA.

USAID has made significant gains by incorporating the private sector into the national AIDS response, including private corporations and the private health care sector. USAID is collaborating with private providers to reduce stigma and discrimination and to improve HIV services, including formative research on the cost-effectiveness of potential counseling and testing models in private clinics and laboratories. USAID also assisted in creating and formally establishing a public-private HIV commission, bringing together private sector providers with public sector programs such as the NAP. The commission integrates reporting on private sector services into the reporting requirements of the public sector. It also establishes private-public alliances in critical areas such as policies, laws, and protocols. Public-private alliances are also developed through Guatemala's HIV Business Council. The Guatemala Council's methodology is being implemented regionally to involve the corporate/business sector in developing workplace policies and to address HIV prevention and HIV stigma and discrimination.

USAID/Guatemala also manages the Central American HIV/AIDS Regional Program, which is designed to help contain the epidemic through targeted behavior change programs for MARPs according to the epidemiology of the disease; to implement improved policies and programs; and to improve the knowledge and skills of medical personnel to provide comprehensive treatment and care to PLWHA. The Program features a multisectoral approach with public, private, faith-based, and secular partners under the framework of the participatory national strategic planning processes. It 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.

Important Links and Contacts

USAID/Guatemala
Km. 6.5 Carretera a El Salvador
Santa Catarina Pinula
Guatemala, Guatemala
Tel.: 502-2422-4000
Fax: 502-2422-4589
Web site: *http://www.usaid.gov/locations/latin_america_caribbean/country/guatemala/*

USAID's HIV/AIDS Web site for Guatemala:
http://www.usaid.gov/our_work/global_health/aids/Countries/lac/guatemala.html.

For more information, see USAID's HIV/AIDS Web site: *http://www.usaid.gov/our_work/global_health/aids*,

Latin American and Caribbean HIV/AIDS Initiative Web site:
http://www.usaid.gov/our_work/global_health/aids/Countries/lacin.html, and Central America Regional Program

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

September 2010