# HIV Policy Assessment in Central America

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Strategic Approaches to Social Inclusion

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**ACRONYMS**

| | |
|---|---|
| AIDS | Acquired Immune Deficiency Syndrome |
| ARV | Antiretroviral |
| CDC | Centers for Disease Control and Prevention |
| COMISCA | Executive Secretariat for the Council of Ministers of Central America and the Dominican Republic |
| DDU | Data Demand and Use |
| FSW | Female Sex Worker |
| GBV | Gender-Based Violence |
| HIV | Human Immunodeficiency Virus |
| IDB | Inter-American Development Bank |
| KP | Key Populations |
| LGBT | Lesbian, Gay, Bisexual and Transgender |
| M&E | Monitoring and Evaluation |
| MEGAS | Spanish Acronym for NASA (National Aids Spending Assessment) |
| MSM | Men who have sex with men |
| NASA | National AIDS Spending Assessment |
| NGO | Non-governmental Organization |
| NSP | National Strategic Plan |
| OAS | Organization of American States |
| PAHO | Pan American Health Organization |
| PASMO | Asociación PASMO, Central American social marketing association |
| PASCA | Program to strengthen the Centro American response to HIV |
| PEPFAR | Presidential Emergency Funds for AIDS Relief |
| PF | Partnership Framework |
| PLWH | Persons Living with HIV |
| PMTCT | Prevention of Mother-to-Child Transmission |
| SW | Sex Worker |
| UNAIDS | United Nations |
| US | United States |
| USAID | United States Agency for International Development |
| USG | United States Government |
| WHO | World Health Organization |

## EXECUTIVE SUMMARY

USAID's Regional HIV/AIDS Program in Central America is undertaking a situation analysis of the current political landscape for HIV in the region. This process involves reviewing current activities and identifying gaps, obstacles and constraints affecting the outcome of HIV policy work during the last five years. Results of the analysis will help shape the next U.S. government strategy for assistance in the region on HIV policy.

In order to better understand the current situation with respect to HIV policy in Central America, USAID commissioned an assessment covering all seven countries in the region, and based on information gathered from more than 100 experts and stakeholders, including representatives of the public sector, civil society, international cooperation agencies and private enterprise.

USAID has supported HIV/AIDS prevention, health systems strengthening, strategic information, and policy in Central America through regional and bilateral programs. USAID's policy support in the region over the past 15 years was recognized by country stakeholders as having made a significant contribution to the development of laws, policies and plans for HIV, and to progress made on stigma and discrimination and gender equity.

Most countries in the region have supportive legal frameworks and national strategic plans in place to respond to the epidemic, and many have anti-discrimination laws that support PLWH as well as other key populations (UNAIDS, 2010). Belize is an outlier, with a sodomy law which was cited by many key informants as one of the principal sources for discrimination in that country.

When asked to rate the effectiveness of current policy in guiding the response to HIV, most interviewees scored the policy environment for HIV in Central America at 3 on a scale of 0-5; all shared the opinion that laws, norms, strategic plans, and international agreements exist, but implementation -and to some extent, knowledge, dissemination and monitoring - of them is limited in most cases. They also commented that many of the laws, plans and norms are outdated and in need of revision, adding new provisions explicitly dealing with sexual diversity, human rights and vulnerable populations. Recognition of the "identidad de género" for transgender women was mentioned specifically by many.

There was general agreement that the region has achieved substantial advances with regard to: (1) access to treatment; (2) reduction of stigma among health service providers; and (3) existence of comprehensive national strategic plans.

However, most informants saw stigma and discrimination against key populations as a major and intractable issue in the region and many cited it as the principal barrier to implementation of HIV/AIDS programs in their respective countries. Conservative cultural norms about sexuality – and a strong normative preference for heterosexuality – were reflected in a lack of political leadership to implement human rights laws guaranteeing protection and equality for key populations. Reflecting the widespread public rejection of sexual diversity, policies do not adequately address gender-based violence against transgender women and men who have sex with men. In fact, gender-based violence is perceived as a "women's issue", with little recognition of its impact on other vulnerable populations.

Many participants asserted that the human rights issues of vulnerable populations are beyond the scope of health ministries or National AIDS Programs and require engagement of legislators, social sector leaders, ombudsmen and decision makers through effective advocacy by civil society.

Civil society efforts were seen as fragmented. Even though they may be working toward the same goals, organizations do not work together. Competition for funds and mutual suspicion among groups were the reasons most cited for this lack of collaboration. Many informants mentioned the need to strengthen the capacity of civil society organizations in advocacy and leadership, with emphasis on strengthening a new generation of leaders, skilled in strategic planning and influencing policy.

Many informants underlined the importance of taking into account the complex social context surrounding HIV, and stressed the need for increasing the involvement of other sectors outside of health, not only in human rights, but also in the financing of the response.

Key informants expressed concern about the rising rates of HIV among youth, as well as adolescent pregnancy, and noted that little work in the policy arena is being done to address the needs of youth. Many lamented the lack of adequate sex education in schools, and the general reluctance of the education sector to address the issue of HIV. Several informants also mentioned the need to reach out to previously neglected populations, such as handicapped persons, certain indigenous groups, and older adults.

Overall, the lack of a sufficiently strong country authority on HIV/AIDS—one that can coordinate donors' efforts and obtain the participation of the full range of non-health sector actors needed to implement a comprehensive approach to HIV/AIDS—was identified across the region as the principal gap related to participation.

In addition, a recurrent concern expressed by representatives of international cooperation agencies was the perceived lack of awareness and planning for donor phase-out over the next three to five years. They noted that approximately 60% of the cost of prevention in the region is currently covered by donors, but governments have been slow to assume country ownership in financing and designing evidence-based prevention strategies, even though this is a necessary step for sustainability of the response to HIV in the region.

## I. BACKGROUND

In Central America, the HIV epidemic is relatively stable and concentrated among key populations—except in Belize, where, to date, it is considered generalized based on international standards[1] (UNAIDS, 2010). HIV prevalence rates in the region range from 2.5% in Belize, to 0.2% in Nicaragua (Table 1). Country-level prevalence rates, however, mask the disproportionate impact that HIV and AIDS have on sub-populations- those persons more vulnerable to infection because of sexual behavior or other factors. Key populations in Central America include men who have sex with men (MSM), transgender women, sex workers (SWs) and prisoners.

**Table 1: HIV Prevalence Rates by Key Population**

| Country | HIV Prevalence Rate % (Ages 15-49)[2] | MSM | FSW[3] | Trans-gender Women[4] | Prison Inmates |
|---|---|---|---|---|---|
| Belize | 2.5% | 10%[3] | n/a | | 4%[5] |
| Costa Rica | 0.3% | 11%[6] | 0.2%[4] | | |
| El Salvador | 0.8% | 7.9%[7] | 4.1%[6] | 25.8%[8] | |
| Guatemala | 0.8% | 18.3%[9] | 1.1%[6] | 14.9%[10] | 12.9%[5] |
| Honduras | 0.8% | 13.1% [11] | 2.3%[6] | | 6.8%[6] |
| Nicaragua | 0.2% | 7.5%[3] | 3.2%[3] | | |
| Panama | 0.9% | 10.6%[12] | 2%[7] | | |

According to UNAIDS (2010), the Central American epidemic is most highly concentrated among MSM—with the majority of countries in the region reporting a prevalence of over 10% in that sub-population. UNAIDS and others have noted that stigma and discrimination play a large role in keeping this part of the epidemic hidden: MSM may be reluctant to go to centers for testing , thus many go undetected, which underestimates the epidemic in this population (UNAIDS, 2010). A related concern is that MSM may be reported as heterosexual men in prevalence estimates, if they have had sex with a woman, which also may lead to underestimates of the true prevalence of HIV among MSM (Hernandez et

[1] The Belize National Program for TB, HIV and other STIs reports that new epidemiological data from 2012 is expected to show a concentrated epidemic. (Dr. Manzanero, personal communication, October 1, 2012).
[2] UNAIDS - HIV and AIDS Estimates. (2009). Retrieved from: http://www.unaids.org/en/regionscountries/regions/latinamerica/
[3] Reporting categories listed are established by countries
[4] Many of these studies are small, not population-based samples.
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al., 2010). The fear of stigma and discrimination, and strong, cultural heteronormative pressure, may lead these same men also to have sex with women, leading to even wider transmission (Soto, 2007).

Recent studies in the region suggest that HIV prevalence is even higher for the female transgender population than for MSM, possibly as high as 40%, with accompanying high levels of stigma, discrimination and violence targeted at this population (Hernandez, Guardado, Paz-Bailey, 2010). Because transgender women are often counted in other categories, such as MSM, the evidence base relating to their HIV prevalence is weak, with only small-scale studies available throughout Central America (Mazariegos, 2010; Ocaña et al., 2008; PAHO, 2012). The lack of national data makes it easier to discount the impact that HIV and gender-based violence are having on transgender women in the region. In 2012 USAID conducted studies of transgender women in four Central American countries (El Salvador, Guatemala, Panama and Nicaragua), and the results of those studies, when available, should add new understanding of the female transgender population.

The last several years have seen progress addressing HIV with female sex workers in Central America, with declining incidence rates in this group reflecting the programmatic and financial focus on prevention among female sex workers and their partners (UNAIDS 2010; Partnership Framework, 2010). Country-level reports by the PASMO project show increased condom use by FSW with clients and partners in Central American countries from 2004 to 2007, and small studies confirm a corresponding, and significant, decline in HIV incidence (Sabido, 2009).

Little data are available about HIV rates among prison inmates in the region, but small-scale studies suggest rates in the range of 4% in Belize to 12.9% in Guatemala (Hembling, 2011; Baral, 2007). Advocates point to this sub-population as being at particularly high risk of HIV, a situation commonly exacerbated by policies prohibiting condom distribution in prisons.

*Resource Allocation Trends*

In 2008, the USG led an assessment to look at gaps in the HIV response in the region. It found that many of the gaps in service delivery, information and policy are related to key populations (Partnership Framework, 2010). Nevertheless, host country governments' financial commitments continue to be relatively small for activities focused on these populations (Ibarra & Sosa, 2002). Most countries in the region have focused their HIV/AIDs response on antiretroviral treatment for people living with HIV (PLWH), in response to advocacy by PLWH organizations over the last twenty years. They also have invested in prevention-of-mother-to-child-transmission (PMTCT) programs, successfully reducing the rate of new infections among children (UNAIDS, 2010). As noted in the USG Partnership Framework, Central American host country governments have had "notably limited coverage" of key populations (2010, p.7), a trend often attributed to prevailing conservative social norms that influence political decisions about allocation of funds (PAHO, 2009).

In Central America, all governments are bearing at least part of the burden of financing HIV programs — ranging from a 79% public sector contribution in El Salvador to a 23% contribution in Honduras, with the other countries falling somewhere in between. Panama and Costa Rica, which receive almost no donor funds, rely on the private sector to make up the difference; whereas Belize, Honduras and Nicaragua receive over half of their funding from donors (COMISCA, 2011; UNAIDS, 2010). The distribution of funds across program elements varies by country as well: Costa Rica spends three-quarters of its HIV

budget on prevention (driven by their spending on condoms), whereas Belize, Panama and Nicaragua spend closer to one-half. El Salvador and Guatemala bring up the rear, spending a third and a quarter, respectively, on prevention programs (COMISCA, 2011).

*Legal framework*

Most countries in the region have supportive legal frameworks and national strategic plans in place to respond to the epidemic (Annex A), and many have anti-discrimination laws supporting PLWH as well as other key populations (UNAIDS, 2010). However, the level of implementation of HIV laws and national policies, the lack of sanctions for non-compliance, and the relative impunity for violating anti-discrimination laws tells a very different story. Despite generally favorable legal and policy frameworks, there are high levels of violence and discrimination among many key populations in the region, which further contribute to the concentration of the epidemic among these populations (Asociación PASMO, 2011). Belize remains an outlier, with an anti-sodomy law still in place that impedes the government's ability to address HIV among MSM.

*USAID assistance in the region*

In Central America, USAID has supported HIV/AIDS prevention, health systems strengthening, strategic information and policy through regional and bilateral programs. USAID's policy support in the region over the past 15 years is widely recognized by country stakeholders as having made a significant contribution to the development of laws, policies and plans for HIV and to progress made on stigma and discrimination and gender equity. These policy programs have worked directly with national and regional policymakers, and strengthened the capacity of key civil society groups, including PLWH and other vulnerable populations, to serve as advocates and citizen monitors. They have also worked to involve the private sector in the Central American HIV response.

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## II. HIV POLICY ASSESSMENT

In preparation for the next five-year cycle of USAID's assistance on policy and HIV in the region, USAID commissioned an HIV policy assessment in Central America. The assessment collected information from 101 stakeholders in seven countries (Table 2), representing the public sector, international cooperation (donors and their implementing partners), civil society, and the private business sector. During interviews averaging 45 minutes, informants were asked for their views on the current policy environment for HIV in their country, gaps in the policy framework and response, and recommendations for how the US Government can most effectively invest its resources on HIV-related policy during the period 2013-2018. The results of the assessment and recommendations to USAID are presented in this report. *The methodology is presented separately in an annex, along with summary data tables, the key informant questionnaires, the list of persons interviewed, and print/online resources consulted.*

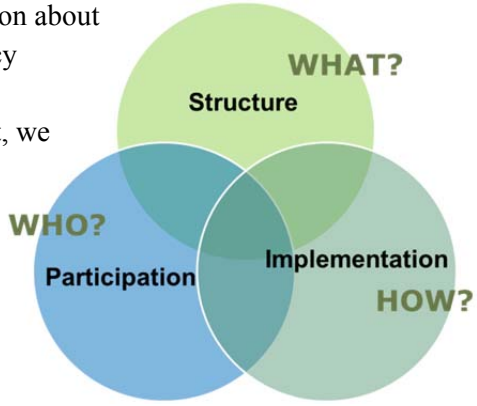
**TABLE 2: Distribution of Key Informants by Sector**

| | Public Sector | Donors/ Socios | Civil Society | Private Sector | TOTAL |
|---|---|---|---|---|---|
| Belize | 4 | 5 | 3 | 1 | 13 |
| Costa Rica | 5 | 4 | 3 | 1 | 13 |
| El Salvador | 5 | 4 | 4 | 2 | 15 |
| Guatemala | 4 | 5 | 2 | 1 | 12 |
| Honduras | 4 | 5 | 2 | 1 | 12 |
| Nicaragua | 3 | 3 | 6 | 1 | 13 |
| Panama | 4 | 3 | 5 | 1 | 13 |
| Regional | 0 | 10 | 0 | 0 | 10 |
| TOTAL | 29 | 39 | 25 | 8 | 101 |

To ensure the anonymity of the respondents, as per the informed consent forms they signed, the discussion of the findings is presented in summary format, reflecting the general trends across the interviews and across countries. Where appropriate, countries that did not fit the general trend are noted as outliers or having special concerns not shared by the majority. Additionally, Annex E contains summary tables of the findings, with illustrative quotes under each topic that provide greater detail and insight. The quotes are identified by sector of the respondent only (i.e., "public sector respondent"), without identifying the person's country, in order to protect the confidentiality of the respondents.

## III. CURRENT POLICY ENVIRONMENT

The first part of the interview guide was designed to capture information about the main components of the policy environment: the structure or policy framework, the manner in which policy is implemented, and who is participating in the policy process. For the purposes of the assessment, we assumed that the three components overlap – who is participating influences what is included in the policy framework, as well as how and to what extent policies get implemented. Likewise, what is contained in the laws and policies will determine who participates in their implementation.




The findings of the assessment, as related to the current policy environment, are presented below according to these three main categories. Subsequent sections summarize comments from stakeholders on the following topics: the factors they considered to be the most important determinants of the implementation of HIV policy in their country, both facilitators (factors that aided implementation) and constraints (barriers to implementation); the links between HIV policy and health systems strengthening and strategic information; the sustainability of current HIV programs; the use of a regional platform for USAID's assistance in HIV policy; and the PEPFAR Partnership Framework.

*What? Structure*

When asked to rate the effectiveness of current policy in guiding the response to HIV, most interviewees gave a rating of 3 out of 5 (5 being the highest possible rating), pointing out that there is a **strong policy framework in place** throughout the region. There was general agreement that there have been real advances in the region with respect to: (1) access to treatment; (2) reduction of stigma among health service providers (although not necessarily among any other group); and (3) the existence of comprehensive national strategic plans (NSPs). Respondents frequently remarked that, while many of the NSPs have been costed, the **NSPs are overambitious** given economic recession and reduced donor funding and the lack of adequate national financial backing from both the health sector and non-health sectors. [See Annex E: Summary Data Tables]

Although recognizing that HIV-related laws, norms, strategic plans, indicators and international agreements are in place and often comprehensive in nature, respondents considered **implementation -and to some extent, knowledge, dissemination and monitoring- of the policy framework to be limited** in most cases. They also commented that many of the **laws and policies are outdated** and in need of revision with new provisions explicitly dealing with sexual diversity, human rights and vulnerable populations. Proposals for revisions to the national HIV law in Nicaragua are under review in the legislature, for example, while a lawsuit has been filed in Belize to overturn that country's anti-sodomy law. Many called for national policies to be updated to reflect new evidence about where the epidemic is now. In the case of Belize, emerging data suggests that the epidemic is concentrated in key populations rather than generalized in the population as a whole, but national policies and services are premised on a generalized HIV epidemic in that country. The need for a **gender identity law**, allowing transgender

women and men to legally identify themselves by their chosen gender identity rather than their DNA-determined sex, was mentioned specifically by many respondents across the region. Respondents felt that this legal recognition would help address stigma and discrimination against transgender people, and facilitate their access to HIV and other health services. Additionally, respondents noted that **HIV policies often are not well linked to other larger, national policies**, such as a country's national development strategy or poverty reduction strategy, which reduces their impact, isolating them as stand-alone policies, with siloed financing. Another frequently mentioned concern was the **lack of alignment** of policies and plans with national laws, norms and regulations. [See Annex E: Summary Data Tables]

*How? Implementation*

Of the three components of the policy environment, respondents consistently identified **implementation as the weakest** and most in need of attention. They noted that the public sector is short on resources to implement the NSPs in their entirety, so public sector **funds tend to be spent on the least controversial programs**, such as PMTCT and ARVs, instead of on programming for key populations like sex workers and transgender women. A common theme across countries was that stigma and discrimination explains much about why public officials don't speak out: action on HIV issues will not win votes, and the public in general disapproves of the behaviors of key populations like LGBT and sex workers. "Policies are made with the head, implementation is done with the heart" as one respondent said, meaning that commitment to implementing HIV policies frequently stems from the personal experience of a decisionmaker – i.e., if they have a friend or family member living with HIV—and not from the policies themselves.

Conservative cultural norms about sexuality – and a strong normative preference for heterosexuality – were reflected in the **lack of political leadership to implement human rights laws** that cover LGBT in cases of crimes and abuse against them, which can in turn place them at increased risk for HIV[13]. While legislators in the region are proud of the laws that have been passed, they "do not notice" when the laws are not implemented. The violent deaths of transgender women in all countries in the region except Panama and Costa Rica, reflects the impunity with which the laws are disregarded, particularly in cases of violence or human rights abuses against LGBT: police are slow to investigate and are known to be abusive to the victims; the judicial systems rarely convict in such cases; and victims themselves only rarely denounce such crimes and report them, citing the uselessness of pursuing justice and a fear of exposing themselves to additional stigma, that of "being a victim."
Respondents raised concerns that prevention programs were not being funded by country governments, in spite of attention to the issue in national strategic plans. Donor key informants variously estimated between 70-90% of prevention program costs in the region are covered by international donors. Many people reported **concerns about access to testing**, commenting that government programs are oriented

[13] Several studies point out the link between violence and increased HIV risk. For example, psychological trauma can increase risky behavior in the future. Fear of violence can impair the ability to negotiate safer sex. Impunity supports a social environment in which victims are shamed and stigmatized, discouraging people who have experienced violence from seeking HIV health and social services (Chiu., J., Blankenship., K., Burris., S., (2011), Gender-Based Violence, Criminal Law
Enforcement and HIV: Overview of the Evidence and Case Studies of Positive Practices. Working
paper prepared for the Third Meeting of the Technical Advisory Group of the Global Commission
on HIV and the Law, 7-9 July 2011. )

toward testing of pregnant women while greater access to testing is needed for key populations. Others reported that while governments purchase tests, key populations do not go to clinics for testing because of real or perceived stigma and discrimination. In Panama, for example, a key informant reported that people generally seek medical attention when HIV has already progressed to AIDS. There is not a "culture of testing" or a "culture of prevention," and he recommended investing in campaigns to promote testing and early treatment. In Belize, where the epidemic has been classified as generalized, similar concerns were raised about the need to focus more efforts on key populations, including increased access to testing and treatment services.

Respondents cited a lack of political will in their countries to implement **comprehensive sexual education in schools, particularly with reference to sexual diversity**, even when supportive policies were in place and curricula available. Some noted that little or no action had been taken to implement the agreement signed at the 2008 International AIDS Conference in Mexico City by health and education ministers from the region to collaborate in HIV education and prevention. In Panama, for example, respondents reported that the current education minister is completely opposed to sex education, and that the Ministry of Education's recent anti-bullying program may even promote homophobia. Others mentioned that Costa Rica was experiencing similar difficulties implementing comprehensive sexual education programs, and El Salvador reported constraints addressing LGBT rights in school sexual education programs.

Some informants considered the relative lack of progress outside of the health sector to be a reflection of the l**ow prioritization of HIV in other ministries/sectors**. In Panama, for example, several informants stated that companies require a negative HIV test as a condition for employment and employees testing positive for HIV are fired or pressured to resign. One person mentioned she had seen a complaint that an HIV test was required for a driver's license. These situations reflect a **lack of enforcement of laws prohibiting discrimination on the basis of HIV status**, and point to the need to engage non-health sectors, including employers, in efforts to implement current policy.

When probed about why implementation was so problematic in their country, a majority of respondents identified the lack of advocacy and lack of *vigilancia* (monitoring by citizens) to push governments to implement their own laws, policies and plans. In countries where the Global Fund had projects, a common response from respondents across sectors was that **civil society organizations were too busy implementing Global Fund projects to do policy advocacy.** They noted that advocacy and citizen monitoring does not generate operating revenue for these organizations, while implementing donor-funded projects on service delivery does. Respondents in a majority of countries noted that the Global Fund is having an unexpected effect, distracting civil society from its necessary function of holding governments accountable for the promises they have made (i.e., laws they have passed and policies they have issued). As a result, civil society is losing its skills in advocacy, or not gaining these skills in the first place. The Global Fund was recognized by respondents in general, however, for providing much-needed money for HIV programs and bringing resources to civil society. [See Annex E: Summary Data Tables]

Across the region, a common theme emerged: implementation of existing policy is not a given, and the existence of a law, policy or national plan does not guarantee its implementation or the allocation of

resources to do so. Instead, the **policy framework is vulnerable to changes in political leadership, socioeconomic conditions, and sociocultural norms**. HIV-related policy in the region is not insulated from the effects of changes in these external factors, and as such, its implementation is weak and inconsistent. Further, the health sector has implemented the bulk of the response to date, and has already addressed the "low-hanging fruit" through health interventions like ARVs and testing. Now, the challenge is to **implement a more holistic response with other sectors, which may help address the structural inequalities that drive the epidemic.**

*Who? Participation*

The involvement in the policy process of stakeholders from a wide range of sectors and at various levels of power can bring more consistent implementation of policies across time and during periods of political transition, economic recession and even in the face of changing social attitudes. There was broad consensus among respondents about the need to strengthen national leadership and authority in HIV for more effective implementation and impact – and to do so in order to coordinate a true multisectoral response. The **lack of real engagement from non-health sectors** influences the "what" (structure) since policies do not fully reflect all potential aspects of response or all the human and financial resources that could be applied. For example, the human rights issues related to key populations are beyond the scope of health ministries or National AIDS Programs and require engagement of legislators, ministries of justice and social protection, human rights commissions, ombudsmen, and other decisionmakers, through effective advocacy by civil society. While there are advocates within health or other government ministries who are convinced of the impact of human rights on HIV, informants frequently stated that they did not have the authority or power to move human rights issues related to HIV to the forefront. Informants remarked that while **multisectoral collaboration was happening "on paper" and in high-level committees**, little substantive collaboration was taking place in practice. [See Annex E: Summary Data Tables]

A general theme across countries was that the **private business sector was underutilized** in the response to HIV. Informants from the business sector itself as well as those outside reported that businesses often want to and could do more to help the response to HIV, but they want to do it on their own terms. Some noted a strong preference in the business sector for working on internal corporate policies instead of co-funding public programs or mass media campaigns ("they already pay taxes to cover public health services"). Other informants discussed the tensions between the business sector and the health sector: some business sector informants expressed reservations about promoting condoms, for example, and preferred a more conservative approach with emphasis on the family and fidelity. They suggested that the issue of HIV could be addressed in the context of the Millennium Development Goals. This suggestion was mirrored by other comments about how to better engage the business sector: that civil society and public sector advocates should frame their messages in such a way that it **speaks to the interests of business sector leaders, including their *"compromiso social,"* and not simply repeat a public health argument for addressing HIV**.

The **less-than-optimal involvement of civil society** was mentioned routinely by respondents in all countries, noting that in the HIV arena, civil society still is weak and divided, with no common goal or

unified voice, and unwilling to form the powerful networks that have worked so well in reproductive health policy, for instance. With the exception of Belize, where civil society is still nascent in the HIV field, informants noted that many of the original leaders have moved from civil society to government or international posts. Early efforts by civil society centered on making ARVs available. Now that governments in the region are providing treatment, HIV is no longer a "life or death" issue and advocacy based on activism has decreased. The need now is for new leadership/approaches coming from a **professionalization of civil society** based on strategic and long-term planning.

The new generation of advocates was described as less professional, less educated and less skilled, some representing highly marginalized key populations like transgender women and sex workers. A common critique in the interviews was that these **new leaders lack the leadership and other skills to make a real impact in the policy arena**. While many have received basic advocacy training, for example, they need more advanced skills building that will allow them to work effectively with high-level policymakers. Affected groups need to know how to advocate for their rights (and in some cases be educated as to what their rights are). Many do not know how to approach decision makers, what arguments to use, or how to dress or speak appropriately at meetings. During the interviews, informants often described civil society as complacent relative to their predecessors, in need of leadership skills, and distracted by the effort to sustain or expand their NGOs.

*Factors Positively Influencing the Implementation of Current Policy*

Several factors were identified by informants as having positively influenced policy implementation during the last five years in the region. The **presence of high-ranking policy champions** in recent years, such as the former president and current minister of health in El Salvador, had raised the profile of HIV and helped to frame it as a development problem, not just a disease to be managed. The important, positive role that PASCA and USAID have played in bringing together different actors was noted frequently during the interviews, with particular reference to **USAID/PASCA's contributions** in convening, consensus-building and keeping the dialogue going on HIV policy. One particularly grateful informant said, "*Gracias a Diós por USAID*." Other informants pointed to the positive role that the **Partnership Framework** played, by increasing the focus on strategic approaches and accountability. Many respondents pointed to the important contribution the **MEGAS** (NASAs) [14] exercise had in the region, as it had provided critical evidence on how funds were being spent currently, compared to where they would likely have the biggest impact on the epidemic.

*Constraints to the Implementation of Current Policy*

Most informants saw **stigma and discrimination** as a huge issue in the region and described it as the # 1 problem and/or barrier to implementation of HIV policy in their countries. Some were even more specific, stating: "If you don't work with them [stigmatized populations], you are wasting your money,"

[14] According to WHO, "The National AIDS Spending Assessment (NASA) resource tracking methodology is designed to describe the financial flows and expenditures using the same categories as the globally estimated resource needs. This alignment was conducted in order to provide necessary information on the financial gap between resources available and resources needed, and in order to promote the harmonization of different policy tools frequently used in the AIDS field." From http://www.who.int/nha/developments/nasa_classifications/en/index.html, accessed October 18, 2012

and "Addressing stigma and discrimination and the human rights of affected groups is a necessary condition to advance in all the other areas." Stigma and discrimination was reported to be affecting the response to HIV in different arenas.

- **Discriminatory health services** (outside of specialized HIV clinics) reduce the demand for services. In Belize, one informant reported that HIV-positive parents fear discriminatory behavior from clinic personnel, so they wait until their baby is very sick before coming to the clinic to have the baby tested for HIV and treated.
- Many **key populations are invisible** and want to stay that way --a finding that was consistently reported throughout the countries. **Internal (or felt) stigma** reduces their advocacy and activism, including about violence they may experience that increases their risk of HIV.
- Reflecting widespread animosity toward sexual diversity, HIV and other **policies do not adequately address LGBT, human rights violations, and GBV** against transgender women and MSM.

Several informants mentioned that more **work with mass media** was needed in order to address stigma and discrimination in the region, and pointed to this as an opportunity for a public-private partnership. They stressed that machismo, homophobia, and transphobia are strongly held attitudes in the general population, making stigma a formidable barrier to dealing effectively with HIV/AIDS. In Panama, a key informant said that the media manipulates MARPS and makes them look ridiculous ("los ridiculiza"), proposing that more work needs to be done to sensitize journalists and educate key populations about how to use the media more effectively.

Other constraints identified by respondents included a **shortage of persons with monitoring and evaluation** skills in most countries. Similarly, there is very little monitoring of HIV policy implementation by civil society, which is divided among itself and competing for project funds from donors and governments. The **lack of political will** to address HIV in a comprehensive manner was explained as a reflection of cultural attitudes in the general population. Informants pointed out that there are deeply held cultural attitudes in the general population against homosexuality as well as a persistent popular belief that HIV is punishment for a "deviant" life style. Public figures are reluctant to go against public opinion on the issue and fear being perceived as gay themselves if they speak out. In Guatemala, respondents reported that although technical staff from the Ministry of Finance and Congress are supportive of efforts to address HIV, the top-level leaders in these organizations are not openly advocating for progress on HIV. A related constraint was identified as not enough public sector funding for HIV programs, and the inefficient allocation of funds. Financing of programs does not generally follow the evidence on the epidemic, but rather is swayed by political imperatives. As a result, all countries reported **inadequate funding for work with key populations.**

Respondents also talked about the **dual nature of acceptance of sexual diversity** in the region as a constraint to implementation. They reported that people tend to publicly reject the idea of sexual diversity, bowing to what they perceive is the norm or expected attitude, but in private, they often are very accepting of loved ones who are gay or MSM. Informants noted that this private acceptance, however, does not generally extend to transgender people. For their part, and quite publicly in many cases, **socially conservative Ministers of Education** in the region constrain advances on implementing comprehensive sexual education that discusses sexual diversity.

Concerns about the validity of the evidence on HIV prevalence among different populations were raised by a variety of informants in multiple countries. MSM advocates and others pointed to the **widespread testing of pregnant woman** in Central American countries. They raised the possibility that the "feminization of the epidemic" is not as pronounced as women's advocates would have everyone believe. Instead, the decreases in the male-female ratio for new infections may reflect the skewed application of testing toward woman, while key populations including transgender women, sex workers and MSM go largely untested. As a result, respondents said, the **data may be overstating the degree to which HIV affects women relative to MSM** and others. Until this question is answered systematically, the debate will continue to divide women's advocates and MSM and transgender advocates, pitting them against each other and diluting their ability to be part of an effective response to HIV in their countries.

Two final constraints were identified in the interviews. **Access to services is available in most countries *for those who know* their HIV status**; but many people living with HIV do not know their status and are unlikely to go for testing or other services. **Complacency** was noted as a major concern for the successful implementation of HIV policy. Old civil society activists are tired from years of advocacy; they achieved universal access to medications, and now they are more interested in resting than in tackling the complex issues that continue to drive the epidemic's spread. Governments are providing universal access, consider that to be sufficient, and are not eager to obligate more resources to HIV when they have more pressing issues, like chronic disease, to address. Lastly, the younger generation of leaders representing key populations lacks the sense of urgency that drove their predecessors to learn how to excel at policy dialogue and policy advocacy.

*Links with Health System Strengthening(HSS) and Strategic Information*

**Health sector reform** in the region was identified as an important opportunity to advance HIV policy, to ensure its operationalization at the decentralized level. Key informants in Honduras, in particular, raised the issue of health sector reform. In other countries, respondent comments related to HSS focused more on the limited access to HIV-related services outside of the capitol city, low awareness at the subnational level of national laws and policies, and the **lack of implementation guidance for subnational** authorities charged with implementing national policy. Others mentioned the need for *vigilancia* (citizen monitoring) and sharing of successful approaches at national and subnational levels.

Respondents rarely commented directly on the topic of strategic information, but many pointed out that national and subnational level **decisionmaking often is driven by political imperatives rather than epidemiological data**. They pointed to the need for increased local capacity to use and analyze data. A common theme across countries was the burden of multiple indicator data collection exercises, some of which are required for donors and others for national purposes. Respondents noted that such indicator exercises need to be streamlined and more strategic, to reduce the reporting burden on poorly resourced public sector and civil society organizations. A regional expert noted that data from studies conducted by CDC in the region are not available to local decisionmakers in a timely way because they first must go through a lengthy review process in Atlanta. It would be beneficial for the region for this data to get to the to end users more quickly, with results disseminated back to the populations that were studied, along with suggestions of how to use the information appropriately.

*Sustainability and Collaboration*

A common theme from key informants across the region was the "**culture of dependency**" on donor funding, especially for prevention programs. Some respondents noted that governments seem comfortable with donor's help on prevention programs but they are slow to bring their own funds to this work, even seeming disinterested in the topic. Many reported a **lack of awareness and planning for expected Global Fund phase-out** or funding prevention activities in future, and no recognition that **prevention is needed now to keep treatment costs down in the future**. Respondents reported that country governments do not seem to be assuming ownership of the full range of programming (prevention, BCC, non-routine data collection), even though this is a necessary step for sustainability of the response to HIV. Instead, they have focused on providing universal access to treatment (and on testing for pregnant women), but without what many informants consider a sustainable plan to continue providing it in the future.

**Stock-outs of ARVs and supplies for CD-4** were identified as a problem in most countries –most prominently in Panama —attributable to **poor systems management, planning and procurement processes and a lack of budget**. Medical personnel talked about the detrimental effects on adherence, resistance, and viral load and the implications for a spike in new infections. Implicit in the concern about resistance is the potential high cost of needing to go to second or even third line drugs which cost considerably more than first-line ones, and particularly in Panama where several informants mentioned the already high cost the government is paying for medications. Activists criticized governments for touting 'universal access' and not providing it, and blamed a lack of political will. One informant in Panama saw the stock-out as a result of stigma and discrimination against the most-affected populations, citing a lack of commitment on the part of officials who "don't care whether they (KPs) get their medications or not." Other factors mentioned included long bureaucratic processes, corruption, and pharmaceutical special interests. Respondents pointed to the **inflated prices often paid for medicines**, blamed on last minute ordering, such that less money was available for other public sector HIV services and programs. Others indicated corruption and less-than-transparent procurement processes. While Central American countries are negotiating prices for ARVs as a block, they often order separately, increasing the final price paid. These problems were identified as causes for concern about whether country governments can truly provide universal access over the long-term, particularly when they have to pay for other programs currently covered by donor funds.

With the exception of El Salvador, where collaboration between the public sector and civil society was reported as a model for the region, most countries reported the need to improve collaboration between these two sectors. Respondents identified **weak public-civil society collaboration** as a barrier to more effective implementation of policies: while the public sector and civil society each have reasonably good levels of collaboration with donors and their implementing partners, they do not work with each other as well. They suggested that donors, including USAID, are in a position to help build this bridge: to strengthen the working relationship between the public sector and civil society organizations.

Recognizing that USAID funds will not be around forever, several informants stressed the **need to transfer the technical expertise of PASCA country teams to local actors**/institutions (e.g., universities, NGOs, public sector technical staff) as part of sustainability planning. PASCA is given a lot of credit for

driving policy change, and informants want to see country counterparts assume the PASCA role now, in advance of any phase-out of assistance.

*Regional Model for USAID's Assistance on HIV Policy*

About half of respondents commented on the use of a regional platform for USAID's assistance on HIV policy in Central America (i.e., PASCA). They discussed the **value-added of the regional model**, especially for working with the business sector as businesses like to exchange ideas and best practices with others in the region ("strength in numbers" and a healthy sense of competition). They also highlighted the value of the MEGAS (National AIDS Spending Assessment) exercise at the regional level, which allowed countries to measure themselves relative to their neighbors. Several respondents acknowledged the **economies of scale** that a regional platform offered to USAID, freeing up more resources for programs in the field. Some noted their country was open to horizontal cooperation and sharing and adopting successful experiences across countries (Panama for example), while others mentioned El Salvador as a model in the region for social inclusion, respect for sexual diversity and attention to transgender women and HIV. The regional platform was recognized as providing opportunities for such **cross-country sharing of best practices**.

Informants often remarked, however, that they **want to be able to pick and choose from a "menu"** rather than implementing a full set of results in a regional platform. They expressed a preference to focus on one or two key areas, going deeper in those areas and really making a difference. They noted that the program cannot be the same for all countries, that the response and needs vary according to the country context. As one respondent said, "**One size does not fit all**." Informants did not seem to know that the current project has flexibility to tailor its technical assistance to country needs. Rather, as some informants said, they accept what is proposed by PASCA, even if they do not think it is the priority, because they perceive it as a prerequisite for receiving any support. A commonly heard remark was that PASCA is "**spread too thin**," or "doing too much with limited resources." Key informants want to see the project continue as long as possible, but with a more **streamlined focus and concentrating** its efforts on what will have the most impact.

In both Belize and Costa Rica, several key informants commented that PASCA's approach, and donor aid in the region in general, does not fit the needs of the country, that they have other needs. For example, respondents in Belize pointed out that, in contrast to other Central American countries, Belize has very basic needs, like obtaining viral load tests, creating a culture of an engaged, independent civil society and addressing levels of homophobia comparable to those seen in the Caribbean. As one respondent noted, "Central America is ahead of Belize! We lack the data for models, so we can't do the same modeling exercises. We need a different program of activities."[15] In Costa Rica, respondents felt that because they receive so little donor support, that they have different needs than other countries, particularly with regards to technical support and capacity building. In particular, several respondents mentioned building capacity for monitoring, evaluation and information systems, noting that "no vamos a poder avanzar en la toma de decisiones o en planificación estratégica sin tener información buena". These comments were

[15] A dissenting voice in Belize saw the differences as a good thing: "Being part of the regional program is very helpful on LGBT issues, because Central America is so far ahead that it gives support to LGBT advocates here in Belize."

not universally stated by all informants in the two countries, but they were repeated enough that they warrant reporting here.

*PEPFAR Partnership Model*

There were divided opinions regarding the Partnership Framework (PF). While some said that it imposed another layer of reporting and bureaucracy and did not recognize the strength of national strategic plans already in place, others commented that the PF **provided space for dialogue** among donors on gaps and contributed to **better integration of effort, particularly across USG agencies**. Some informants said that the PF served to make each country more aware of its responsibilities in HIV and to increase the clarity and focus of efforts and the use of strategic information. Respondents gave credit to the PF for being systematic and logical but did not think it has had much impact at the operational level.

Although only about one-fourth of all respondents commented on the PF at all, several discussed the "**Sign and Forget Syndrome**," where a government minister or official signed the PF in order to access USG funds, but then promptly forgot about it. Similarly, the PF often is considered "someone else's commitment," having been signed by a previous minister or official who has since left office. Key informants believed that both of these problems reflected what they perceived as a l**ack of investment by PEPFAR in building a sustained relationship** with the PF counterparts. More than one person remarked that PEPFAR officials made a big "show" at the signing of the framework, and then appeared again only once a year to ask for the indicators they need to report to Washington. The final set of generally observed comments on the PF related to indicators. Key informants considered the PF indicator exercise to be extra work, duplicative of the country's own indicator exercises, and reflecting a **lack of respect** by PEPFAR for the country's own strategic plans. Respondents did not believe the PF had increased countries' sense of ownership of the programs funded by PEPFAR in the region.

## IV. GAPS IN POLICY FRAMEWORK AND RESPONSE

Respondents identified several areas where the current policy framework and response is inadequately addressing the epidemic. These gaps are categorized according to the three components of the policy environment: Structure, Implementation and Participation.

*What? Structure*

**Human rights:** Current laws and policies in many countries in the region are not clear or explicit about the basic human rights that apply to key populations, like LGBT and sex workers. The population in general in these countries often is not sensitized to the fact that LGBT and sex workers should enjoy basic human rights that must be respected. Key populations themselves may be unaware of their rights or not empowered to demand them. The situation is exacerbated for transgender women, for whom the lack of gender identity laws makes them vulnerable to abuse and severely limits their access to employment and education.

**Youth:** There are high rates of risky sex behaviors and pregnancy in adolescents, many of whom also have HIV and/or other STIs, and are victims of abuse. Key informants noted that little work, in the policy

arena or anywhere else, is being done to address HIV among youth. Yet, they pointed out that the rate of HIV infection in this group is trending upward in the region: "We see more and more young people getting HIV." Rates of HIV are estimated to be highest among transgender youth, who are the most vulnerable to physical and sexual violence and other forms of abuse. Respondents across the region highlighted the dismal situation of transgender youth, who routinely are thrown out of school & their family home at an early age, have few opportunities for employment other than sex work, and typically live in poverty. Although legally they are minors (children), government programs do not afford them protected status, at least in practice, and they are not able to access government support that might be available to other homeless children. Informants also pointed to a gap in programs aimed at changing attitudes among youth about acceptance/inclusion, stigma and discrimination, gender norms and risk reduction in sexual behavior.

**Gender-based Violence:** Low levels of awareness and scarce data about the link between GBV and HIV mean that current policy frameworks pay little or no attention to this issue. Informants across the region reported a general lack of recognition of GBV against MSM and transgender women, in spite of high-level attention to violence against women. GBV is largely seen as a women's issue in the region, where violence against women was described as "frequent." Women are at risk of violence from their husbands or partners; the risk is particularly high for HIV+ women and for female sex workers. Female sex workers and transgender women are at high risk of abuse from police as well. Gender-based violence among transgender women in the region is a daily experience, rarely reported and even more rarely prosecuted. It is considered to be a significant factor driving the high rates of HIV among transgender women, with perhaps 1 in 4 infected in the region. Transgender women in prisons face horrendous abuse, no access to condoms to protect themselves, and little recourse to justice. Protocols for post-exposure prophylaxis are not well-disseminated, and there frequently is poor or no access to PEP for LGBT and prison inmates who are victims of sexual violence. Informants pointed out that an effective response to GBV and HIV must include the police and military, as first-line responders and often perpetrators, in addition to the judiciary and prison systems.

**Underserved Minorities**: New cases of HIV are being diagnosed in populations which have been traditionally considered of low risk, such as the handicapped, senior citizens, and certain indigenous groups with limited access to services (in the words of one expert: "Tardó 20 años, pero la epidemia ya está llegando a ellos." Informants noted that it is important to find mechanisms to reach out to these groups with HIV information and prevention messages. Additionally, prison inmates were identified across the region as being at special risk for HIV and having few or no protections under the law or in practice.

*How? Implementation*

**Creating political will:** Considering the lack of political will to implement HIV policy in the region, many informants mentioned the need to work on sensitizing or raising the consciousness (*sensibilización*) of public officials. In general, health ministers and officials are sensitized, but leaders in other sectors are not and tend to dismiss HIV as a "health problem." Even among health leaders, however, advocates for HIV need to make more effective arguments about why HIV should get attention and resources when other health priorities are pressing in the region (e.g., high rates of diabetes and blood pressure in Belize and elsewhere). While policymakers may express their support for HIV, it does not always translate into

funding ("*la voluntad es superficial*"). Efforts to foster political will on HIV have to be constant since public officials and governments change regularly. Respondents regarded sensitization of key decisionmakers, particularly outside of the health sector, as a necessary step to obtain funding to implement the multisectoral national strategic plans on HIV.

**Citizen monitoring** (*vigilancia de implementación*): Policy implementation is influenced to a great degree by how effective the champions for that policy are at holding the government accountable for what it has promised in the policy. Informants across the region pointed to the lack of citizen monitoring – a lack of holding governments to their promises – and identified it as a problem for implementation of current policy. Some attributed this to poor levels of knowledge and dissemination of HIV-related policy, outside of the key actors in the field of HIV.

*Who? Participation*

**Multisectoral engagement and collaboration:** The lack of a sufficiently strong country authority on HIV/AIDS -one that can coordinate donors' efforts and obtain the participation of the full range of non-health sector actors needed to implement the national strategic plan- was identified across the region as the principal gap related to participation. Informants pointed out that while national AIDS commissions exist and have multisectoral representation, in practice, these bodies are health-focused and the other sectors do not feel responsible for HIV. Strengthening the skills and authority of the national AIDS commissions (NAC, CONASIDA) remains a large gap in the response.

## V. RECOMMENDATIONS

The assessment yielded a clear set of recommendations to USAID as it designs the next stage of HIV policy assistance in the region. The recommendations are grouped according to areas in need of continued support, new priorities for support and possible new partners to consider in the next phase of USAID's assistance in HIV policy in the region. The recommendations flow from the discussion of the current policy environment and gaps presented in Sections III and IV and, as such, are presented in bullet form. The supporting arguments for each can be found in the previous sections.

*Areas in Need of Continued Support*

1. Updating and alignment of laws and policies to address PLWH, LGBT, GBV and human rights, in HIV-specific as well as national policies

2. Advanced training and *acompañamiento* on advocacy and policy dialogue for civil society and public sector organizations, including efforts to foster a bottom-up (community-based) response

3. Sensitizing public officials in non-health sectors, reframing HIV as a development issue and highlighting its relevance to each sector. These efforts should include taking advantage of international conferences of the PAHO/WHO, OAS, IDB and others, that offer opportunities for discussion and agreements on HIV policy with leaders outside of the health sector.

4. Skills building on M&E for the public sector, recognizing that a small number of M&E experts in each country are stretched very thin across all sectors.

5. Data Demand & Use (DDU) capacity building and related issues, including (a) matching data to decisionmakers - linking data and decisions and understanding why data-based decisions are important, (b) skills building on how to present data well, so decisionmakers can easily digest it and see its relevance to their particular area of concern, and (c) faster approval and dissemination of CDC-funded studies in the region, such that the data gets to end users more quickly and the results disseminated back to the populations that were studied with suggestions of how to use the information appropriately.

*New Priorities for Policy Work*

1. Leadership building, including strengthening the national authority in countries to coordinate a multisectoral response (CONASIDA, NAC) and the leadership skills of the next generation of civil society actors

2. Citizen monitoring/*vigilancia* of policy implementation and human rights violations, including sustained training on human rights for MARPs and working more closely with ombudsmen and other existing institutions (like the reproductive health observatories in some countries)

3. Helping countries prepare for donor phase-out, including how to fund prevention programs for key populations; sustaining funding of HIV programs even while chronic diseases like diabetes and high blood pressure gain more attention and compete for funds; and strengthening host country skills and commitment to strengthening the policy environment

4. Systems management and procurement processes for ARVs, tests and other medical supplies

*Potential New Partners*

1. Youth organizations and ministries

2. Police and prison management organizations, Ministry of Governance

3. Human Rights Commissions *(Procuraduria de DDHH)*, Ministries of Justice

4. Congressional leaders, especially to address human rights

5. Business executives, owners and corporate boards, to go beyond human resource directors to those leaders who decide the direction companies will take on issues like HIV

6. Organizations working with underserved populations like specific minorities and senior citizens – including indigenous populations, where, as one donor noted, "*Tardó 20 años, pero la epidemia ya está llegando a ellos."*

## VI. INNOVATIVE APPROACHES TO CONSIDER

 Workplace wellness movement: A proven way of involving the private business sector is to engage them on issues that impact their bottom line: the productivity of their labor force and work days lost to illness or poor health. The global "workplace wellness" movement has taken root in Latin America in recent years and has proven a less controversial way of addressing reproductive health and HIV prevention and treatment in the workplace than standalone efforts on HIV workplace programs. For one example, see the write-up on the Mexico Workplace Wellness Council, at http://alliance.weforum.org/Case-Studies/case-study-council.htm. Also see the article, "Empresas Saludablemente Responsables," published in Expansión, 9-22 de Julio, 2012 (www.cnnexpansion.com.mx).

 Contraceptive security in LAC: The LAC contraceptive security regional initiative, funded by USAID for the last decade, supported an array of promising practices that can help to guide the secure procurement of HIV medicines and gender-aware services in LAC. As country partners confront the reality of the end of Global Fund money for HIV work in the region and the likely scenario that several governments will not pick up the gap in funding for HIV prevention programs with MARPs, a transitional strategy is needed. Several countries are already experiencing stock-outs of antiretrovirals (ARVs) and have much to learn from how family planning transitioned from donor funds to being self-sufficient. Because HIV prevention in the LAC is focused on MARPs, it is laden with gender norms and gender-based stigma and discrimination, and as such, is subject to political winds and decisions based on something other than the evidence. Promising practices to look at in contraceptive security in the region include a USAID-supported pilot intervention in the Dominican Republic to engage civil society in advocacy for women's health, including gender equity as a principal goal, while in Guatemala, USAID co-funded efforts to create civil society-academia-congressional partnerships in the form of "observatories" (the OSARs, http://www.osarguatemala.org/) to monitor implementation of laws, policies and budget allocations related to family planning and secure supplies of contraception in the face of stiff opposition to family planning from conservative political and religious leaders. [Excerpted from: Giannoni, Tonya, N. Diamond, M. Kincaid and D. Lallement. 2012. USAID Regional LAC Regional Sustainable Development Office Gender Assessment. Washington: DevTech Systems]

 Private sector expertise: During the interviews for this assessment, a respondent suggested that governments and their partners involve the private business sector in two activities where the business sector has significant expertise: negotiating ARV prices and identifying ways to improve procurement systems. While the team did not find any examples of this kind of collaboration, it warrants further investigation, as a very promising approach. It also would respond directly to comments from private sector key informants who stressed that the private sector is not being fully utilized in the response to HIV in the region, and that they would like to do more.

 National sustainability or "graduation" plans: As USAID phased out family planning programs in the LAC region during the 1990s and 2000s, including social marketing of contraceptives, it used a "graduation plan" approach to help countries prepare during the transition. An important lesson from the family planning experience is that all parties must be fully engaged in the design of the plan, and take ownership of the plan including benchmarks for progress, or the plan will be quickly forgotten and not useful to those intended to benefit from it.

- Citizen monitoring approaches: USAID supported the development and testing of an approach to engage citizens in monitoring the quality of health services for HIV in Mali and Vietnam. The approach built on earlier models such as the Multisectoral Citizens Groups (MCGs) in Mexico (multisectoral coordination bodies at the decentralized (state) level that advocated for HIV budgets at the state level); reproductive health and rights monitoring programs in Peru; and Guatemala's engagement of citizen groups in monitoring the implementation of the peace accords and then of family planning laws (the OSARs). For more details, see: http://futuresgroup.com/newsroom/news/futures_group_world_aids_day_2010_special_publication and http://pdf.usaid.gov/pdf_docs/PDACS820.pdf

- Involvement of public figures: Political, business and religious leaders as well as celebrities and sports figures in various countries have been involved in national testing days for HIV and other public campaigns to raise awareness of HIV and to reduce HIV-related stigma (South Africa, Swaziland, Botswana). Similar approaches have been used to raise awareness about gender-based violence and violence against women (e.g., the subway photo campaign showing models and celebrities with bruised faces in Mexico and the USA). Such high-profile campaigns are useful to give short-term boosts to complement sustained education and awareness raising programs (e.g., the huge spike in calls to the National AIDS Hotline in the USA when basketball player Magic Johnson publicly announced he was HIV positive). See for example: http://www.aidshealth.org/archives/news/partners-hope-to-make-hiv and http://opim.wharton.upenn.edu/risk/library/WP2012-02_RiskCtr_YouthAIDS-PSI.pdf

- Data use and demand (DDU) approaches: The many lessons learned from the USAID Measure Evaluation Project, among other USAID-funded interventions, point to the value of DDU approaches to influence policymakers and promote evidence-based decisionmaking. For details on these approaches, see http://www.cpc.unc.edu/measure/tools/data-demand-use.

- Regional events provide an opportunity for stakeholders to share best practices within and across sectors and allow for South-to South exchanges on country ownership and sustainability. Key informants in the assessment frequently pointed the valuable exchanges and positive outcomes stemming from the private business sector forums that PASCA has organized in recent years.

| Country | Law | National Policy[16] | Strategic and Operational Plans |
|---|---|---|---|
| Belize | none | National HIV/AIDS Policy. Belize 2006 | Getting to Zero. Belize HIV Strategic Plan 2012 - 2016. and Getting to Zero. Belize HIV Operational Plan 2012 - 2014. |
| Costa Rica | Ley General Sobre el VIH/SIDA (29 de abril de 1998) | Política Nacional de VIH y Sida. Costa Rica, 2007 | Plan Estratégico Nacional de VIH. 2011-2015 |
| El Salvador | Ley y Reglamento de Prevención y Control de la Infección Provocada por le Virus de Inmunodeficiencia Humana (23 Noviembre 2001) | Política de Atención Integral a la epidemia de VIH/Sida. El Salvador, 2007 | Plan Estratégico Nacional Multisectorial de la respuesta al VIH-Sida e ITS (2011-2015) |
| Guatemala | Ley General para el combate del VIH y SIDA y la Promoción, Protección y Defensa de los Derechos (26 junio 2000) | Política pública 638-2005. Respecto de la Prevención a las infecciones de transmisión sexual –ITS- y a la respuesta a la epidemia del síndrome de inmunodeficiencia adquirida –sida-. Guatemala 2005 | Plan Estratégico Nacional 2011 - 2015 para la prevención, atención y control de ITS, VIH y Sida. Guatemala, junio 2011. |
| Honduras | Ley Especial Sobre VIH/SIDA (30 septiembre 1999) | none | Plan Estratégico Nacional: Honduras (2008-2012) |
| Nicaragua | Ley de Promoción, Protección y Defensa de los Derechos Humanos ante el SIDA (14 octobre 1996) | Política Nacional de Prevención y Control de ITS, VIH y Sida. Nicaragua, 2006 | Planes Estratégicos Nacionales: Nicaragua (2006 - 2010) |
| Panama | Ley SIDA Panama Ley Promocion, Protection y Defensa de los Derechos Humanos ante el SIDA (5 enero 2000) | Política Pública Nacional sobre VIH y Sida. Panamá 2008 | Plan Estratégico Multisectorial (2006-2010) (approved in 2007) |

[16] http://www.pasca.org/content/pol%C3%AD%C2%ADticas-nacionales-y-sectoriales

In order to gather the information required to meet the objectives of the assessment, Iris Group used a combination of document review and key informant interviews with stakeholders throughout the region.

Document Review: The team reviewed publicly available documents related to the PASCA project, including work plans, annual reports and results reporting. Country-level government strategies on HIV, documents related to the Global Fund, the USG Partnership Framework for Central America, and donor and foundation publications and reports related to HIV and policy were also reviewed. The document review informed the interview process in each country, as well as the analysis stage and identification of recommendations. See Annex H for a full list of documents consulted during the assessment.

Key Informant Interviews: The team conducted a total of 101 interviews in seven countries (40 men, 61 women; (averaging 12 interviews per country) with representation from four key sectors: public, civil society, private/business and donors. Non-health sector key informants in the public sector included Ministries of Labor, Family, Education, Social Development, Social Inclusion, Gender, and Human Rights Defender's Offices. Civil society key informants were drawn from advocacy and service delivery organizations, organizations representing key populations and organizations of persons living with HIV. Private sector representatives were identified from among those firms currently collaborating with PASCA on HIV business councils, workplace initiatives or similar expressions of interest in HIV and businesses. Donors included UNAIDS, other multilateral and bilateral donor agencies and large foundations active in the region on HIV issues. Iris Group reviewed lists of key stakeholders that USAID compiled, as well as received suggestions from the PASCA team, and vetted the proposed list of key informants with USAID before commencing the interviews. Iris Group sent out requests for interviews by email, attaching a letter of introduction from USAID/Guatemala in order to improve the odds of obtaining a positive response to the request for an interview.

The team followed interview guides to ensure consistency in the type of information gathered across countries, allowing for cross-country comparisons and aggregation if warranted and appropriate. The wording of the interview guides was tailored to each sector, but all sought to answer the three main research questions of the assessment:

1. What is the current policy environment and current response to HIV/AIDS in Central America?

2. What, if any, gaps exist in the policy environment and response in the region, and what new or innovative approaches could be used to further improve the policy environment?

3. In light of policy-related interventions already in place or planned through host country governments, donors and other stakeholders, where should the USG program on HIV in the region invest its resources on HIV policy during the 2013-2018 period?

The interview guides relied on open-ended questions to facilitate thoughtful dialogue during the interviews. The guide used with public sector and international cooperation agencies (donors and implementing partners) was tailored for use with civil society organizations and again for use with private sector informants. For the full versions of each interview guide, see Annex C .

Interviewers took notes throughout the interviews and, if the informant signed a consent form agreeing to it, their interview was recorded in order to be able to cross-check information and identify illustrative quotes during the analysis phase. In-person interviews were conducted in Guatemala (#), Panama (#), Honduras (#) and El Salvador (#), while phone or Skype call interviews were conducted with key informants in Belize (12), Costa Rica (#), Nicaragua (#) and the US (#). All of the interview tapes and notes were kept confidential, as outlined in the research protocol. The consent form is attached as Annex D.

Data analysis – Upon completion of the interviews, the team used manual qualitative coding methods to code the interview notes vis-à-vis the key research questions, and review the results to identify and categorize common themes. As part of the analysis, the team identified and prioritized the factors that facilitated improvements in the HIV policy arena in the region during the last five years, as well as any gaps in the policy response. In addition, the team identified barriers to implementing policy activities in the region and in individual countries. The analysis of findings guided the formation of recommendations for future work. Summary tables of the findings, with supporting illustrative quotes (identified only by category of respondent), are contained in Annex E.

Presentation of findings – The assessment team prepared a PowerPoint presentation detailing the findings of the assessment and recommendations in order to facilitate a discussion to validate the findings and recommendations prior to submitting the draft assessment. The team leader and senior consultant delivered the presentation in-person at a briefing for the USAID/Central America Region health team in Guatemala City on October 4, 2012.

Final Report – The report of the assessment, in English, was submitted in draft to USAID for review during October 2012, revised and then submitted in final. An executive summary of the report was prepared in Spanish for distribution by USAID to country stakeholders.

| Week | Dates | Tasks |
|---|---|---|
| 1 | July 30-Aug 3 | -Prepare and submit workplan, timeline and team composition |
| 2 | Aug 6-10 | -USAID review of deliverables<br>-Prepare list of key informants<br>-Gather documents for review<br>-Country clearance requests |
| 3 | Aug 13-17 | -Document collection<br>-Preparation of key informant interview guides and stakeholder meeting discussion guides<br>-Logistical arrangements for country visits (request meetings, travel arrangements) |
| 4 | Aug 20-24 | -Document review<br>-Preparation of key informant interview guides and stakeholder meeting discussion guides<br>-Logistical arrangements for country visits (request meetings, travel arrangements) |
| 5 | Aug 27-31 | -Document review<br>-Logistical arrangements for country visits (request meetings, travel arrangements) |
| 6 | Sep 3-7 | -TDY to Guatemala (Kincaid, Fortune-Greeley, Alvey) for in-briefing with Mission and key informant/stakeholder meetings |
| 7 | Sep 10-14 | -TDYs to Panama (Alvey), Honduras (Fortune-Greeley) and El Salvador (Kincaid) for key informant/stakeholder meetings |
| 8 | Sep 17-21 | -Skype interviews (Kincaid and Fortune-Greeley) with stakeholders in Belize, Nicaragua and Costa Rica<br>-Systemization and analysis of interview data<br>-Submit outline of final report to USAID, with table of contents, initial findings and challenges and opportunities |
| 9 | Sep 24-28 | -Analysis and report writing<br>-Preparation of presentation |
| 10 | Oct 1-5 | -TDY to Guatemala (Kincaid) to present and validate findings with USG PEPFAR team and other stakeholders as requested by USAID<br>-Submit draft report to USAID on October 5 |
| 11 | Oct 8-12 | -USAID review of draft report |
| 12 | Oct 15-31 | -Receive USAID comments and revise draft accordingly<br>-Submit final report to USAID on October 31 |

**INTERVIEW GUIDE - PUBLIC SECTOR AND DONORS/CAs**

**Policy Assessment of HIV/AIDS in Central America**

Informant's Name: _____

Title: _____

Organization/Country: _____

Date: _____

Consent granted to tape record the interview? ___yes ___ no

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*Briefly summarize the objectives of the assessment as follows:*

*USAID's Regional Program for Central America has contracted us to conduct an assessment of the policy environment and response to HIV/AIDS in the region. The results of the assessment will help shape the next USG strategy for assistance in the region on HIV policy. Specifically, we are interested in the following three questions (which are laid out in the email request for the interview):*

1. *What is the current policy environment and policy response to HIV/AIDS in Central America?*
2. *What, if any, gaps exist in the policy environment and response in the region, and what new or innovative approaches could be used to further improve the policy environment?*
3. *In light of policy-related interventions already in place or planned through host country governments, donors and other stakeholders, where can the USG program on HIV in the region most effectively invest its resources on HIV policy during the 2013-2018 period?*

*Explain that this is not an evaluation of current programming, but rather an exercise to collect information about the current situation and identify recommendations for future interventions.*

*Note that they have been selected for the interview because they are recognized as a thought leader and stakeholder in the field of HIV in the region. Emphasize that we very much appreciate their participation in the assessment, and we ask that they speak frankly about their observations and opinions.*

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**Part A: What is the current policy environment and policy response to HIV/AIDS in Central America?**

1. (a) Has current policy -laws, national policies/plans, institutional policies- been effective in guiding the response to the HIV epidemic in the region? In your country? In other words, has it been implemented and with the intended consequences? How so?
   (b) Has it adequately addressed key HIV-related issues such as stigma and discrimination, gender inequality, LGBT rights, GBV, key populations and prevention? To what extent and how? *Use the table below to prompt/guide the discussion across categories of policy/associated factors, and the key issues*

To what extent are the issues addressed in each category: rank as **High/Med/Low, none**

| Key Issue / Category | S&D | Gender | LGBT | GBV | Key pops | Prevention | HSS, Cap Bldg |
|---|---|---|---|---|---|---|---|
| **Laws, constitution** | | | | | | | |
| **Nat'l policy or plans** | | | | | | | |
| **Norms, instit. policies** | | | | | | | |
| **Indicators, M&E** | | | | | | | |
| **Budget line, $ allocated** | | | | | | | |
| **Political will** | | | | | | | |
| **Internal champions (govt)** | | | | | | | |
| **External champions (NGO, private sector, donors)** | | | | | | | |

2. To what extent were the objectives of existing HIV-related policies achieved over the last 5 years? Are these advances sustainable? *Prompt for details.*
3. What were the main factors affecting the implementation of the policies? These might include something specific to an official policy/law (e.g., language, enforcement mechanism, specificity of the policy) and/or politically significant factors (change in leadership, skills of leadership, policy champions, internal or external advocates, changing socioeconomic or other conditions).
4. Are there any particular obstacles or constraints (barriers to implementation of policy) affecting the outcome of HIV policy work in the region/country? Would it be appropriate/effective for USG assistance to help remove these obstacles or constraints (barriers to implementation of policy)?

5. How do donors and donor-funded projects coordinate their assistance to avoid duplication of efforts? Is there a donor coordinating mechanism at the country level? Does it meet regularly? Is it effective? Is it sustainable?
6. Are all sectors – public, private, civil society and donors - working together effectively to implement HIV-related policy? Is the collaboration sustainable? Are there any areas where collaboration could be improved?

**Part B: What, if any, gaps exist in the policy environment and response in the region, and what new or innovative approaches could be used to further improve the policy environment?**

7. Are there any gaps in the policy environment? Do policies adequately address stigma and discrimination related to HIV? *(use table from Question 1 above to prompt discussion as needed)* LGBT rights? GBV? Gender equality? Prevention among key populations?
8. What would improve the situation/fill the gaps? Can you suggest any new or innovative approaches?
9. Are there any new priorities for HIV-related policy in your country? In the region?
10. Are you aware of any initiatives planned by the government or international organizations/donors to address these gaps?

**Part C: In light of policy-related interventions already in place or planned through host country governments, donors and other stakeholders, where should the USG program on HIV in the region invest its resources on HIV policy during the 2013-2018 period?**

11. Do you have any recommendations to the USG regional program on HIV about where it can most effectively contribute resources to improve the policy environment over the next few years?
12. Do you consider current USG assistance in the area of HIV policy to be sustainable in your country? In the region? Have the Partnership Framework and the PEPFAR focus on country ownership increased the extent to which USG assistance supports your country's goals in this area?

## INTERVIEW GUIDE - CIVIL SOCIETY

### Policy Assessment of HIV/AIDS in Central America

Informant's Name: _____

Title: _____

Organization/Country: _____

Date: _____

Consent granted to tape record the interview? ___yes ___ no

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*Briefly summarize the objectives of the assessment as follows:*

*USAID's Regional Program for Central America has contracted us to conduct an assessment of the policy environment and response to HIV/AIDS in the region. The results of the assessment will help shape the next USG strategy for assistance in the region on HIV policy. Specifically, we are interested in the following three questions (which are laid out in the email request for the interview):*

1. *What is the current policy environment and policy response to HIV/AIDS in Central America?*
2. *What, if any, gaps exist in the policy environment and response in the region, and what new or innovative approaches could be used to further improve the policy environment?*
3. *In light of policy-related interventions already in place or planned through host country governments, donors and other stakeholders, where can the USG program on HIV in the region most effectively invest its resources on HIV policy during the 2013-2018 period?*

*Explain that this is not an evaluation of current programming, but rather an exercise to collect information about the current situation and identify recommendations for future interventions.*

*Note that they have been selected for the interview because they are recognized as a thought leader and stakeholder in the field of HIV in the region. Emphasize that we very much appreciate their participation in the assessment, and we ask that they speak frankly about their observations and opinions.*

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**Part A: What is the current policy environment and policy response to HIV/AIDS in Central America?**

1. (a) Has current policy -laws, national policies/plans, institutional policies- been effective in guiding the response to the HIV epidemic in the region? In your country? In other words, has it been implemented and with the intended consequences? How so?
   (b) Has it adequately addressed key HIV-related issues such as stigma and discrimination, gender inequality, LGBT rights, GBV, key populations and prevention? To what extent and how? *Use the table below to prompt/guide the discussion across categories of policy/associated factors, and the key issues*

To what extent are the issues addressed in each category: rank as **High/Med/Low, none**

| Key Issue / Category | S&D | Gender | LGBT | GBV | Key pops | Prevention | HSS, Cap Bldg |
|---|---|---|---|---|---|---|---|
| **Laws, constitution** | | | | | | | |
| **Nat'l policy or plans** | | | | | | | |
| **Norms, instit. policies** | | | | | | | |
| **Indicators, M&E** | | | | | | | |
| **Budget line, $ allocated** | | | | | | | |
| **Political will** | | | | | | | |
| **Internal champions (govt)** | | | | | | | |
| **External champions (NGO, private sector, donors)** | | | | | | | |

2. What were the main factors affecting the <u>implementation</u> of the policies? These might include something specific to an official policy/law (e.g., language, enforcement mechanism, specificity of the policy) and/or politically significant factors (change in leadership, skills of leadership, policy champions, internal or external advocates, changing socioeconomic or other conditions).
3. Are there any particular obstacles or constraints (barriers to implementation of policy) affecting the outcome of HIV policy work in the region/country? Would it be appropriate/effective for USG assistance to help remove these obstacles or constraints (barriers to implementation of policy)?

4. Are all sectors – public, private, civil society and donors - working together effectively to implement HIV-related policy? Is civil society being fully involved and utilized to address the epidemic? Are there any areas where collaboration could be improved?

**Part B: What, if any, gaps exist in the policy environment and response in the region, and what new or innovative approaches could be used to further improve the policy environment?**

5. Are there any gaps in the policy environment? Do policies adequately address stigma and discrimination related to HIV? *(use table from Question 1 above to prompt discussion as needed)* LGBT rights? GBV? Gender equality? Prevention among key populations?
6. What would improve the situation/fill the gaps? Can you suggest any new or innovative approaches, particularly related to the role that civil society can play?
7. Are there any new priorities for HIV-related policy in your country? In the region?
8. Are you aware of any initiatives planned by civil society to address these gaps?

**Part C: In light of policy-related interventions already in place or planned through host country governments, donors and other stakeholders, where should the USG program on HIV in the region invest its resources on HIV policy during the 2013-2018 period?**

9. Do you have any recommendations to the USG regional program on HIV about where it can most effectively contribute resources to improve the policy environment over the next few years?

**INTERVIEW GUIDE - PRIVATE SECTOR**

**Policy Assessment of HIV/AIDS in Central America**

Informant's Name: _____

Title: _____

Organization/Country: _____

Date: _____

Consent granted to tape record the interview? ___yes ___ no

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*Briefly summarize the objectives of the assessment as follows:*

*USAID's Regional Program for Central America has contracted us to conduct an assessment of the policy environment and response to HIV/AIDS in the region. The results of the assessment will help shape the next USG strategy for assistance in the region on HIV policy. Specifically, we are interested in the following three questions (which are laid out in the email request for the interview):*

1. *What is the current policy environment and policy response to HIV/AIDS in Central America?*
2. *What, if any, gaps exist in the policy environment and response in the region, and what new or innovative approaches could be used to further improve the policy environment?*
3. *In light of policy-related interventions already in place or planned through host country governments, donors and other stakeholders, where can the USG program on HIV in the region most effectively invest its resources on HIV policy during the 2013-2018 period?*

*Explain that this is not an evaluation of current programming, but rather an exercise to collect information about the current situation and identify recommendations for future interventions.*

*Note that they have been selected for the interview because they are recognized as a thought leader and stakeholder in the field of HIV in the region. Emphasize that we very much appreciate their participation in the assessment, and we ask that they speak frankly about their observations and opinions.*

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**Part A: What is the current policy environment and policy response to HIV/AIDS in Central America, particularly as related to workplace programs?**

1. (a) Has current policy (laws, national policies/plans, institutional policies) been effective in encouraging a business/workplace response to the HIV epidemic in your country? How so?
   (b) Does current policy adequately address key HIV-related issues such as stigma and discrimination, gender inequality, LGBT rights, GBV, key populations and prevention?
2. What were the main factors affecting the implementation of the policies in the private/business sector? These might include something specific to an official policy/law (e.g., language, enforcement mechanism, specificity of the policy) and/or politically significant factors (change in leadership, skills of leadership, policy champions, internal or external advocates, changing socioeconomic or other conditions).
3. Are there any particular obstacles or constraints (barriers to implementation of policy) to implementing workplace-based programs/policies related to HIV in the region/country? Would it be appropriate/effective for USG assistance to help remove these obstacles or constraints (barriers to implementation of policy)?
4. Are all sectors – public, private, civil society and donors - working together effectively to implement HIV-related policy? Is the private sector being fully utilized to help respond to the epidemic? Are there any areas where collaboration could be improved?

**Part B: What, if any, gaps exist in the policy environment and response in the region as regards the private/business sector, and what new or innovative approaches could be used to further improve the policy environment?**

5. Are there any gaps in the policy environment, particularly as related to the private/business sector? Do most/any companies have workplace policies adequately address stigma and discrimination related to HIV? LGBT rights? GBV? Gender equality? Prevention among key populations?
6. What would improve the situation/fill the gaps? Can you suggest any new or innovative approaches?
7. Are there any new priorities for HIV-related workplace policy/programs in your country?
8. Are you aware of any initiatives planned by the private/business sector to address these gaps?

**Part C: In light of policy-related interventions already in place or planned through host country governments, donors and other stakeholders, where should the USG program on HIV in the region invest its resources on HIV policy during the 2013-2018 period?**

9. Do you have any recommendations to the USG regional program on HIV about where it can most effectively contribute resources to improve the policy environment over the next few years?

**CONSENT FORM – HIV POLICY ASSESSMENT IN CENTRAL AMERICA**

*This research is being conducted by Mary Kincaid, Nancy Alvey and Hannah Fortune-Greeley of the Iris Group, under contract to USAID's Regional Program for Central America. We are inviting you to participate in this assessment because you are knowledgeable about the policy environment for HIV in the region.*

*The protocol involves a 30-45-minute interview conducted by Mary, Nancy or Hannah. The interview will take place in person or over the phone at a time convenient for you. You will be answering questions about what works well about the current policy environment for HIV in Central America, the gaps, if any, in the policy environment and response, and your thoughts about where the USG program on HIV should invest its resources during the 2013-2018 period.*

*With your permission, the interview may be audiotaped.*

___ I agree to be audiotaped during my participation in this study.

___ I do not agree to be audiotaped during my participation in this study.

*We will take all recommended procedures to keep your personal information confidential. To help protect your confidentiality, standard methods to protect privacy will be maintained. Your identity and your organizational affiliation will remain confidential. Only the researchers will have access to your name and your affiliation. Only the researchers will have access to the voice recordings, which will be identified by number, not name. Data will be securely stored with the researchers on a computer. Hard copies of data will remain in the locked cabinet in the office of the principal researcher. All data will be destroyed (i.e., shredded or erased) when their use is no longer needed. In all reports and articles about this research project, your identity will be protected to the maximum extent possible.*

| | |
|---|---|
| NAME | |
| SIGNATURE | |
| DATE | |

Table A: What? Structure

| Finding | Illustrative Quotes | Sector of Respondent |
|---|---|---|
| **Strong policy framework in place** | • *El marco está* | Public |
| | • *Bien enfocadas las politicas* | Donor/IP |
| | • *Sí existe, pero todavia esta debíl. Tenemos una nueva propuesta de ley que va a mejorar la respuesta.* | Public |
| | • *[Nuestro país], especialmente en la parte de protección social- ha tenido más avances.* | Donor/IP |
| **NSPs are overambitious** | • *Hay un plan estratégico nacional, muy trabajado, y que cubre todo lo que debe cubrir, incluso es demasiado ambicioso.* | Donor/IP |
| | • *La propuesta es buena, pero si el gobierno no lo asume…* | Civil Society |
| **Outdated laws and policies** | • *The national policy needs to be revised so that it includes all those things that have been emergent.* | Donor/IP |
| | • *Need to align the institutional policies of the government (housing, civil Service, military, police) with the curent HIV law and international codes and agreements. For example, the police require an HIV test to enter the force. (translated from Spanish)* | Public |
| | • *[La ley y la política nacional] se han desactualizados* | Donor/IP |
| | • *Se necesita actualización de la política* | Public |
| **Gender identity law** | • *En cuanto a población vulnerable, todavía no existen políticas públicas para estas poblaciones.* | Donor/IP |
| | • *Hace falta impulsar mucho mas a políticas que garanticen el aseguramiento del acceso universal a los medicamentos.* | Donor/IP |
| | • *In the policy, yes, [LGBT and gender issues] have been addressed, but when it came to operationalizing the policy is where some of it may be lost particularly as it relates to legislative reform and legislative changes that make it a more enabling environment for progress in those areas.* | Donor/IP |
| **HIV policy not linked to National** | • *En algunos casos la reglamentación no sigue la ley, por ejemplo, se pierde el concepto de la confidencialidad* | Private |

| Nicaragua | | | |
|---|---|---|---|
| **Name** | **Title** | **Institution** | **Sector** |
| Samira Montiel | Procadura Especial para la Diversidad Sexual | Procuraduría de Derechos Humanos | Public |
| Sobeyda C. Morales Mendoza | Coordinadora de Area | Ministerio de Educacion | Public |
| Carmen Olivares | Coordinadora de Programa de VIH | Ministerio de la Familia | Public |
| Enrique Picardo | Coordinador de Salud | Movimiento Comunal de Nicaragua | Civil Society |
| Norman Gutierrez | Executive Director | Centro de Educación para la Prevención del VIH | Civil Society |
| Maria Elena Davila | Referente Nacional | Red de Mujeres Trabajadoras Sexuales | Civil Society |
| Arely Cano | Directora | ASONVIHSIDA | Civil Society |
| Maria Consuelo Sanchez | Directora Ejecutiva | Asociacion Quincho Barrilete | Civil Society |
| Silvia Martinez | Coordinadora Nacional | REDTRANS | Civil Society |
| Álvaro Guerra Báez | Coordinador de la Comisión de VIH | Consejo Superior de la Empresa Privada | Private |
| Marianela Corriols | Health Specialist | USAID Nicaragua | International Cooperation |
| Anne Largaespada | Country Representative | PASCA | International Cooperation |
| Valeria Bravo | Asesora Oficial de Programa de VIH y sida | UNDP | International Cooperation |

| Costa Rica | | | |
|---|---|---|---|
| **Name** | **Title** | **Institution** | **Sector** |
| Carlos Valerio | | Defensoría de los Habitantes de la República | Public |
| Gloria Terwes | HIV Program Coordinator | CS SS | Public |
| Teresita Solano | Vigilancia ETS y VIH | MOH | Public |
| Rosa Maria Vargas | Jefe | Unidad de seguimiento de Indicadores de salud | Public |
| Alejandra Acuña | Jefatura Unidad Planificación Estratégica en Salud y Coordinadora de Conasida | MOH | Public |
| Gabriela Solano, Daria Suarez | Director | CIPAC | Civil Society |
| Lisbeth Taylor | Profesora catedrática | Univ. de CR | Civil Society |
| Karina Van Wijk | Coordinadora General | Defensa de niños y niñas internacional -DNI | Civil Society |
| Nubia Ordonez | Coordinadora | Grupo la Sala | Civil Society |
| Erika Linares | Directora de Inversion Social | Asociación Empresarial para el Desarrollo | Private |
| Ana Catalina Ramirez | Focal Point for HIV and Labor | ILO | International Cooperation |
| Mariela Garron | Country Representative | PASCA | International Cooperation |
| Laura Sanchez | Encargada VIH y sida | UNFPA | International Cooperation |
| Miriam Fernandez | Coordinadora Tecnica | PASCA | Cooperation |

| Honduras | | | |
|---|---|---|---|
| **Name** | **Title** | **Institution** | **Sector** |
| Justa Urbina | | MOH | Public |
| Olga Alvarado | Viceministra | Sec. of Youth | Public |
| Sandra Pinel | Directora, Redes y servicios | MOH | Public |
| Mayte Paredes | Apoyo Tecnico a VM, Riesgos Poblacionales | MOH | Public |
| Jose Zambrana | Director | Apuvimeh | Civil Society |
| Denis Martinez | Director | Asonapvsidah | Civil Society |
| Jheisy Torres | Asesora legal | COHEP | Private |
| Brian Husler, Karla Zepeda | National Director, Deputy director | Global Fund | International Cooperation |
| Rolando Pinel | Director | Aidstar I | International Cooperation |
| Juan de Dios Paredes | Director | ULAT | International Cooperation |
| Yadira Almodovar Diaz | Director | Aidstar II | International Cooperation |
| Kellie Stewart, Ritza Avilez | Health officer, HIV Specialist | USAID | International Cooperation |

| Regional | | | |
|---|---|---|---|
| **Name** | **Title** | **Institution** | **Sector** |
| Lucia Merino | Director/Chief of Party | PASCA | International Cooperation |
| Lucrecia Castillo | Program Officer for Health and HIV/AIDS, Central America Regional Program | USAID | International Cooperation |
| Britt Herstad | Regional HIV Advisor | USAID | International Cooperation |
| Lindsay Stewart | Senior Advisor on HIV/AIDS | USAID | International Cooperation |
| Zonia Aguilar | Subdirector | PASCA | International Cooperation |
| Enrique Zelaya | Country Coordinator for Mexico and Guatemala | UNAIDS | International Cooperation |
| Giovanni Meléndez | Especialista en Programas de Prevención | USAID | International Cooperation |
| Heidi Mimh | Regional Coordinator | PEPFAR | International Cooperation |
| Cesar Nuñez | Regional Director for Latin America | UNAIDS | International Cooperation |

## Guatemala

### Donors

| | | | |
|---|---|---|---|
| USAID | USAID | Lucrecia Castillo | Gerente de Programas |
| | USAID | Giovanni Meléndez | Especialista en Programas de Prevención |
| | USAID | Daniel Muralles | Health Officer |
| Multilateral | PAHO | Sergio Aguilar | Asesor para VIH |
| Multilateral | UNAIDS | Enrique Zelaya<br>Fernando Cano | Representante<br>Asesor en MyE |
| USAID Projects | USAID/PASCA | Lucía Merino | Directora Programa Regional |
| | USAID/PASCA | Jorge Luis Berger | Representante de País |
| | USAID/PASCA | Zonia Aguilar | Subdirector |
| | USAID PASMO | Edgar Orantes | Gerente de País |

### Public

| | | | |
|---|---|---|---|
| MOH | CONASIDA | Iris López | Coordinadora |
| Sec. of Planning | Segeplan | Lucrecia Corzantes for Lcda. Dora Coc | Dirección de Equidad |
| Ministry of Education | MINEDUC | Telma Miranda | Representante ante el MCP |
| MOH | Programa Nacional de Sida | Dra. Zonia Pinzón | Sub-directora del PNS |
| MOH | Programa Nacional de ITS, VIH y sida | Dr. Miguel Tó | Coordinador |
| CCM | MCP | Lic. Alvan Aleman | Presidente Junta Directiva |
| SDP | Hospital Roosevelt | Dr. Carlos Mejía | Jefe Depto. Medicina<br>Director Clínica Infecciosas |
| SS | IGSS | Dr. José Ortiz | Jefe de Epidemiología |
| MOH | Ministerio de Salud | Ing. Alex Manuel Lopez | Unidad de Planificación Estratégica |

### Civil Society (include Key Populations)

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| Trans, KP | OASIS | Jorge López | Director Ejecutivo |
| PLWH | Asociacion Gente Nueva | Hugo Valladares | Director Ejecutivo |

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| KP, PLWH | MCP | Audelio Ramírez | Representante de Poblaciones afectadas |
| FSW | OMES | Yanira Tobar | Representante Legal |
| Trans | REDMMUTRANS | Galilea Bracho | Coordinadora General |
| PVV | ITPC | Alma De Leon | Directora Regional |
| PLWH | Asociacion Vida | Joel Ambrosio | Presidente Junta Directiva |
| RP Fondo Mundial | Hivos | Mirjam Mush | Directora Ejecutiva |
| Trans | OTRANS | Debby Maya Linares | Oficial de Programas |
| | Proyecto Vida | José Estrada/ Hermana Dee Smith | Administrador/Medios de comunicación |
| PLWH | Red de mujeres positivas en accion/ICW | Claudia Rosales | Coordinadora de comunicación estratégica |
| | REDNADS | Carlos Romero Prieto | Secretario Ejecutivo |
| **Private/Business** | | | |
| | APIB/CACIF | Ana Clarisa Villacorta | Directora Ejecutiva |
| | ASAZGUA | María Silvia Pineda | Directora RSE |
| | CACIF | Roberto Ardón | Director Ejecutivo |

| El Salvador | | | |
|---|---|---|---|
| **Donors** | | | |
| Multilateral | UNAIDS | Herbert Betancourt | Coordinador Onusida ES |
| Multilateral | Global Fund Project/UNDP | Celina de Miranda | Coordinadora de Proyecto |
| USAID Projects | USAID PASCA | Alexia Alvarado | Rep de Pais |
| USAID Projects | USAID PASMO | Susan Padilla Calderón | Rep de Pais |
| USAID | USAID | Maricarmen Estrada | Gerente de proyectos |
| Multilateral | PAHO/WHO | Mirna Elizabeth Perez | Consultora nacional |
| Multilateral | UNFPA | Luis Palma | Asesor Nacional de VIH |
| Multilateral | UNDP | Claudia Dubón de Morales | |
| Multilateral | UN WFP | Elia Marina Martinez | Asistente de Programas |
| | | | |
| **Public** | | | |
| MOH | CONASIDA | Francisco Carrillo | Secretario |
| Legal | PDDH | Jaime Argueta | Coordinador Unidad VIH |
| | Secretaría de Inclusión Social | Cruz Edgardo Torres | Director de Diversidad Sexual |
| Ministry of Education | Ministerio de Educación | Iris de Reyes | Jefa Departamento Derechos Humanos Valores y Ciudadanía |
| MOH | MINSAL | Salvador Sorto | Tecnico de M Y E |
| MOH | MINSAL | Ana Isabel Nieto | Coordinadora de Programa VIH |
| MOH | Global Fund Project/MINSAL | Guadalupe Flores | Coordinadora de Proyecto |
| Ministry of Social Development | Secretaría de Inclusión Social | Barbara Romero | Directora de Diversidad Salud |
| MOH | Programa Nacional de VIH | Veronica Avalos | Colaboradora Tecnica MyE |
| MOH | Ministerio de Salud | Eduardo Espinoza | ViceMinistro de Salud |
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| **Civil Society (include Key Populations)** | | | |
| Women | CONAMUS | Isabel Payes | Directora CONAMUS |

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|---|---|---|---|
| Transvestites | COMCAVIS TRANS | Karla Avelar | Directora |
| LGBT | Asociacion ENTRE AMIGOS | William Hernandez | Director Ejecutivo |
| CCM | MCP -ES | Marta Alicia Magaña | Directora Ejecutiva |
| PLWH | REDCA | Otto Ramirez | Secretario |
| FSW | Movimiento de Mujeres Orquideas del Mar | Haydée Lainez | Directora |
| | FUNDASIDA | Francisco Ortiz | Director Ejecutivo |
| FBO | Iglesia Comunitaria Metropolitana | Luis Guzman | Director |
| PLWH | Asociación Atlacatl | Odir Miranda | Director Ejecutivo |
| Academic | Colegio Médico | Ivan Solano | Representante Colegio Médico en CONASIDA |
| PLWH | REDSAL | Doris Acosta | Directora |
| Training | Grupo PROCAMPOLY | Yanira Olivo de Rodriguez | Directora de Capacitación y Desarrollo |
| PVV | REDCA REG | Sergio Montealegre | Director proyecto regional del FM |
| | | | |
| **Private/Business** | | | |
| | Asociación Nacional de la Empresa Privada | Lila Guillermo Guidos | Attorney |
| | ES Asociacion of Human Resources Administrators | Janira Olivo de Rodriguez | President of MCP |
| | Asociación Nacional de la Empresa Privada | Waldo Jiménez | ANEP |

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| **Panama** | | | |
| **Donors** | | | |
| Multilateral | UNAIDS Panama | Ricardo García | Coordinador de País |
| USAID Projects | PASMO | Samuel Escudero | Gerente interino |
| USAID Projects | PASCA | Diego Postigo | Representante de País |
| Multilateral | UNFPA Panama | Edilma Berrío | Asesora Nacional en VIH |
| | Cruz Roja Panameña | Miguel Ariza | Punto Focal de VIH |
| USAID Projects | Proyecto Capacity | Vacante | Representante de País |
| Multilateral | Cesar Núñez | UNAIDS Regional | Director Regional para América Latina |
| Multilateral | Licda Bautista | UNFPA Regional | Asesora Regional VIH |
| Multilateral | Mark Connolly | UNICEF TACRO | Asesor Regional VIH |
| **Public** | | | |
| MOH | Programa Nacional de ITS/VIH/SIDA | Aurelio Núñez | Jefe de Programa |
| Ministry of Social Development | Ministerio de Desarrollo Social | Virginia Castillero | Coordinadora de Orientación y Atención Integral |
| Legal | Defensoría del Pueblo | Edith Tristán | Encargada de Unidad Especializada en VIH |
| SDP | Hospital Santo Tomás | Rigoberto Samaniego | Infectólogo Jefe de Sala |
| | | | |
| MOH | Programa Nacional de ITS/VIH/SIDA | Rosa Lowe | Técnica de Monitoreo y Evaluación |
| MOH | Instituto Conmemorativo Gorgas | Nestor Sosa | Director |
| MOH | Ministerio de Salud | Vacante | Sub Directora de Salud de la Población |
| Social Security | Caja de Seguro Social | Rudick Kant | Epidemiólogo |
| **Civil Society (include Key Populations)** | | | |
| PLWH, Women | Grupo Génesis Panamá | Miguel Sánchez | Director |

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| PLWH, Women | Grupo Génesis Panamá | Miguel Sánchez | Director |
| FSW | Mujeres con Diginidad y Derechos | Dulce Ana | Directora |
| | Aid for AIDS | Rita Banus | Coordinadora General |
| | Red Cross | MiguelAriza | HIV point person |
| LGBT | AHMNP | Ricardo Beteta | Presidente |
| PLWH | Probidsida | Orlando Quintero | Director |
| PLWH, | Grupo Génesis Panamá | Fernando Solís | Coordinador de |
| LGBT | AHMNP | José Ramón Castillero | Coordinador de Proyectos |
| FP (IPPF) | APLAFA | Hilda Martínez | Coordinadora de Monitoreo y Evaluación |
| FP (IPPF) | APLAFA | Juana Cooke Camargo | Directora Ejecutiva |
| PLWH | Viviendo Positivamente | Dayra García | Directora |
| | IDEHSA | Manuel Burgos | Presidente |
| Prevention | EMESSAR | Carmen García | Coordinadora Técnica de Proyectos |
| | Consultora | Evelina Aedo | Consultora Independiente |
| **Private/Business** | | | |
| | Consejo Empresarial para la Prevención del VIH/sida | Lic. Fernando Márquez | |
| BC | CONEP | Ezequiel Vargas | Representante |
| | CONEP | Alfredo Burgos | Director Ejecutivo |
| | Cicatelli | Venus Tejada | Coordinadora de Proyecto |
| | Cicatelli | Jose Luis Chung | Director de Finanzas |

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| **Honduras** | | | |
| **Donors** | | | |
| USAID | USAID Honduras | Kellie Stewart | Health Officer |
| USAID | USAID Honduras | Ritza Avilez | HIV Specialist |
| Multilateral | Global Fund | Sr. Brian Husler | Director Nacional |
| USAID Projects | ULAT | Dr. Juan de Dios Paredes | Director |
| USAID Projects | Aidstar I | Dr. Rolando Pinel | Director |
| USAID Projects | Aidstar II | Sra. Yadira Almodovar | Directora |
| Multilateral | UNAIDS | Sr. Alberto Stella | Director |
| USAID Projects | Meta | Alejandro paredes | |
| Multilateral | PAHO | Dra. Gina Watson | Directora |
| **Public** | | | |
| MOH | Redes y Servicios | Dra. Sandra Pinel | Directora |
| MOH | Riesgos Poblacionales | Dra Maytee Paredes | Apoyo Tecnico a la VM en implementacion de la Estrategia de Atencion Integral de VIH |
| Ministry of Youth | | Olga Alvarado | Viceministra |
| MOH | | Justa Urbina | |
| MOH | National AIDS Program | Dr. Héctor Galindo | Director |
| Ministry of Education | | Elia del Cid | Viceministra |
| MOH | Redes y Servicios | Dra. Yolani Batres | Viceministra |
| **Civil Society (include Key Populations)** | | | |
| MSM, Transvestites | ASONAPVSIDAH | Denis Martinez | Director |
| PLWH | APUVIMEH | Jose Zambrana | Director |
| Garifunas | ECOSALUD | Dra. Sonia Guity | Directora |
| CSW | Asociacion Hondurena de Mujer y Familia | Maria Concepcion Caceres | Directora |
| PLWH | Llaves | Rosa Gonzalez | Directora |
| MSM | CSSI | Raul Coto | Director |
| | PRODIM | Javier Calix | Director |
| **Private/Business** | | | |
| | Jheisy Torres | COHEP | Asesora Legal |
| **Costa Rica** | | | |
| **Donors** | | | |

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|---|---|---|---|
| | UNFPA | Laura Sánchez | Encargada VIH y sida |
| Multilateral | ILO (OIT) | Ana Catalina Ramírez Abarca | Punto Focalpara VIH y Mundo de Trabajo |
| USAID Projects | PASCA | Mariela Garron | Representante de Pais |
| | PASCA | Miriam Fernández | Coordinadora Técnica |
| Multilateral | UNFPA | Patricia Salgado | Representante a.i. de país |
| | UNFPA | Oscar Valverde Cerros | Oficial de Salud Sexual y Reproductiva |
| Multilateral | UNAIDS | Ivonne Zelaya | Punto Focal de país |
| | Capacity | Emmanuel Gómez | Representante de país |
| | Capacity | María José Longhi | Coordinadora de Campo |
| | PASMO | Kattia López | Coordinadora de Cambio de Comportamiento |
| | Cruz Roja Juventud Costa Rica | Ana Artavia Durán | Coordinadora proyectos VIH |
| **Public** | | | |
| Legal | Defensoría de los Habitantes de la República | Carlos Valerio | Profesional de Defensa Área Calidad de Vida |
| | Ministerio de Salud | Alejandra Acuña | Jefatura Unidad Planificación Estratégica en Salud y Coordinadora de Conasida |
| | Ministerio de Salud | Rosa María Vargas Alvarado | Jefe Unidad de seguimiento de Indicadores de salud |
| | Ministerio de Salud | Teresita Solano Chinchilla | Vigilancia ETS y VIH |
| SS | CCSS | Gloria Terwes Posada | Coordinadora Programa a nivel institucional de VIH |
| | Ministerio de Salud | Andrés Sánchez | Jefatura Dirección de Garantía de Acceso a los Servicios de Salud |
| | Ministerio de Salud | Juan Carlos Valverde | Encargado de VIH en servicios de salud |
| MOH | Ministerio de Salud | Dra. Sisy Castillo | Vice Ministra de Salud Presidenta de CONASIDA |
| Academic | universidad de Costa Rica, Escuela de Tecnología de la salud | Lizeth Taylor | Profesora catedrática, Representante UCR ante CONASIDA |

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| MOJ | Ministerio de Justicia y Paz | Dixiana Alfaro | Jefe Nacional de Servicios |
| SS | CCSS | Dr.José Miguel Rojas | Director Dirección de Desarrollo de Servicios de Salud |
| SS, SDP | CCSS | Dr. Oscar Porras | Coordinador Clínica de VIH Hospital Nacional de Niños |
| | CCSS | Dr. Julián Peña | Coordinador Clínica de VIH Hospital México |
| | CCSS | Dr. Néstor Azofeifa | Coordinador Clínica de VIH Hospital San Rafael |
| | CCSS | Dr. Antonio Solano | Coordinador Clínica de VIH Hospital Calderón Guardia |
| | CCSS | Dr. Alfredo Messino | Coordinador Clínica de VIH Hospital Monseñor Sanabria |
| SS, SDP | CCSS | Carmen Vargas Mejía | Coordinadora Clínica Atención VIH Hospital San Juan de Dios |
| **Civil Society (include Key Populations)** | | | |
| FSW | LA SALA | Nubia Ordoñez | Coordinadora |
| LGBT | Centro de Investigación y Promoción para Amércia Central de Derechos Humanos - CIPAC- | Daria Suárez Rehaag | Directora |
| Niños/niñas | Defensa de niños y niñas internacional - DNI-CR | Karina van Wijk | Coordinadora General |
| LGBT | CIPAC | Daria Suarez Rehaag | Directora Ejecutiva |
| Transvestites | TRANSVIDA | Yanán Hernández González | Presidenta |
| Albergue | Nuestra Señora del Carmen | Randall Valverde Chinchilla | Coordinador tema VIH-sida |
| PLWH, FBO | Hogar de la Esperanza / Observatorio Centroamericano | Orlando Navarro Rojas | Director |

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|---|---|---|---|
| Women | ICW | Ruth Linares Hidalgo | Presidenta Junta Directiva |
| LGBT | MULABI | Natasha Jiménez | Coordinadora |
| Demography | Asociación Demográfica Costarricense (ADC) | Cristian Gómez | Coordinador de Proyectos |
| | Asociación Demográfica Costarricense (ADC) | Cinthia Chacón | Encargada de proyectos VIH |
| Youth | Centro Nacional de Juventudes | Manuel Francisco Abarca Arias | Promotor de Salud |
| Albergue | Asociación Unidos en la Esperanza | Mariangella Mata Guevara | Vocal I de Junta Directiva |
| Albergue | Asociación Unidos en la Esperanza | Thelma Baldares C. | |
| Diversidad sex y PVIH | Asociación MANU | Manuel Agüero Campos | Presidente |
| | CIPAC | Francisco Madrigal | Director Ejecutivo |
| | CIPAC | Gabriela Solano Rojas | Administradora de Proyectos |
| FBO | Iglesia Luterana Costarricense -ILCO- | Manuel Agüero Campos | Responsable Programa VIH-sida |
| SDP | Clínica VIH Hospital Calderón Guardia | Yadira Martínez López | Voluntaria, grupo par |
| Women | Asociación Esperanza Viva | Rosibel Zúñiga Guardia | Presidenta |
| **Private/Business** | | | |
| | AED | Erika Linares | Directora de Inversión Social |
| | UCCAEP | Jaime Molina Ulloa | Presidente de la Junta Directiva |
| Unión de Cámaras y Asociaciones de la Empresa privada | UCCAEP | Shirley Saborío | Directora Ejecutiva |
| Asociación Empresarial para el Desarrollo | AED | Luis Javier Castro Lachner | Presidente de la Junta Directiva |
| | AED | Silvia Lara | Directora Ejecutiva |

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| **Belize** | | | |
| **Donors** | | | |
| Multilateral | UNAIDS | Melissa Sobers | National Program Officer |
| Multilateral | UNICEF | Sherlene Tablada | Adolescent Development and HIV Officer |
| USAID Projects | Capacity Project | Jose Victor Perera | Country Representative |
| USAID Projects | USAID/PASCA | Adele Catzim-Sanchez | Country Representative |
| USAID Projects | PASMO | Guadalupe Huitron | Country Representative |
| Multilateral | UNFPA | Erika Goldson | Assistant Representative |
| Multilateral | UNDP | Mariana Mansur | HIV Programme Coordinator |
| | Drew Carey Foundation | Shiela Middleton | Programme Coordinator |
| **Public** | | | |
| MOH | Ministry of Health | Dr. Marvin Manzanero/Lorna Perez | Director National AIDS Program |
| Ministry of Women | Women's Department | Icilda Humes | Director |
| Ministry of Labor | Ministry of Labour | Claire Lamb | HIV Focal Point |
| MOH | National AIDS Commission | Kathy Esquivel | Chairperson |
| Ministry of Social Development | Ministry of Human Development | Judith Alpuche | CEO |
| Youth | Youth for the Future | Eckert Middleton | Manager HIV Unit |
| MOH | NHI | Ruth Jaramillo | Manager Primary Care |
| MOH | Ministry of Health | Natalia Largaespada Beer | Technical Advisor Maternal and Child Health |
| MOH | Ministry of Health | Aisha Andrewin | Epidemiologist |
| **Civil Society (include Key Populations)** | | | |
| | National AIDS Commission | Martin Cuellar | Executive Director |
| LGBT | UNIBAM | Caleb Orozco | Executive Director |
| HIV+ persons | C | Eric Castellano | President |

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|---|---|---|---|
| | Net+/Redca+ | | |
| OVCs | Hand in Hand Ministries | Abel Vargas | Executive Director |
| Women, Advocacy | POWA | Michelle Irving | Executive Director |
| Women | WIN Belize | Carolyn Reynolds | Executive Director |
| FBO | Belize Council of Churches | Rev. Leroy Flowers | President |
| SRH & Youth | BFLA | Joan Burke | Executive Director |
| Youth | Belize Red Cross | Lilly Bowman | Executive Director |
| OVCs | NCFC | Pearl Stuart | Executive Director |
| | Consultant | Joe Hendrikx | consultant |
| | Consultant | Martha Carillo | consultant |
| **Private/Business** | | | |
| | Belize Chamber of Commerce | Amparo Mason | Member of the Board, Belize Chamber of Commerce (also Public-Private Sector Liaison, Office of the Prime Minister) |

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| **Nicaragua** | | | |
| **Donors** | | | |
| USAID | USAID Nicaragua | Marianella Corriols | Especialista de Salud |
| Multilateral | UNDP | Valeria Bravo | Asesor Oficial de Programa de VIH y sida |
| USAID Projects | PASCA | Anne Largaespada | Rep de Pais |
| | Cruz Roja Nicaraguense | Karla García | Directora Nacional de Salud y Bienestar Social |
| **Public** | | | |
| Ministry of Family | Ministerio de la Familia | Carmen Olivares | Coordinadora de la Dirección de VIH |
| Legal | Procuraduría de Derechos Humanos | Samira Montiel | Procuradora Especial para la Diversidad Sexual |
| Ministry of Education | Ministerio de Educación | Sobeyda Morales | Coordinadora de Área |
| MOH | MINSA | Enrique Beteta | Secretario General |
| SS | Instituto Nicaraguense de Seguridad Social | Aurora Soto | Coordinadora Unidad de Proyectos de VIH- Proyecto Fondo Mundial |
| MOH | Ministerio de Salud | Sonia Doña | Coordinadora Componente Nacional de ITS, VIH y sida |
| Military | Cuerpo Médico Militar | Félix Olivas López | Jefe de Departamento de Medicina Preventiva |
| MOH | CORESIDA | Orlando Somarriba Watts | Presidente de CORESIDA |
| MOH | CONISIDA | José Antonio Medrano | Secretario Técnico |
| SS | Instituto Nicaraguense de Seguridad Social | Ana Francis Obando | Médica Técnica en VIH |
| Social Development | Ministerio de Gobernación | José Castaño | Director de Oficina de Prevención y Asistencia Social |
| Ministry of Labor | Ministerio del Trabajo | Francisco Bolaños Méndez | Director General de Higiene y Seguridad del Trabajo |
| Disaster Response | SINAPRED | Guillermo González | Secretario Ejecutivo |
| SDP | Centro de Educación y Promoción Social | Esperanza Camacho | Coordinadora Zona Norte |
| **Civil Society (include Key Populations)** | | | |

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|---|---|---|---|
| Trans | REDTRANS | Silvia Martinez | Coordinadora Nacional |
| Prevention | Centro de Educación para la Prevención del VIH | Norman Gutiérrez Morgan | Director Ejecutivo |
| CSW | Red de Trabajadoras Sexuales | María Elena Dávila | Referente nacional |
| PLWH | ASONVIHSIDA | Arely Cano | Presidenta |
| HR | Movimiento Comunal de Nicaragua | Enrique Picardo | Coordinador de Salud |
| youth, GBV | Asociación Quincho Barrilete | María Consuelo Sánchez | Directora Ejecutiva |
| | CORLUSIDA | Miurell Verónica Watson Warman | Presidente Comisión de Salud |
| Prevention | Fundación Nimehuatzin | Pascual Ortells Chabrera | Director Técnico |
| IEC | Fundación Xochiquetzal | Yelba Jarquin Rodriguez | Subdirectora |
| Academic | Asociación Nacional de Infectología | Guillermo Porras | Presidente |
| PLWH | ANICP+VIDA | Julio Mena | Director Ejecutivo |
| **Private/Business** | | | |
| | Consejo Superior de la Empresa Privada | Álvaro Guerra Báez | Coordinador de la Comisión de VIH |

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