IMPROVING THE QUALITY OF STI AND HIV SERVICES IN GUATEMALA
Center for Human Services: The CHS mission is to help clients meet today’s challenges and take advantage of tomorrow’s opportunities by providing a comprehensive array of education, training, advocacy, and health-related programs and services.

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I. The Context

A. Demographic Context

Between 1984 and June 2009, Guatemala reported 13,782 cases of acquired immunodeficiency syndrome (AIDS) and 6,074 of human immunodeficiency virus (HIV) infection.\(^1\) With almost all cases attributed to sexual transmission, and the majority found in the 20–39 year old age group, the HIV epidemic is concentrated both geographically and in a number of vulnerable groups, including men who have sex with men (MSM) at (11.5% in December 2006) and commercial sex workers (CSWs) at 8.7 percent. Proxies for the general population, including pregnant women and military forces, had 2006 infection rates of 0.9 and 0.7 percent, respectively. The geographic departments most affected were Suchitepéquez, Izabal, Guatemala, Escuintla, Retalhuleu and Quetzaltenango; a corridor along the southern part of the country that includes ports, commercial zones, and the main east-west highway in the country.\(^2\)

In 2002, the Guatemalan Ministry of Public Health and Social Assistance (MOH), the United States Agency for International Development’s (USAID) Program for Strengthening the Central American Response to HIV (PASCA), the U.S. Centers for Disease Control and Prevention (CDC), and other partners implemented a regional, multi-center study to guide strengthening of the surveillance system for HIV and other sexually transmitted infections (STIs). The study aimed to better determine the prevalence of HIV and STIs, sociodemographic characteristics of infection, and risk behavior patterns of MSM and CSWs.\(^3\)

At the time of this study, Guatemala already had a mandatory STI control program in which CSWs—particularly those working off the street in fixed establishments—are checked every few weeks for sexually transmitted infections and treated. Building on this program to strengthen STI services and improve their integration with voluntary counseling and testing (VCT) and treatment services for HIV offered a number of opportunities to address needs highlighted in both the national data and the multi-center study.

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\(^3\) Estudio Multicéntrico Centroamericano de Prevalencia de VIH/ITS y Comportamientos en Poblaciones Específicas en Guatemala: Resumen de Principales Hallazgos. Guatemala City: MOH and PASCA. May 2003, p. 2.
Strengthening existing STI services was an excellent entry point for primary prevention of HIV, through the provision of VCT services and treatment and support referrals. This approach had the potential to greatly improve access for all groups to STI, HIV, and other reproductive health services at the primary health care level outside Guatemala City.

STI infection facilitates the acquisition of HIV and, by definition, follows the same sexual transmission route responsible for almost all HIV infection in the country. Given the high levels of stigma and discrimination and treatment challenges related to HIV, improved attention to STIs gave the opportunity for behavior change interventions that might also prevent an eventual HIV diagnosis, especially in vulnerable groups. In just one example from the multi-center study, Guatemalan MSM diagnosed with syphilis were 2.7 times as likely to be infected with HIV than other MSM, who themselves were at higher risk than the general population. Surveillance of STIs could serve as an early alert system for HIV trends, helping identify populations at risk for HIV as well as short-term risk behavior change, especially in these vulnerable groups.

USAID agreed to support the MOH to implement the World Health Organization’s (WHO) recommended syndromic management approach to STI diagnosis and treatment in selected frontline health centers in high-prevalence zones. These services would also be expanded to offer VCT and referral services for HIV.

In order to address these issues, USAID turned to an existing project, USAID/Calidad en Salud, already working closely with the MOH for several years to improve maternal and child health and nutrition service delivery programs.

In addition to the proposed STI/HIV intervention, USAID/Calidad en Salud supported the MOH and its partners in five major technical areas:

- Family planning and contraceptive security
- Maternal and neonatal health
- Nutrition interventions for women and children
- Child health and
- Quality management systems

In addition, the project helped the MOH strengthen:

- Advocacy and policy dialogue
- Health systems management
- Health information systems and
- Information, education, and communication for behavior change

Beginning in June 2005, USAID/Calidad en Salud and the MOH also joined forces to improve STI/VCT services, particularly for three vulnerable groups: commercial sex workers, men who have sex with men, and people living with HIV/AIDS (PLWHA).

The MOH/project team identified 26 health centers to add to eight centers which USAID’s Impact Project had previously supported in HIV service provision. Joint selection of the 34 participating centers in 12 geographic health areas followed these criteria:

- Areas with high prevalence of HIV, according to December 2004 national data
- Presence of priority groups, including MSM, CSW, and PLWHA
- Basic MOH health infrastructure, such as a clinic already providing regular STI control for CSWs

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In syndromic management of sexually transmitted infections, the clinician diagnoses and treats the patient based on clusters of symptoms and clinical findings—or syndromes—rather than on specific disease(s) confirmed through lab testing. In the absence of generalized diagnostic and lab capacity, presumptive treatment of possible STI causes is a cost-effective way to bring effective STI screening and treatment services as close to the population as possible.

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Adding an STI/HIV component posed some initial management challenges for USAID/Calidad en Salud. The STI/HIV priority sites in the mostly urban, commercial corridor in southern Guatemala did not overlap much with the program’s maternal and child health sites, primarily in the rural, northern highlands. Staff had little experience working directly with these sensitive topics or client groups. USAID/Calidad en Salud continued its effective strategy of working with and through the MOH and also hired a dynamic advisor, who had retired from her position as director of a model public STI clinic in the capital. The advisor’s credibility and knowledge of national norms, systems, and health personnel proved critical to the program’s success in strengthening both Ministry systems and the responsiveness of USAID/Calidad en Salud from within these structures.

Although its disparate sites did not allow for coordinated implementation, the project took care to ensure integration of messages across all technical components. For instance, pregnant women reached with prenatal care services supported by USAID/Calidad en Salud were counseled in prevention-of-mother-to-child transmission (PMTCT) of HIV and offered VCT. Family planning materials produced with project support discussed STIs/HIV. CSWs and pregnant women were offered family planning information. At the MOH’s request, USAID/Calidad en Salud provided technical support for a Counseling Guide for Feeding Babies of HIV+ Mothers.

II. The STI/HIV Program

A. Objectives and Strategies

The overall objective of this component was to strengthen the quality of STI and voluntary HIV counseling and testing services for high-risk groups in 34 health centers in 12 high-prevalence geographic areas.

To achieve this objective, the program used four strategies:

- Improving the quality of service delivery
- Improving the demand for and use of these services
- Integrating HIV/STI within reproductive health services, and
- Strengthening HIV/STI surveillance and monitoring systems

The major results from implementing these strategies follow.
My dream is not to even have an STI or an HIV service. Wouldn’t it be great to just be able to say to whoever walks in the door, “how can we serve you”? —HIV Advisor

B. Summary of Key Results
Figure 1 below shows the positive trend in the 34 project sites in meeting STI/HIV service standards. Adequately screening clients for STIs topped 90 percent over five measurements. Following national norms for diagnosis and treatment of STIs improved from a low of 60 percent to 80 percent overall, with decreases in January and April 2009 due to stockouts in medicines used in syndromic management of STIs. Indicators related to optimal provision of VCT services topped 75 percent in the last five measurements.

Trends in the provision of VCT services for the period January 2005 through March 2009 are shown in Figure 2 below. In addition to more than doubling the number of voluntary tests given, the number of clients receiving a test who then received post-test counseling with their results rose 28 percentage points, for an increase of 58 percent.

As a result of program interventions, staff in all 34 sites now provide improved services including syndromic management of STIs as well as VCT and family planning services on a continuous basis, usually with on-site rapid HIV testing and timely post-test counseling to explain test results and implications.

This report describes in some detail the interventions the MOH and USAID/Calidad en Salud implemented to achieve the results summarized above.
Figure 1: Trends in Provision of STI Screening, Diagnosis, Treatment and VCT Services in Strengthened Health Centers, September 2008–June 2009

<table>
<thead>
<tr>
<th>Indicator 1: STI screening</th>
<th>Sep 08</th>
<th>Oct 08</th>
<th>Nov 08</th>
<th>Dec 08</th>
<th>Jan 09</th>
<th>Feb 09</th>
<th>Mar 09</th>
<th>Apr 09</th>
<th>May 09</th>
<th>Jun 09</th>
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</thead>
<tbody>
<tr>
<td>Percentage compliance</td>
<td>82.38</td>
<td>79.00</td>
<td>92.17</td>
<td>83.33</td>
<td>90.32</td>
<td>96.90</td>
<td>91.50</td>
<td>93.61</td>
<td>92.93</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Indicator 2: STI diagnosis and classification</th>
<th>Sep 08</th>
<th>Oct 08</th>
<th>Nov 08</th>
<th>Dec 08</th>
<th>Jan 09</th>
<th>Feb 09</th>
<th>Mar 09</th>
<th>Apr 09</th>
<th>May 09</th>
<th>Jun 09</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage compliance</td>
<td>65.67</td>
<td>59.67</td>
<td>81.25</td>
<td>70.80</td>
<td>66.50</td>
<td>78.27</td>
<td>83.95</td>
<td>75.39</td>
<td>79.83</td>
<td>82.47</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Indicator 3: STI treatment</th>
<th>Sep 08</th>
<th>Oct 08</th>
<th>Nov 08</th>
<th>Dec 08</th>
<th>Jan 09</th>
<th>Feb 09</th>
<th>Mar 09</th>
<th>Apr 09</th>
<th>May 09</th>
<th>Jun 09</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage compliance</td>
<td>61.00</td>
<td>62.85</td>
<td>81.67</td>
<td>70.93</td>
<td>67.11</td>
<td>77.18</td>
<td>80.20</td>
<td>75.72</td>
<td>82.83</td>
<td>83.73</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Indicator 4: Referral for Counseling</th>
<th>Sep 08</th>
<th>Oct 08</th>
<th>Nov 08</th>
<th>Dec 08</th>
<th>Jan 09</th>
<th>Feb 09</th>
<th>Mar 09</th>
<th>Apr 09</th>
<th>May 09</th>
<th>Jun 09</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage compliance</td>
<td>70.38</td>
<td>70.21</td>
<td>84.00</td>
<td>80.20</td>
<td>72.11</td>
<td>72.86</td>
<td>80.90</td>
<td>81.39</td>
<td>82.33</td>
<td>78.93</td>
</tr>
</tbody>
</table>


Figure 2: Trends in the Provision of Pre- and Post-Test HIV Counseling in 34 Health Centers, January 2005–March 2009

<table>
<thead>
<tr>
<th>% post-test counseling</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>Oct 08–Jun 09</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator</td>
<td>4,067</td>
<td>5,868</td>
<td>9,034</td>
<td>10,848</td>
<td>7,746</td>
</tr>
<tr>
<td>Numerator</td>
<td>1,959</td>
<td>3,826</td>
<td>6,387</td>
<td>7,734</td>
<td>5,896</td>
</tr>
<tr>
<td># Health Centers</td>
<td>13</td>
<td>18</td>
<td>15</td>
<td>19</td>
<td>21</td>
</tr>
</tbody>
</table>

Source: MOH monthly service statistics (SIGSA 6) through 3rd quarter 2009. Preliminary data
Denominator: # of clients offered HIV test with pre-test counseling
Numerator: # of clients who received a test and post-test counseling
C. Project Activities

1. Situation Analysis in Participating Health Centers
The National AIDS Program and the project team conducted a structured needs assessment in the 34 proposed clinic sites to document the state of syndromic management and VCT services in the eight centers previously supported by USAID/Impact and syndromic management in the sites to be added.

Principal findings from the needs assessment included:

- Ad hoc reporting of STIs, rather than adherence to existing reporting protocols. For example, the same case might be reported as vaginal discharge or a specific condition such as trichomonosis or vaginitis, making compilation of data difficult.
- Although a high percentage (97%) of centers had access to national STI/HIV/AIDS norms, staff were unfamiliar with them.
- Priority client groups, particularly MSM, had very low demand for STI services at participating health centers. The study documented that MSM accounted for only 89 of 45,321 patients evaluated in the participating centers in the previous trimester (0.2%) and 91 percent of these (81) had been attended at one model STI clinic in Guatemala City.5
- There were either separate waiting rooms and/or separate hours for CSWs to attend obligatory STI control sessions away from other clients. CSWs only accounted for 3.4 percent of clinic visits during the trimester.
- Only 42 percent of lab staff had received up-to-date training on laboratory analysis of STIs.
- Health centers reported regular stockouts of tests, reagents, and supplies.

All recommendations, as outlined in the report, were planned and implemented between July 2005 and September 2009.

2. Improving the Quality of Service Delivery
a. Capacity building
Findings from the detailed needs assessment guided the training or orientation of staff of the 34 participating health centers, as needed, in various aspects of STI/HIV service delivery. Capacity building occurred in training sessions, facilitative supervision visits, during study visits to a model clinic, and/or during learning sessions related to continuous quality improvement activities.

As was the overall USAID/Calidad en Salud strategy, staff supported relevant MOH structures and personnel to plan and implement all capacity-building exercises, greatly enhancing sustainability.

A sampling of clinicians, counselors, and lab personnel participated in three-day study visits to a model STI clinic in Guatemala City, which also serves as the national STI laboratory reference center. For many, this was a first exposure to the provision of sensitive and comprehensive services for MSM or PLWHA, including direct contact with these groups; VCT services; how to examine men; screening for human papillomavirus, breast cancer and/or tuberculosis; and cytology. Staff from the clinic and rural health centers established a referral link that many visitors used almost immediately, and often.

<table>
<thead>
<tr>
<th>Group</th>
<th>Topic</th>
<th>Number Trained*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinicians (MDs/RNs/auxiliary nurses)</td>
<td>Integrated STI/HIV services, including VCT</td>
<td>93</td>
</tr>
<tr>
<td>Counseling staff</td>
<td>STI/HIV/FP counseling and reporting</td>
<td>45</td>
</tr>
<tr>
<td>Lab technicians</td>
<td>STI/HIV diagnosis</td>
<td>37</td>
</tr>
<tr>
<td>Various service delivery staff</td>
<td>Three-day study visits to STI/HIV model clinic</td>
<td>53</td>
</tr>
<tr>
<td>Health center staff</td>
<td>Stigma and Discrimination</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1. TOT</td>
<td>1. 53</td>
</tr>
<tr>
<td></td>
<td>2. 2-day trainings to cover all project health centers</td>
<td>2. 793</td>
</tr>
</tbody>
</table>

* through June 2009

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The project coordinated with the MOH and donor agencies to reprint and disseminate a wide range of useful normative and technical documents and develop training materials and job aids that lacked. By working in committee with the MOH and associates, materials were directly incorporated into national systems as well as project-supported health centers.

For a full list of project-supported manuals, job aids, and information, education, and behavior change communication (IEC/BCC) materials in Annex 1.

b. Continuous quality improvement

University Research Co. (URC), the contractor implementing USAID/Calidad en Salud, has in-depth experience in many countries successfully applying CQI methodologies to health services. Multidisciplinary, facility-based CQI teams use an evidence-based and collaborative problem-solving cycle to measure, implement, assess, and refine approaches to quality improvement. USAID/Calidad en Salud had already trained and supported continuous quality improvement teams in its maternal and child health components with good result.

USAID/Calidad en Salud launched CQI in its STI/HIV component in July 2007 with a demonstration phase that included nine centers in the department of Guatemala. An expansion phase that included the rest of the 34 project health centers ran from September 2008–September 2009. Staff from URC/Nicaragua helped the team adapt the basic methodology to the needs of the program, using experience and tools from at least six Latin American countries.

CQI teams at each facility typically included the physician, nurses and auxiliaries, the data analyst, social worker, secretary, and others, as appropriate. All teams convened every few months in learning sessions to monitor results against indicators, share strategies, and solve problems. Between learning sessions, individual teams worked to improve services, took monthly internal measurements, and analyzed progress against indicators, reinforcing the ability to take action internally.

Just as individual teams improved their ability to work together over time, so the collective group also explored service problems more deeply over the course of four learning sessions and a closing meeting, improving systems and standards as they progressed. For example, at the first learning session, when deciding what to measure as a baseline for STI service improvement, participants realized

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**CREATING SAFE SPACES FOR PEER SUPPORT**

Through peer exchanges such as participatory trainings, study visits to a model STI clinic serving high-risk groups, and CQI learning sessions, the project created nonjudgmental opportunities for service providers to raise sensitive issues and explore questionable behaviors. Teams quickly learned that scoring poorly on quality improvement indicators was just the starting point for an upward quality spiral. As confidence developed, service providers sometimes realized — and publicly admitted — that the services they provided to marginalized groups including CSWs and MSM, were degrading or abusive. Teams became very motivated and curious to learn from, and support, each other’s efforts to provide the highest quality services.

“I used to think my role was to be the control, the barrier between ‘those people’ [CSWs] and the community; that I was supposed to keep them apart. Now I realize that ‘those people’ are the community. I am ashamed of how I used to treat those women.”

— Nurse discussing her experience in CQI learning sessions

The collaborative learning methodology built skills in de-personalized and evidence-based management through improved data measurement and use. It proved an excellent—and protected—way to both expose problems and share best practices that sister teams were eager to try for themselves. Teams felt the methodology gives staff better control over their own services, especially helpful in coping with uncertainty and rapid change, such as transitions between governments and high mobility of both staff and client groups.
that there was neither active STI screening nor a standard clinic intake form that both structured and captured an integrated client assessment. Although staff had been trained in HIV/STI norms, there was no regular monitoring or supervision to support active screening, either in vulnerable groups or the general population. This led, under the leadership of the MOH, to development of standardized medical history forms for adolescents, adults, and older adults that assess a variety of risk factors. Teams used this form, since adopted by the MOH, to develop the first standards for monitoring the quality of STI/VCT services.

In later learning sessions, teams identified and addressed unnecessary medical barriers to VCT, such as pre-test fasting, and other specifics of STI/VCT service delivery.

Sample results of the CQI initiative:

- The MOH has agreed to reinforce the continuous quality improvement (CQI) systems in the 34 participating clinics and expand the methodology to new sites with support from the Global Fund to Fight AIDS, Tuberculosis, and Malaria.

- Development of a standardized medical history form allows systematic assessment, at every visit, of risk and healthful behaviors, including multiple partners, substance abuse, exercise profiles, nutrition, etc. Some centers complain about availability of the form, with supply dependant on the animation of the HIV coordinator for the health area.

- Health center staff improved their syndromic management skills as well as the rapidity of receiving and conveying HIV test results to clients.

- Standardization of medical histories and training and monitoring of their use improved the quality of service statistics and reporting.

- At least three centers adapted or expanded clinic hours to better serve their clientele.

- The CQI team in the Zone 6 health conducted an internal training session and re-organized themselves so that trained counseling staff would be available every day to offer VCT services, improving the continuity of care.

- Facility-based CQI teams improve and measure quality on a regular basis.

- Teams began to implement client satisfaction studies, for which they had formats and a suggested, regular process.

### c. Infrastructure improvements

#### i. Tests, supplies, equipment, and basic furnishings

Based on national service delivery norms, the project provided a one-year supply of 8,000 rapid HIV tests, 350 confirmatory tests, reagents, and supplies needed to bring VCT and STI counseling, testing, and lab services closer to the population. Then regional (area) health departments were to provide these supplies.

To strengthen STI/HIV logistics, USAID/Calidad en Salud helped the MOH develop a user’s manual and orient relevant health center staff to Pipeline, a projection tool meant to improve supply continuity. Although approved by a technical committee, key staff in the central MOH stores perceived it as a parallel system that would create more work, rather than a supportive tool, and did not use it.

At the end of the project, staff still experienced stockouts in some reagents, supplies, and HIV tests—even in the model STI clinic in Guatemala City—despite reported timely requisitions at the facility level. They attributed the problem to poor political support for STI/HIV services and weaknesses in national competitive bidding and procurement processes, despite USAID/Calidad en Salud advocacy at the national and regional levels for inclusion of STI service requirements in program budgets. In the short term, the MOH expects to purchase tests and supplies with Global Fund support. However, persistent delays caused by central procurement processes still need to be addressed.

In addition, despite field validation of rapid HIV tests in the Guatemalan context, there remains a need for a less expensive test with longer shelf life, which would contribute significantly to the affordability, availability, and efficiency of services.

Significant project collaboration for national capacity in chlamydia and gonorrhea diagnosis and sentinel STI

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6 Estableciendo la atención integral para la prevención, captación, y atención de las personas con ITS y promoción de la oferta de PVS a través de la estrategia del Colaborativo ITS/PVC. Guatemala City: MOH/Calidad en Salud, November 2007, p. 4.
surveillance is addressed below in Section 5: Strengthening HIV/STI Surveillance and Monitoring Systems.

Participating clinics also received, as needed, basic office and exam room furnishings, such as gynecological exam tables, desks, and chairs. The project supplied audiovisual equipment and informational materials for use in improved waiting room space.

**ii. Assistance with clinic rehabilitation**

The MOH, USAID/Calidad en Salud, the Global Fund, and the Pan American Health Organization (PAHO) developed a strategic partnership to rehabilitate a number of participating health centers. Through USAID/Calidad en Salud’s provision of lab supplies, reagents, HIV tests, and direct program support for STI/HIV services, the MOH and Global Fund agreed to reprogram that donor’s STI/HIV budget to rehabilitate health centers for improved privacy and confidentiality. PAHO also contributed funds for clinic rehabilitation.

USAID/Calidad en Salud provided technical support for clinic redesign to enhance the quality of STI/HIV service provision, particularly to improve privacy and confidentiality of services. Staff facilitated architect site visits as well as the necessary government and donor paperwork. The difficulty of meeting some requirements, such as verification of government ownership of the land where the clinic is located, delayed rehabilitation in several sites until 2010.

Rehabilitated clinics provide adequate privacy and demonstrate commitment to STI/VIH service quality, particularly to marginalized groups and the providers who serve them. They both motivated staff and increased client confidence and comfort.

**d. Improved reporting of service statistics**

USAID/Calidad en Salud worked at all levels to improve the quality of routine reporting of STI/HIV service statistics. Additional assistance to the national STI sentinel surveillance system is discussed in Section 5.

At the national level, the team assisted the MOH to:

- update HIV reporting norms and guidelines to better align with national and international indicators
- arrange four workshops, financed by PAHO, for national rollout of the updated, electronic HIV component of the health management information system (SIGSA-SIDA)

- develop the MANGUA reporting system for Integrated Service Centers providing a variety of treatment and support services to HIV-positive clients

In the field, the program provided:

- computer equipment and training for improved reporting in the 34 project sites
- project consultants to monitor and backstop HIV coordinators and HMIS staff in all geographic health areas in the country, upgrading their computers with the new reporting system and troubleshooting problems such as cleaning viruses from computers and providing ad hoc reinforcement of training

USAID/Calidad en Salud also contributed to the development and correct use of national counseling guidelines that include how to report on pre- and post-test counseling services.
A number of problems still remain, with some health areas not submitting reports in a timely manner, making program monitoring more difficult. Although health centers typically post and regularly review STI service statistics according to sex, age, and vulnerable groups, proactive use of disaggregated service statistics and data trends for decisionmaking needs to be reinforced, especially at the regional and national levels.

3. Improving the Demand for and Use of STI/HIV Services

a. Stigma and discrimination

Stigma and discrimination may be the biggest challenge to addressing the HIV pandemic in Guatemala, currently concentrated in severely marginalized populations including MSM, CSWs, and PLWHA.

The MOH and USAID/Calidad en Salud made important initial steps in addressing stigma and discrimination in STI/HIV services at the primary care level through:

- A diagnostic study of health worker attitudes and practices
- National strategy formulation for addressing stigma and discrimination in STI/HIV services
- Training of trainers and interactive cascade training to 30 health centers, with four centers pending
- Development of facilitator and participant training manuals to address the topic
- Learning sessions of quality improvement teams
- Diffusion and discussion of relevant national norms and laws
- Study visits to clinics offering high-quality integrated services to stigmatized groups
- Planned training expansion with other donor support
- Multiple improvements to STI/HIV services outlined elsewhere in this report, enhancing the quality and the importance of these services within the health system

The initial clinic assessments and early interactions with the program’s priority groups highlighted the critical role that stigma and discrimination play in their low demand for and use of health center STI/HIV services. To better understand this phenomenon, the National AIDS Program and USAID/Calidad en Salud implemented a cross-sectional study in August 2007 to explore this important obstacle to seeking care.

Eight project-supported health centers in three regions of Guatemala (metropolitan, southeast, northwest) took part in the study. One hundred thirty-two health care providers, including both administrative and clinical personnel, participated in focus groups and an additional 14 focus groups were held with the three priority groups to explore their experiences in seeking services and as a complement to the provider information. One hundred thirty-two service providers then answered a validated questionnaire that was developed from the literature and findings from the focus groups. The questionnaire and the focus groups addressed service provider knowledge, attitudes, and practices related to stigmatizing and discriminatory behaviors in STI/HIV as well as structural obstacles to providing high-quality services.

Key findings of the stigma and discrimination study included:

- Specific lacks in provider knowledge of STI/HIV diagnosis and treatment that were directly addressed in project training plans.
- Breaches in patient privacy and confidentiality and other stigmatizing and discriminatory behaviors that providers were unaware were problematic.
- Requests by high-risk groups, particularly MSM, for a reporting and sanction system for abusive and discriminatory service provision.
- Lack of supplies and facilities that would ensure universal precautions, proper waste disposal, and equal access to testing services.
- Discrimination between client groups themselves, especially against MSM, underscoring the difficulties this particular group faces in any public acknowledgment of their sexual diversity (including attending an STI/HIV clinic).

The MOH and project team adopted virtually all the study’s recommendations through development and implementation of a strategy to reduce stigma and discrimination.7

One finding of the diagnostic study was that, despite sometimes egregious examples of even abusive behavior, few providers were aware that they often discriminated,

and 86 percent felt they did not need any training on the subject. The project took a dual approach of addressing the issue repeatedly through a combination of inputs while creating safe spaces—including the participatory stigma and discrimination training and CQI learning sessions—for health center staff to explore their attitudes, practices, fears, and sometimes unpopular misgivings. This led to clear shifts in individual attitudes and behaviors as well as some systemic changes.

For instance, one training participant strongly disagreed with the idea that HIV-positive women should be able to have children, if desired. Better understanding of mother-to-child HIV transmission mechanisms, discussions with her peers, and a later session on human rights—including the right to form a family—changed her mind completely and she left determined to provide rights-based service to her clients. Witnessing such dramatic shifts was also motivating to other health care providers.

A technical committee led by the MOH and including curriculum design specialists and HIV activists developed the training curriculum, using WHO standards and reference materials. Dynamic community activists and National AIDS Program trainers conducted two workshops to train 53 facilitators who, by the time this report was written, had trained 793 administrative, laboratory, and clinical staff in 30 health centers supported by the project. The MOH plans to complete the training in the four remaining project sites and reinforce and expand the program, with support from the Global Fund and other donors.

Training challenges continue to include:

- Addressing highly sensitive topics, with expected behavior change, in a two-day workshop
- Balancing the advantages of training all health center staff together with the need to address classism and widely varying educational levels within training groups
- Providing adequate support to facilitators new to the topic in order to maintain the high quality of facilitation required to replicate the training
- Adequate inclusion of and links to representatives of vulnerable groups in information-sharing and planning

The training was so powerful, the USAID/Calidad en Salud project conducted it for its own staff to explore the negative impact of stigma and discrimination on service quality and health outcomes, as well as issues of racism and classism in Guatemalan society, public services, and project interventions.

The stigma and discrimination interventions are just beginning to create an impact on demand for and use of services by vulnerable groups. Practices such as reporting positive HIV serostatus to brothel owners or other employers, marking serostatus on health cards, and discouraging pregnant CSWs from working without offering a viable alternative have been reduced, according to reports from service providers. Health workers are beginning to understand that such practices divert sex workers—particularly HIV-positive ones—to private STI control services that do not offer VCT, so they will not be identified, reported, and perhaps fired.

A few health centers have established good service links with nongovernmental groups supporting men who have sex with men, a group that is particularly reluctant to be publicly identified. Greater effort needs to be made to connect health services to community outreach and support networks, where this community can access

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This is the first project in the country that went right to the root of the problem—stigma and discrimination. We always start with HIV and make this issue a “cross-cutting theme”, which basically means no one has to do anything about it...Activists in this country have been trying to address stigma and discrimination with health care providers for the last twenty years.

—Project master trainer

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services discreetly and with confidence. The credibility of health services is low, and working with and through trusted groups should facilitate access in both directions.

One indicator of improved access for vulnerable groups is that health center staff report many fewer quarrels and disruptions in STI/HIV service waiting rooms. All project-supported health centers now offer STI/HIV services on a regular, if not daily basis to everyone, rather than segregate CSWs in special STI control sessions where they were often examined and treated in an, at best, condescending, assembly line fashion.

Although STI control for sex workers is mandatory, being able to make individual appointments; sit in a clean, well-equipped space that offers privacy; discuss all your health problems with a trained provider; and be assured of confidential treatment has lowered high defenses raised in response to discriminatory and offensive treatment.

Despite these advances, much remains to be done, particularly in extending services to MSM, who face crushing stigma in society. Health workers wonder if current plans to support a separate clinic for this client group will ghettoize treatment and contribute to further stigma.

Calidad en Salud’s IEC/BCC Advisor to lead the MOH’s Health Promotion and Education Department, where she conducted a series of graphic design workshops. This support is clearly evident in the high quality of the BCC materials the MOH produced to promote improved and integrated STI/HIV services to the priority groups of CSWs, MSM, and PLWHA.

USAID/Calidad en Salud supported the MOH’s development of an IEC/BCC strategy for STI/HIV and a range of behavior-focused materials for commercial sex workers, men who have sex with men, persons living with HIV/AIDS, and owners of entertainment establishments. (See Annex 1 for a list of materials). All materials followed good design principles, focused on desired behaviors, were tested and validated with their specific audience, and reprinted by the project.

Last year, on the day honoring public health workers, our health center made a float for a small parade that said ‘AIDS kills’. We were all dressed up like death and standing around a coffin. Another float right next to us—organized by community HIV activists—had as their theme ‘AIDS doesn’t kill; discrimination kills’.

It seemed funny at the time, but now I realize they were right: discrimination is a death sentence. We all know of suicide cases when a positive HIV test result was given.

—Health Center Director

b. Behavior change communication
Prior to the addition of an STI/HIV quality improvement initiative, USAID/Calidad en Salud provided intensive technical support to the MOH, at its request, to improve strategic planning and design of high-quality communication materials. This included a year-long secondment of USAID/
Through engagement in the committee, USAID/Calidad en Salud reprinted existing materials, such as national laws and norms, for use in its project sites and supported the development of a range of materials that were then printed by other donor agencies for national distribution.

With the improved availability of high-quality STI/HIV services in project sites, BCC activities to increase demand become even more important, in order to create a pull from the demand side for timely availability of tests, reagents, supplies, and continued MOH priority to STI/HIV services.

4. Integrating HIV/STI Within Reproductive Health Services

All project activities supported the objective of offering high-quality STI/HIV services at the health center level. As described, the MOH and USAID/Calidad en Salud built this initiative on the existing infrastructure for STI service provision—typically the mandatory STI control program for CSWs offered once per week, separate from clinic services for the general public. By the end of the project, 34 health centers were offering STI, VCT, and family planning services on a regular, if not daily, basis to the general public, including improved attention to high-risk groups.

Key Service Integration Results

- The first project in the experience of national HIV/STI program leaders to address STIs comprehensively and integrate them with HIV and other reproductive health services
- Family planning services routinely offered to STI and HIV service clients, and vice versa.
- Development, diffusion, and training in 34 health centers for correct use of:
  - clinical records covering structured screening and service provision
  - national norms for integrated STI/HIV treatment, including syndromic management of STIs, voluntary HIV counseling and testing protocols, and family planning services
- At least three centers have reorganized to provide a general waiting area where all clients are routinely offered all available services.
- Effective collaboration with the MOH, Global Fund, CDC, and PAHO for infrastructure planning; tests, supplies, and equipment; clinic refurbishment

5. Strengthening HIV/STI Surveillance and Monitoring Systems

As described earlier, USAID/Calidad en Salud provided significant support to improved laboratory and reporting capacity at the 34 project sites as well as improved national norms and systems for capturing STI/HIV service statistics (e.g., rollout of SIGSA-SIDA, integrated medical record forms, assistance with development of MANGUA for reporting integrated HIV treatment services). This contributed to overall monitoring of STI and HIV, especially if service statistics are analyzed for trends and gaps.

USAID/Calidad en Salud also directly supported improvements in the national STI/HIV surveillance system. An effective partnership of national health agencies, CDC,
and USAID/Calidad en Salud succeeded in adding rapid diagnosis and testing of gonorrhea and chlamydia to a national reference laboratory at the Zone 3 health center in Guatemala City, strengthening its role as a national resource for both STI/HIV service delivery and surveillance. USAID/Calidad en Salud equipped the center with PACE 2 diagnostic equipment, supervised its installation, trained staff in the testing process, and provided necessary reagents and supplies. This is the only such equipment in the country.

The partners also worked to expand the national STI and HIV sentinel surveillance system (VICITS) to three health centers in addition to the Zone 3 center (Puerto Barrios, Escuintla, and Quetzaltenango). The Fundación Sida i Societat supported the development of the site in Escuintla, with USAID/Calidad en Salud coordinating so that it used the same indicators as the other sites. Although the sentinel system is not yet functional in Quetzaltenango, data from the three other sites are already contributing to planning.

Key Sentinel Surveillance Results

- Three improved sentinel surveillance sites functioning (one pending)
- National capacity to diagnose chlamydia and gonorrhea and monitor infection trends
- Effective collaborative effort of MOH, USAID/Calidad en Salud, and CDC

III. Conclusion

By the end of the project, as planned, 34 health centers in 12 priority geographic areas were providing integrated, high-quality STI/HIV services on a regular, if not daily, basis. Services include syndromic management of STIs; VCT with increasing rates of post-test sharing of results, with counseling; and on-site testing. A national STI reference center (Health Center 2, Zone 3) was strengthened to provide chlamydia and gonorrhea diagnosis on a permanent basis.

A. Best Practices

- Assisting the MOH, in every activity, to implement its strategies and strengthen systems enhanced both relevance and sustainability. As a result, the MOH plans expansion to new sites using project approaches, training plans and materials, equipment lists, etc.
- Excellent coordination, through working in technical committees, expanded clinic rehabilitation, availability of IEC/BCC and training tools, scope of training programs, quality of reporting and surveillance systems, etc.
- Technical support contributed to the development and diffusion of national norms for integrated HIV/AIDS/STI services.
- Complementary participatory methodologies such as CQI teamwork and learning sessions, visits to model clinics, and state-of-the-art training created safe spaces to explore sensitive topics and negative attitudes and behaviors.
- Assistance to national and regional initiatives helped create a supportive environment for service delivery: national lab capacity, sentinel surveillance system, advocacy for budgeting for STI/HIV at both national and regional levels, and development and diffusion of improved reporting systems
- Development and use of an integrated medical record that screens for multiple risks

B. Recommendations

Recommendations to Further Reduce Stigma and Discrimination

- During the expansion phase supported by the MOH, provide regular venues for new stigma and discrimination trainers to interact and get support, particularly given the novelty and sensitivity of the topic.
- Bring trainers together to assess first phase training and materials, i.e., the relative importance of universal precautions vs. stigma and discrimination topics.
- Sensitize all clinic staff involved in providing other health services to CSW, MSM, and PLWHA in stigma and discrimination, in order to improve the overall quality and integration of services.
- Expand stigma and discrimination interventions in hospitals.
- Expand and/or link to efforts to address stigma and discrimination issues related to ethnicity, classism, etc.

Recommendations to Improve Access of Vulnerable Groups

- Strengthen community mobilization and regular client satisfaction assessments with vulnerable groups to increase use of and demand for improved services.
• Include representatives of priority vulnerable groups, as appropriate, in training, client satisfaction monitoring, and quality improvement efforts.

• Strengthen links between clinics and vulnerable groups in the community, possibly through training and support of HIV-positive outreach personnel from vulnerable groups.

• Provide organizational development and compliance support to small community groups representing marginalized populations that are learning to access and manage larger funding mechanisms, such as USAID or the Global Fund. (One example is the New Partners Initiative Technical Assistance Project under the U.S. President’s Emergency Plan for AIDS Relief)

Recommendations Regarding Behavior Change Communications

• Conduct a follow-up evaluation of use and impact of BCC materials at the community level.

• Finish the Carnet de la Mujer, a planned identity card that also carries messages CSWs want on preventive practices related to alcohol and drug use, weight control, prenatal care, etc.

Recommendations for Service Integration

• Strengthen smooth referral to all available clinic services for vulnerable groups

• Explore ways to improve partner notification and access to STI/VCT services.

• Support MOH efforts to expand project integration interventions to more facilities.

• Explore better integration of MOH norms and systems across programs.

Recommendation for Sentinel Surveillance System:

• Verify functionality of pending sentinel site in Quetzaltenango
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Consejería. Undated.
# Annex: STI/HIV Materials and Tools Supported by USAID/Calidad en Salud

<table>
<thead>
<tr>
<th>Information, Education, Communication/ Behavior Change Communication Tools</th>
<th>Objective</th>
<th>Target Audience</th>
<th>Number Printed by Project</th>
</tr>
</thead>
<tbody>
<tr>
<td>National IEC/BCC Strategy</td>
<td>Guide IEC/BCC activities in the national STI/HIV/AIDS program</td>
<td>National and regional AIDS Program staff, program managers and health education coordinators</td>
<td>Technical input only</td>
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<tr>
<td>Three-fold condom brochure for female commercial sex workers</td>
<td>Memory aid for negotiating condom use</td>
<td>Female commercial sex workers</td>
<td>50,000</td>
</tr>
<tr>
<td>Three-fold condom brochure for MSM</td>
<td>Memory aid for negotiating condom use</td>
<td>MSM</td>
<td>50,000</td>
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<tr>
<td>ID card for Female CSWs</td>
<td>Identify CSWs for STI control; reinforce healthful practices</td>
<td>Female CSWs</td>
<td>Not finalized</td>
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<tr>
<td>Three-fold STI brochure for female CSWs</td>
<td>STI prevention messages and encouragement to visit health centers</td>
<td>CSWs</td>
<td>50,000</td>
</tr>
<tr>
<td>Three-fold STI brochure for MSM</td>
<td>STI prevention messages and encouragement to visit health centers</td>
<td>MSM</td>
<td>50,000</td>
</tr>
<tr>
<td>Client flyer</td>
<td>Encourage condom use</td>
<td>Clients</td>
<td>150,000</td>
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<tr>
<td>Invitation to visit services</td>
<td>Invite MSM to use health services</td>
<td>MSM</td>
<td>50,000</td>
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<tr>
<td>“Successful Business&quot; leaflet</td>
<td>Remind business owners of STI control requirements and benefits of healthy workers</td>
<td>Business owners</td>
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<tr>
<td>&quot;Yo vivo bien&quot; leaflet for PLWHA</td>
<td>Healthful behaviors for PLWHA</td>
<td>PLWHA</td>
<td>20,000</td>
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</table>

<table>
<thead>
<tr>
<th>Tools for Service Providers</th>
<th>Objective</th>
<th>Target Audience</th>
<th>Number Printed by Project</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manual for counseling and managing emotions</td>
<td>Strengthen skills in counseling and managing emotions</td>
<td>Counselors</td>
<td>10,000</td>
</tr>
<tr>
<td>Set of pictorial cards depicting emotions;VCT</td>
<td>Job aid to support counseling and managing emotion</td>
<td>Counselors</td>
<td>10,000</td>
</tr>
<tr>
<td>Stigma and discrimination poster</td>
<td>Reminders of stigma-reducing practices</td>
<td>Counselors</td>
<td>10,000</td>
</tr>
<tr>
<td>Laboratory Diagnostic Manual for STIs</td>
<td>To diagnose STIs, with emphasis on syndromic management, following national protocols</td>
<td>Laboratory staff</td>
<td>50</td>
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<tr>
<td>STI/HIV/AIDS Counseling and Reporting Guidelines</td>
<td>To improve integrated counseling and report according to national protocols</td>
<td>Counselors</td>
<td>Technical input only</td>
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<tr>
<td>Manual on Use of SIGSA-SIDA</td>
<td>To correctly report HIV-related data electronically using the upgraded health management information systems</td>
<td>Program managers and data management staff</td>
<td>Technical input only</td>
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<tr>
<td>Pipeline Users Manual (logistics)</td>
<td>To understand requisition processes and make requests in a timely fashion</td>
<td>Program managers and data management staff</td>
<td>35</td>
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<tr>
<td>Guide for Nutrition of Infants of HIV-Positive Mothers</td>
<td>Strengthen infant feeding counseling</td>
<td>Counselors</td>
<td>Technical input only</td>
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<tr>
<td>Laminated counseling cards on feeding infants of HIV-Positive Mothers</td>
<td>Job aids for counseling on infant feeding</td>
<td>Counselors</td>
<td>Technical input only</td>
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<tr>
<td>Flipchart: Let’s Talk about STIs, HIV, and AIDS without shame, fear, or prejudice</td>
<td>Job aids for counseling</td>
<td>All service providers</td>
<td>Technical input only</td>
</tr>
<tr>
<td>Training Manuals for facilitators and participants: Reduction of Stigma and discrimination related to STI/HIV/AIDS</td>
<td>To implement interactive training to reduce stigma and discrimination in health services</td>
<td>Facilitators and training participants</td>
<td>As needed</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Reprints of Existing Tools for Use in Project Sites</th>
<th>Objective</th>
<th>Target Audience</th>
<th>Number Printed by Project</th>
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</thead>
<tbody>
<tr>
<td>Manual for Syndromic Management of STIs</td>
<td>To correctly apply service protocols</td>
<td>Clinical Service Providers (doctors, nurses, auxiliaries)</td>
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<tr>
<td>Flowchart for syndromic management of STIs (job aid)</td>
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<tr>
<td>Flowchart for syndromic management of STIs (poster)</td>
<td></td>
<td></td>
<td>600</td>
</tr>
<tr>
<td>Trilogy of STI-HIV/AIDS Laws</td>
<td>To correctly apply national STI-HIV/AIDS policy and reduce stigma and discrimination</td>
<td>All service providers</td>
<td>500</td>
</tr>
<tr>
<td>HIV Bulletin</td>
<td></td>
<td></td>
<td>500</td>
</tr>
</tbody>
</table>