National HIV/AIDS Strategy 2007-2011

MINISTRY OF HEALTH

GUYANA NATIONAL HIV/AIDS STRATEGY 2007-2011

Government of Guyana National HIV/AIDS Programme
http://www.hiv.gov.gy

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PREFACE

HIV/AIDS is both a National and International crisis. Together with nuclear war, global warming, chronic and sustained armed conflicts in various parts of the world and inequitable international finance and trade policies, HIV/AIDS constitute one of the world's most challenges. HIV/AIDS today represents one of the greatest potential threat to achieving the Millennium Development Goals (MDGs).

Guyana has boldly pursued polices and programs intended to reverse the impact that HIV/AIDS has had on our country. In putting together a 2002-2006 National Strategy, we embarked on an ambitious program at a time when all programs were being supported only by the Central Government and at a time when few local or international NGOs were willing to be involved in the Guyanese fight against HIV/AIDS.

Fortunately, soon after the introduction of the 2002-2006 National Strategy, Guyana became a recipient of significant amount of funds from various sources – PEPFAR (the US Emergency Fund to fight against HIV/AIDS), CIDA (the Canadian Development Agency), the World Bank, the Global Fund to Fight Against HIV/AIDS, TB and Malaria. Significant assistance was derived, too, from traditional technical partners, which all increased their involvement in the fight. These included PAHO, UNICEF, UNFPA and UNAIDS and CAREC and CDC.

The result was that Guyana has been able to make significant progress in the fight against HIV/AIDS. The Guyana program includes all components in the fight against HIV/AIDS and the new national strategy is designed so as to roll-out the various programs. Ultimately, the major theme of the new strategy is UNIVERSAL ACCESS.

Most of the tools to fight against HIV/AIDS are known and are available for use. The limitation is often access to these tools. National access is determined by several factors, including availability of funds and human resource capacity and recognition that lifestyle is a major determinant of the disease and consequently, major lifestyle changes are required.

But new tools are also becoming rapidly available and a country's ability to quickly access these new tools, including new drugs and vaccines is also important for a successful; fight against HIV/AIDS. Our strategy must be designed to take immediate advantage of new tools and not have to wait several years, long after the introduction of these prevention and treatment, care and support tools in developed countries, to be able to access them in our country.

Guyana has made significant progress in our fight against HIV/AIDS. We have a chance to successfully reduce the impact of HIV/AIDS in our country. We have a chance to be a model for how to combat this scourge.

I commend the 2007-2011 National Strategy and urge every one to work diligently to implement the various programs. It is again an ambitious program and we faithfully implement the various activities outlined in the strategy, we are bound to succeed.

Even as I express our profound gratitude to all those who have worked on this document, I urge everyone that only a robust effort to provide universal access to all the prevention, treatment, care and support programs quickly to people will suffice.

Thank you.

Dr. Leslie Ramsammy
Minister of Health, Guyana

LIST OF ACRONYMS AND ABBREVIATIONS

ABC	Abstinence, Be Faithful, Correct, Consistent, Condom Use
AIDS	Acquired Immunodeficiency Syndrome
AIS	AIDS Indicator Study
ANC	Ante-natal clinic
ART	Anti-retroviral therapy
ARV	Anti-retroviral
BCC	Behaviour change communication
BSS	Behavioural surveillance survey
CAREC	Caribbean Epidemiology Centre
CARICOM	Caribbean Community
CBO	Community-Based organisation
CCM	Country Coordinating Mechanism
CHART	Caribbean Regional HIV/AIDS Training
CIA	Central Intelligence Agency
CIDA	Canadian International Development Agency
CIOG	Central Islamic Organisation of Guyana
CMC	Central Medical Centre
CSIH	Canadian Society for International Health
CSW	Commercial Sex Workers
CT	Counselling and Testing
DDC	Department of Disease Control
DHHS/CDC	United States Centers for Disease Control and Prevention
DOD	Department of Defence
DOTS	Direct Observation Therapy Strategy
EP	Emergency Plan
EU	European Union
FBO	Faith-based organisation
FTE	Full Time Equivalent
G+	The Network of Guyanese Living with HIV and AIDS
GDF	Guyana Defence Force
GDP	Gross Domestic Product
GECOM	Guyana Elections Commission
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GHARP	Guyana HIV/AIDS Reduction and Prevention Programme
GOG	Government of Guyana
GPC	Guyana Pharmaceutical Corporation
GTUC	Guyana Trades Union Congress

GTZ	German Agency for Technical Cooperation
GUM	Genito-urinary Medicine
HBC	Home-based care
HDI	Human Development Index
HFLE	Health and Family Life Education
HIPC	Heavily Indebted Poor Countries Initiative
HIS	Health Information System
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information Systems
HRM	Human Resource Management
HSDU	Health Sector Development Unit
ID	Identification
IDB	Inter-American Development Bank
IDEA	Institute for Democracy and Electoral Assistance
IEC	Information, Education and Communication
IHV	Institute of Human Virology
ILO	International Labour Organization
IMF	International Monetary Fund
JHPIEGO	Johns Hopkins Program for International Education in Gynaecology and Obstetrics
LIDC	Low Income Developing Country
LMIDC	Low Middle-Income Developing Country
M&E	Monitoring and Evaluation
MARPS	Most at Risk Populations
MCH	Maternal Child Health
MDR	Multi Drug Resistance
MMU	Materials Management Unit
MOH	Ministry of Health
MSM	Men who have sex with men
NAC	National AIDS Committee
NAPS	National AIDS Programme Secretariat
NBTS	National Blood Transfusion Service
NDC	Neighbourhood Democratic Council
NGO	Non Governmental Organisation
NLID	National Laboratory for Infectious Diseases
NTCC	National Training Coordination Centre

OIS	Opportunistic infections
OPEC	Organisation of Petroleum Exporting Countries
OVC	Orphans and vulnerable children
PAC	Presidential AIDS Commission
PAHO	Pan American Health Organization
PCVS	Peace Corps Volunteers
PEPFAR	President's Emergency Plan for AIDS Relief
PLWHA	People living with HIV and AIDS
PMIS	Patient Management Information System
PMTCT	Prevention of Mother to Child Transmission
PNC-R	People's National Congress-Reform
RAC	Regional AIDS Committee
RDC	Regional Democratic Council
QI	Quality improvement
S&D	Stigma and discrimination
STI	Sexually Transmitted Infection
SOP	Standard Operating Procedures
TA	Technical Assistance
TB	Tuberculosis
TIMS	Training Information Management System
TTIS	Transfusion-transmitted infections
UK	United Kingdom
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Program
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
USDOL	United States Department of Labour
USG	United States Government
WHO	World Health Organization

SECTION 1

INTRODUCTION

The Government of Guyana has declared HIV/AIDS a National Priority and has made this priority an important plank in its Poverty Reduction Strategy Program (PRSP). The Government has committed itself to an accelerated, comprehensive, multi-sector, multi-level response and has declared that only through a well – coordinated partnership with local and international partners could Guyana respond effectively to the challenge of HIV/AIDS. The Government is convinced that HIV/AIDS is a barrier to development.

The Plan that follows is based on a number of Government commitments and policy positions:

- Universal access to HIV testing for all citizens: know you status campaign.
- Universal access to PMTCT: ensure that all women of reproductive age and their families have access to PMTCT through antenatal clinics (public and private).
- Universal access to ARV-based treatment and CD4 based management to all PLWHA.
- Link all relevant public health programmes to HIV services: just as all TB patients are tested for HIV, similarly a VCT programme will be located within the Hanson, Malaria and other relevant programmes.
- Move to an "**opting out**" programme for HIV testing: starting with the PMTCT programme an "**opting out**" procedure will be introduced and will be used in conjunction with VCT
- Promote legislation to prevent stigma and discrimination based on HIV status
- Provide foster care as part of OVC.
- Develop curricula for HIV/AIDS as examination subject in school.

1.1_STRATEGIC GOAL

The overall strategic goal of the 2007 -2011 NSP for HIV/AIDS remains the same as that of the NSP 2002-2006:

> **"To reduce the social and economic impact of HIV and AIDS on individuals and communities, and ultimately the development of the country".**

Overall Strategic Objective

The **overall strategic objective** is to reduce the spread of HIV and improve the quality of life of PLWHAs.

Specific Objectives:

Some of the specific objectives are to:

- Empower citizens by providing universal access for HIV/AIDS care, support, education and awareness program.
- Promote behaviour changes that reduce risks among all people, especially vulnerable groups.
- Enable each citizen to know his or her HIV status by providing easy accessible counselling and testing and by promoting an "opt-out" strategy.
- Provide easily accessible universal PMTCT services to all pregnant women and their families.
- Ensure safe blood supply.
- Provide treatment, care and support for OVC.
- Provide treatment, care and support for all PLWHA.
- Create space for the involvement of all citizens and groups in the multi-sector fight against HIV/AIDS, including space for the involvement of PLWHA.
- Reduce stigma and discrimination through BCC program, supported by an adequate legal framework.
- Build capacity for the overall response.
- Improve the information system and strengthen the surveillance program.
- Strengthen the overall coordination of the HIV/AIDS response program.

1.2_THE NATIONAL STRATEGIC PLAN 2007-2011

Guyana is at a critical point in its HIV/AIDS response where its National Programme is faced with new challenges. As a result the National Response has to be scaled-up to deliver more programmes, services and activities that reach a wider cross section of people. Over the last two years, through a combination of strong political leadership and the use of National HIV/AIDS Strategic Plan 2002 -2006, the Government has been able to mobilize significant financial resources to support the HIV/AIDS programme. It is therefore important that these new resources are used efficiently and effectively over the next four years if the country is to attain universal access and achieve its long-term goal of reducing the social and economic impact of HIV/AIDS on individuals and communities and ultimately the development of the country.

As we prepare to launch the new program, there is also the question of the adequacy of resources to implement the strategy outlined. The plan being articulated in this document clearly demonstrates that Guyana will need to use present resources productively and must also mobilize more resource in order to fully implement the ambitious program planned for 2007-2011. The exceptionality of the HIV/AIDS pandemic requires that the resources must be mobilized and Guyana must not be forced to curtail its plan in order to fit available resources.

Cognisant of the problem of donor coordination, earlier this year at a Care and Treatment Workshop in April 2005, the Minister of Health, Dr. Leslie Ramsammy, in his address said: **"The time had come to collectively review these various work plans, to identify the gaps, and to decide on the allocation of responsibilities for implementing the new strategic plan which was to be developed. It was hoped that a work plan for the next two years could be drafted which would promote collaboration among the various agencies and avoid duplication**."[1] This issue of harmonisation put forward by the Minister is important and timely. In February 2003, at a meeting in Rome, a Declaration on Harmonisation was signed by a number of donor

[1] *PAHO Workshop Report, The Guyana HIV/AIDS Care and Treatment Plan, May 2005.*

agencies[2]. The agreement encourages donor agencies to improve coordination among themselves and with countries when responding to national priorities.

The National Strategic Plan 2007-2011 seeks to harmonise and align the resources and responses of all its partners to ensure that they meet Guyana's National Priorities. It is intended to strategically guide the future direction of Guyana's National HIV/AIDS Response since it outlines the basic approaches, principles, strategic priorities, objectives and strategic activities. The formulation of the plan will also be aligned with one National Monitoring and Evaluation Plan.

The new Plan also seeks to build on the good work that was carried out during the development of the 2002-2006 National HIV/AIDS Strategic Plan that was designed using a participative process, involving the National AIDS Programme and the major partners within the public, private and donor communities.

This 2007-2011 Plan aims to provide the following benefits:

- A structured framework that will allow Government to continue to its leadership and to build the capacity to manage and implement the programmes, interventions and activities of the National response across the various sectors.
- A structured framework that can be used to make optimal use of the financial and technical resources.
- An opportunity to strengthen the leadership and management initiatives that began with the Presidential Commission on AIDS.
- A structured framework that encourages harmonisation and alignment among partners in the achievement of the National priorities of Guyana's HIV/AIDS response.
- An opportunity to coordinate and streamline the HIV/AIDS work plans of the various agencies based on common arrangements, procedures and systems.
- A chance to build capacity for a monitoring and evaluating system so that the GOG can measure the impact of its multi-sectoral national HIV/AIDS response.
- An effective vehicle for encourage the involvement and empowerment of all the stakeholders and partners reaching all vulnerable populations.

A National Monitoring and Evaluation plan complements this framework so the information can be used to measure progress and impact and to inform actions that will need to be taken to strengthen the response during implementation.[3]

The National Strategic Plan 2007-2011 takes into consideration a number of declared public policy statements by the Government. Those are detailed in Section: 4.4

The plan also takes into consideration a number of national and regional development plans. These include:

- The National Development Strategy (NDS)
- The Poverty Reduction Strategy Program (PRSP)
- The National Health Plan 2003-2007
- The National AIDS Policy Document
- Caribbean Charter on Health II (CCH II)
- The CARIBBEAN Regional HIV/AIDS Strategic framework, and

[2] *The Rome Declaration on Harmonization, High Level Forum on Harmonization, 24-25 February ,2003, where senior officials from more than 20 bilateral and multi-lateral development organizations and approximately 50 countries reaffirmed their commitment to achieving the Millennium Development Goals and agreed to harmonize their policies, procedures and practices.*

[3] *National M&E Plan outlines the detailed indicators and targets that will be used to monitor and evaluate the HIV/AIDS response.*

- PAHO/WHO Regional HIV/STI Plan

The Plan further takes cognizance of partnerships programs, such as:

- The World Bank HIV/AIDS Reduction Program
- The Global Fund HIV/AIDS Program
- PEPFAR (GHARP)
- CIDA's HIV/AIDS/STI Program

The plan is also consistent with international declarations and commitments that Guyana is a part of these include:

- MDGs
- UNGASS Declaration 2001
- The 3 Ones
- 3x5 Initiative
- UNAIDS Declaration of universal access.

SECTION 2

HIV/AIDS IN GUYANA

Guyana (215,000 square km), a developing country, located on the northeast coast of South America, is bordered by the Atlantic Ocean, Suriname, Brazil and Venezuela. It is considered part of the Caribbean and is a member of the Caribbean Community (CARICOM). However, Guyana is today pursuing stronger political, economic and social engagements with its South American sister countries, particularly, the neighbouring countries of Brazil, Suriname and Venezuela.

Political context: Guyana is a fledgling democracy, having reversed a period of non-democratic rule between 1968 and 1992. The strengthening and expansion of democratic institutions, coupled with recent constitutional and parliamentary reforms, have resulted in greater participation of parliament and civic society in decision-making and fiduciary oversight.

This former British territory gained independence on 26th May 1966 and became a republic in February 1970. An executive president is both the head of state and government. There are several levels of elected government ranging from parliament and Regional Democratic Councils (RDCs) to Neighbourhood Democratic Councils (NDCs) and Community Development Committees (CDCs). Members of parliament comprise members, representing national slates and geographic regions, elected by a system of proportional representation. The local government system consists of ten RDCs, seven mayoralties and sixty-five NDCs. There are also Amerindian village councils that operate under separate legislation. The RDCs are administratively responsible for delivery of services – health, education, etc - to their populations.

A NDS was formulated in 2000 by a civic group, consisting of more than 150 professionals and Private Sector Individuals, with financial support from the Government and with the Carter Center of the USA playing a facilitating role. The NDS was formally adopted by Parliament on December 15, 2005 and a mechanism was established for its updating and monitoring of its implementation.

Economic Context: Guyana is HIPC, with a per capita GDP of US$ 869 in 2004. From 1991-97, GDP grew at an average of 7.3% per annum but, following internal political turmoil, unfavourable weather conditions and external shocks, this growth trend has been difficult to sustain in the period 1998-2004 (-1.8% to +3.0%). Guyana is today categorized as Low Middle-Income Developing Country (LMIDC). It graduated from its position as a Low Income Developing Country (LIDC), where it was for the whole of the 1970s, 1980s and most of the 1990s.

Debt Servicing: Between 1970 and 1992, Guyana accumulated one of the highest debt burdens in the world as the debt rose from 30% to 470% of GDP. By 1992, 94% of its earnings had to go towards servicing interests on its debt. Since then, through prudent fiscal management, growing economy and debt relief, Guyana has succeeded in significantly reducing this burden. As a satisfactory-performing country, Guyana has benefited from significant debt-relief.

Social Context: A national population census was conducted in 2002.The census recorded a multi-racial population of 751,223 (up from 723,673 from the 1991 Census). The sex distribution of the population shows that 50.1 % were males and 49.9% were females. Approximately 35.5% of the population was under 15 and 7% over 60 years old. The age group mostly affected by HIV/AIDS (15-49) represents 51.3% of the population. Approximately 28.4% of the population lives in urban areas and 71.6% live in rural areas. The coastal Regions 2 (49,253),3 (103,061),4 (310,320),5 (52,428) and 6 (123,695) account for 85.1% of the population. The rural interior (Regions 1, 7, 8 and 9) is very sparsely populated with 9.4%. East Indians represent approximately 43.5% of the population, African/Black 30.2% and the Amerindian population 9.2%. Mixed-heritage accounted for 16.7% of the population. Other ethnic groups in the country include 0.26% Portuguese (whites) and 0.2 Chinese. The Christian (various denominations) population is 55.4%, the Hindus make up 28.4% and the Muslims make up 7.2%. Very small groups include the Bahai and the Rastafarians. Adult literacy is estimated as 98%[4]. The gross enrolment rate at the secondary level is 76% and at the primary level 99%. These represent significant increases from a decade ago. There are also increasing numbers of students at the University of Guyana and in various vocational institutions in the country.

Guyana is gradually recovering from debilitating poverty circumstances. The difficult economic circumstances of the 1970s and 1980s culminated in poverty rates of between 65 and 86% for the period 1988 and 1991. In 1993, after the restoration of democracy, absolute and critical poverty fell to 43.2 and 27.2%respectively and this further improved in 1999, when approximately 36.3% of the population lived in absolute poverty (US$ 510 per year or US$1.40 per day) and 19.1% in critical poverty (US$ 364 per year or US$1 per day). Guyana was declared eligible for debt relief under the HIPC in 1997 and is now part of the enhanced HIPC program. Guyana is in the third year of its Poverty Reduction Strategy. Funds from debt relief are allocated to expenditures in the social sectors (education, health, housing and water) and to poverty alleviation programs. The PRSP budget is expected to increase allocation to health by about 30% of recurrent budget. In 2005, Guyana ranked 107th on the Human Development Index 2005 Report. The Gender-related Development Index (GDI) for Guyana is 79th in 2005. The GDP Index increased from 0.59 (2002) to 0.64 (2003) and 0.7 in 2005.

TABLE 1_KEY MORTALITY INDICATORS, ADJUSTED FOR UNDER-REPORTING[5]

INDICATOR	REPORTED RATE PER THOUSAND	ESTIMATED RATE ADJUSTED
Stillbirth rate	17.1-18.2	19.5-34
Neonatal mortality rate	13.5-18.1	26-36
Infant mortality rate	18-54	30-54
Under five mortality rate	31.3 –72	40-72
Maternal mortality/100,000)	101-133	168
Crude death rate	5.4	7.5

[4] *Human development Report 2005, UNDP.*
[5] *National Health Plan 2003-2007.*

TABLE 2_MAJOR CAUSES OF DEATH BY AGE GROUP NATIONALLY	
AGE GROUP	**LEADING CAUSES OF DEATH**
Under 5	Perinatal, ARI[1], ADD[1], accidents/injuries, HIV/AIDS
5-15	Accidents/injuries, ARI[1], ADD[1], cancer, malnutrition/anaemia
15-44	HIV/AIDS, accidents/injuries, suicide, ARI[2]/ADD[2]
45-64	Heart disease[3], cerebrovascular disease (stroke), diabetes, cancer

TABLE 3_DISTRIBUTION OF HEALTH SERVICES BY REGIONS													
	NATIONAL TOTALS	COASTAL REGIONS						HINTERLAND REGIONS					
		3	4	5	6	10	TOTAL	1	2	7	8	9	TOTAL
Health Post	**182**	25	10	2	1	13	51	31	17	15	16	52	131
Health Centre	**112**	13	25	14	24	10	86	4	12	3	4	3	26
District Hospital	**18**	3	0	3	3	2	10	3	1	1	1	2	8
Regional Hospital	**4**	1	0	0	1	1	3	0	1	0	0	0	1
National Hospital	**5**	0	4	0	1	0	5	0	0	0	0	0	0
Totals	**321**	**42**	**39**	**18**	**30**	**26**	**155**	**38**	**31**	**19**	**21**	**57**	**166**
% total population	**100**	13.3	81.0	7.1	19.7	5.4	86.5	2.5	6.0	2.0	0.8	2.1	13.4
Private Hospitals	**5**	-	5	-	-	-	5	-	-	-	-	-	-
Private Doctors	**115**	5	80	5	20	4	114	0	0	0	0	1	1
Total Beds	**2,187**	183	951	37	554	146	1,871	85	107	56	28	40	316
Public Acute Beds	**1,631**	183	615	37	334	146	1,315	85	107	56	28	40	316

TABLE 4 HEALTH NEEDS & PREDICTED CHANGES FOR THE GUYANESE POPULATION

CONDITION	ESTIMATED NUMBERS	PREDICTED TO CHANGE	AGES AFFECTED	DISTRIBUTION	NATIONAL PROGRAM	PRIMARY CARE INVOLVED
INFECTIOUS						
HIV/AIDS	25,000	Increase	<5; 15-44	All	Yes	Yes
Malaria	30,000	Stable	All	Hinterland	Yes	Yes
TB	600	Increase	All	All	Yes	Yes
Syphilis/other STIs	15,000	Increase	15-64	All	No	Yes
Filariasis	20,000	Decrease	1-44	Urban	Yes	Yes
NUTRITION AND ANAEMIAS						
Anaemia	320,000	Decrease	All	All	Planned	Yes
Malnutrition	10,000	Decrease	<5	All	Planned	Yes
Intestinal Worms	12,500	Stable	All	All	No	Yes
Vascular						
Hypertension	65,000	Increase	>45	All, Higher Afro Guyanese	Planned	Yes
Diabetes	40,000	Increase	>45	All, Higher in East Indians	Planned	Yes
MISCELLANEOUS						
Accidents and Injuries	17,000	Stable	All	All	No	Yes
Suicide	100	Stable	All	All, Higher in East Indians	Planned	Yes
Risk factors						
Smoking	130,000	Increase	>15	All	Planned	Yes
Obesity	125,000	Increase	All	All	Planned	Yes
Diet	All	-	All	All	Planned	Yes
MATERNAL AND CHILD HEALTH						
Antenatal and Postnatal Care	Pregnant women	-	>12	All	Yes	Yes
EPI	All infants	-	0-2	All	Yes	Yes

Sector financing: health care services in the public sector are free. Total public sector expenditure is estimated at US$ 33m or about $US48.5 per capita for 2003. It is believed that public sector expenditure accounts for more than 80%, with out-of-pocket and insurance contributions (private sector expenditure) accounting for less than 20% of the total health care cost in the country (figure 2). In 2002, health expenditure amounted to 8.4% of total government expenditure (10.1% if debt payments are excluded) and trends for this are shown in table 7. While it is obvious that the health sector requires a greater injection of financial resources, it must also be obvious that the ability of government to do so in the foreseeable future is restricted. Note that the government already commits more than 37% (table7) of its total expenditure on the social services and that with debt servicing, more than 50% of public sector expenditure is accounted for. In addition, the country's revenues are usually significantly below budget projections (>-15%). The country receives significant technical cooperation support for the health sector and in 1999, donors accounted for 5.22% of government health spending (compared with 11% in 1997). All the funds are grants. The principal sources of external financing in 1999 and 2000 were the Inter American Development Bank, UN agencies, PAHO, USAID and GTZ. Guyana's immunization program benefits significantly from GAVI.

TABLE 5_SECTOR EXPENDITURE 1992-2001

	1991	1993	1994	1995	1996	1997	1998	1999	2000	2001
Per Capita GDP ($US)	350	531	612	680	766	808.3	777.5	770.3	773	737.9
Social Sector Exp. as % of Total Expenditure	8.9	20.4	25.6	22.2	29.7	28.7	29.6	31	32.5	35.2
Public expenditure on health ($GY,000,000)	703	2,022	2,737	2,214	2,686	2,769	2,951	3,550	4,423	4,402
Public expenditure on health as % of total public expenditure	3.6	7.9	9.0	6.3	6.8	7.6	6.8	7.6	7.4	6.9
Total per capita health expenditure in US$	8	29.1	34	39	43.4	45.4	45.4	46	48	48

2.1 THE UNFOLDING STORY OF HIV/AIDS IN GUYANA

There appears to be a stabilization of the epidemic

The first documented case of HIV/AIDS in Guyana was in 1987. Since this documented first case, UNAIDS estimated that Guyana has an adult prevalence of HIV infection of about 2.5% (range 0.8% to 7%) at the end of 2004.

Surveillance studies among some vulnerable populations seem to suggest a stabilization of the epidemic. The following Table supports this assertion:

TABLE 2.1.1: HIV PREVALENCE AMONGST VULNERABLE POPULATIONS

POPULATION	GENDER	YEAR	PREVALENCE (%)	REMARKS
Blood Donors	All	2001	1.0	Blood Bank survey
		2004	0.8	
Pregnant Women	Female	1993	3.7	
		1995	7.1	
		2000	5.6	ANC Survey
		2002	3.9	PMTCT Sites
		2003	3.1	PMTCT Sites
		2004	2.5	PMTCT Sites
		2004	2.6	ANC Survey
		2005	2.1	PMTCT Report
STI Patients	Male	1992	13.2	Clinic Records
		2002	15.1	Clinic records
		2004	19.8	Clinic Records
		2005	17.3	Clinic Records
	Female	1993	6.5	Clinic Records
		2002	12.0	Clinic Records
		2004	15.8	Clinic Records
		2005	16.9	Clinic Records
CSW	Female	1992	25.0	CSW Survey
		1997	45.0	CSW Survey
		2004	26.6	BBSS, 2004
MSM	Male	2004	21.25	BBSS, 2004
TB Patients	All	1997	14.5	Clinic Records
		2003	30.2	Clinic Records
		2005	?	Clinic Records
Miners	Males	2000	6.5	1 mine
		1999	11.9	1 mine
		2004	3.9	22 mines

Guyana has officially recorded 7,512 cases up to the end of 2004. The data in Table 2.2.2 below provides further evidence that the epidemic has stabilized. With greater accessibility to VCT and Treatment and Care Centers, more testing for HIV is being done by the public and private sectors and NGOs. Under-reporting was a serious problem in the early years and while significant under-reporting is still a problem, this issue is being gradually addressed. In spite of increased testing, the number of new recorded cases has remained relatively stable between 2001 and 2005 as seen in Table 2.1.2 and Fig. 2.1.1

Fig. 2.1.1_HIV/AIDS in Guyana 1987-2004
Reported Cases & Incidence

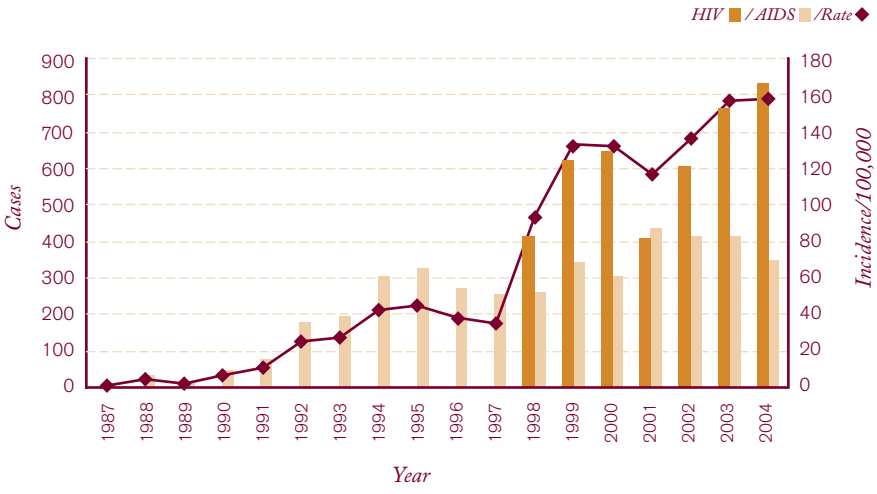


TABLE 2.1.2: HIV AND AIDS CASES FROM 1987 – 2004 BY GENDER (2000-2004)

CLASSIFICATION	1987-1999	2000	2001	2002	2003	2004
HIV	Male	348	174	301	339	368
	Female	300	226	268	368	408
	Unknown	0	9	39	55	61
	Total	648	409	608	762	837
AIDS	Male	175	232	243	232	117
	Female	132	185	146	163	204
	Unknown	0	18	26	22	27
	Total	307	435	415	417	348
HIV/AIDS	Year Total	955	844	1023	1179	1185
Cumulative (All cases from 1987)	2326	3281	4125	5148	6327	7512

Young people are disproportionately affected and there is an increasing feminization of the epidemic

The data demonstrate that while the early epidemic affected more men than women, there is an increasing feminization of the epidemic and more women are recorded with HIV today than men, especially in the age groups of 15 and 24. More than 90% of the recorded cases occur among the age groups of 15 to 49.

TABLE 2.1.3_DISTRIBUTION OF AIDS CASES BY GENDER AND AGE GROUPS (1999-2004)

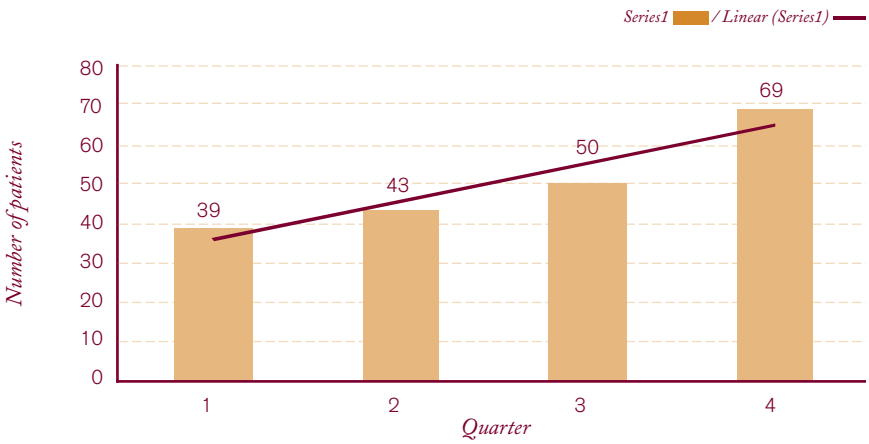
AGE GROUP	1999		2000		2001		2002		2003		2004		TOTAL		TOTAL
	M	F	M	F	M	F	M	F	M	F	M	F	M	F	
<1	3	0	2	2	7	3	0	0	0	0	0	0	12	5	17
1-4	10	1	6	5	9	4	9	5	7	5	1	4	42	24	66
5-14	1	2	3	0	6	4	5	5	2	5	5	5	22	21	43
15-19	4	7	3	4	1	9	4	3	0	2	4	2	16	27	43
20-24	19	14	16	16	20	28	9	16	13	13	9	14	86	101	187
25-29	30	53	35	23	32	24	43	30	28	21	20	17	188	168	356
30-34	51	20	25	30	48	28	48	27	54	37	42	19	268	161	429
35-39	32	14	30	24	33	14	37	26	38	28	40	17	210	123	333
40-44	20	9	26	9	19	20	24	11	25	19	26	9	140	77	217
45-49	20	8	11	6	15	15	15	8	20	11	15	7	96	55	151
50-54	6	3	3	7	5	7	14	2	16	7	11	3	55	29	84
55-59	3	2	3	4	4	3	4	3	2	0	5	2	21	14	35
60+_	3	2	8	2	6	4	13	0	2	1	3	1	35	10	45
NS	2	2	4	0	27	22	18	10	23	14	25	17	99	65	164
	204	137	175	132	232	185	243	146	232	163	204	117	1290	880	2170

Treatment is Working

Guyana has moved from a centralized treatment program to providing treatment nationally. Treatment with ARVs started in April 2002 at one treatment centre (the GUM Clinic). Since then several new centres have been introduced in the public and private sector. At the end of 2005, there were eight (8) public health centres offering treatment and care, including the provision of ARVs and CD4 testing. These centres are located in Regions 2,3,4,6,7 and 10. In addition, treatment is being provided in Regions 1, 8 and 9 through visiting specialist teams. The St. Joseph's Mercy Hospital is a private hospital that also offers treatment and care under the Ministry of Health's program. These treatment and care programs are offered freely to PLWHA. Private physicians and hospitals also provide treatment, but these private arrangements have not yet become part of the national surveillance.

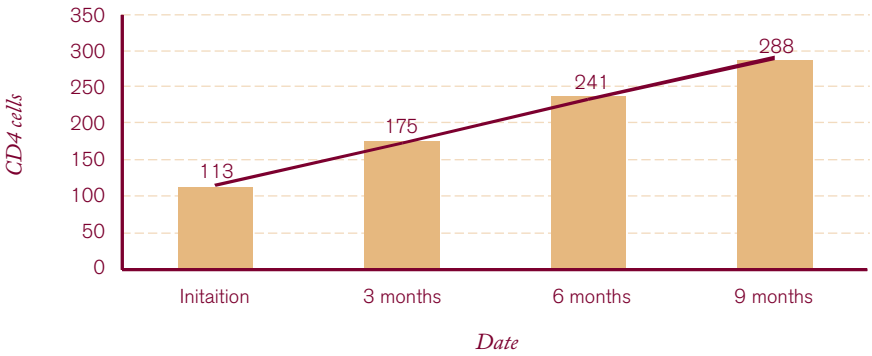
The numbers of person accessing the treatment program has accelerated since the beginning of 2005. Fig. 2.1.2 shows the number of PLWHA who were initiated into the treatment program by quarter in 2005. During the first quarter of 2005, the number of PLWHA that were initiated into the treatment program was 13 per month. This increased to 23 per month in the last quarter of 2005. At the end of 2005, there were 1202 on treatment in the national program, exceeding the 3 by 5 target of 1,000 for the end of 2005.

Fig. 2.1.2_Number of Persons Initiated on Treatment by Quarter in 2005



The immunological status of PLWHA and who are on treatment has significantly improved. Immunological monitoring of PLWHA started in September 2004 with the introduction of CD4 testing. This has been one of the factors that have led to the increased initiation of persons on ARV treatment. Clinical decisions on when to start ARV treatment is now based on a protocol that include the use of CD4. When the ARV treatment program started in 2002, the decision was based on a sydromic model, without CD4. At the start of the program, a cut-off of CD4 count of 200 was used. Since September 2005, the CD4 cut-off has been increased to 350. Treatment with ARVs has resulted in significant clinical and immunological improvement for PLWHA. For example, the average CD4 count for PLWHA at initiation for ARV treatment in 2005 was 113. The CD4 count improved significantly by 3,6 and 9 months after treatment with ARV started, as seen in Fig. 2.1.3

Fig. 2.1.3_CD4 Monitoring



Viral Load Status of PLWHA has also shown indication that treatment is working: Viral load testing was introduced through the Ministry's program with St. Joseph's Mercy Hospital. This program is through the sponsorship of PEPFAR and is being implemented in collaboration with CRS and the Baltimore-based Institute of Human Virology (IHV). Preliminary analysis shows that PLWHA and who are on HAART are generally doing well based on viral load testing. In a survey of 114 PLWHA on HAART for up to six months, 26.3% had a viral load of under 400 and 68.6% had viral load of <1,000. When the 114 PLWHA were grouped into two groups (those doing well and those not doing well, the viral load status was as follows:

Group	Mean Viral Load	Median Viral Load	75th Percentile VL
Clinical Failure	28,950	5,175	45,770
Doing Well	1,165	600	811

AIDS-Related Deaths have stabilized (Table 2.1.3 and Fig. 2.1.4). In the 1990s, there were increasing numbers of persons whose deaths were directly attributed to HIV/AIDS. The number of deaths per year has slowed down and appears to have been stabilized. This may be directly because increasing numbers of persons are accessing treatment and care and survival time is increasing.

TABLE 2.1.3: MORTALITY RATE OF AIDS IN GUYANA (1999 – 2003)

	1999		2000		2001		2002		2003	
	M	F	M	F	M	F	M	F	M	F
AIDS Deaths	302		312	171	240	165	284	191	206	168
	39.2		81.5	43.3	62.2	41.4	75.5	50.9	54.8	44.7
Crude Death Rate	39.2		62		51.6		63.2		49.8	

Fig. 2.1.4_Guyana HIV/AIDS Crude Death Rate 1999-2004

Voluntary Counseling and Testing:

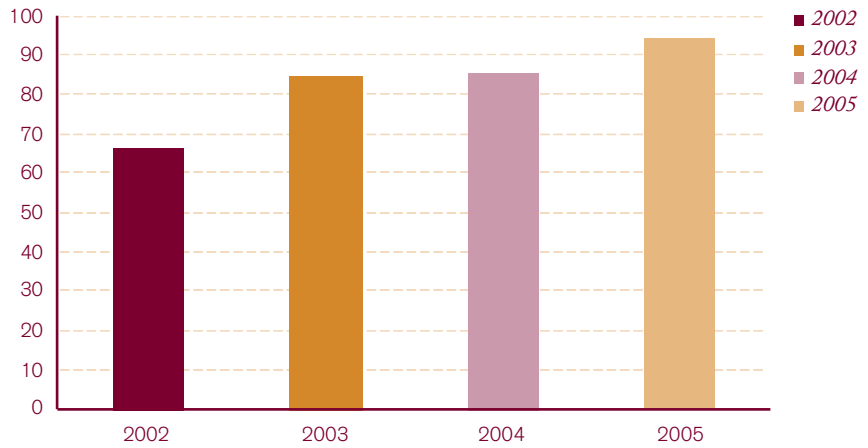
Lack of knowledge of VCT impedes the Government's effort for Guyanese to know their status. Thus, only 17% of MSM, 28% of CSW, 32% of GUYSUCO employees, 34% of uniform services personnel, 55% of out of school youths and 66% of In-school youths knew of the availability of VCT (BSS 2004). By 1998, only 2 VCT sites were operating in Guyana by the Public Sector (New Amsterdam in Region 6 and at the GUM clinic). By the end of 2005, VCT was available in Regions 2, 3, 4, 5, 6, 7, 9 and 10. Besides the 56 PMTCT sites, which all offer VCT, there are 28 fixed sites, including 10 sites operated by NGOs. Mobile teams also provide VCT in un-served areas and a number of NGOs now also offer VCT in Regions 2, 3, 4, 6 and 10. One private sector site, operated by St. Joseph's Mercy Hospital, is also providing VCT. A rapid test algorithm has been developed, field tested and validated and is in use at all VCT sites.

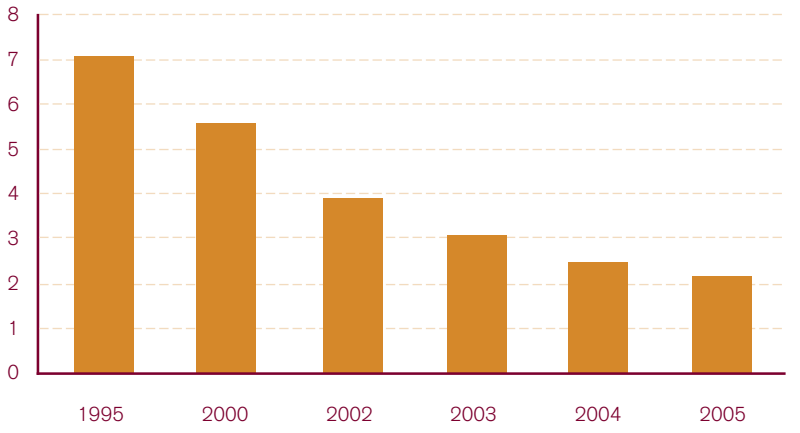
Reversing the Trend of HIV Infections among Pregnant Women

Limited studies and limited surveillance results are available for the period prior to 2001. Several small surveillance studies among pregnant women done between 1993 and 2000 showed an increasing HIV prevalence, reaching about 7% in 2000. The emergence of a PMTCT program in 2001 have since provided a better picture of the HIV situation among pregnant women in Guyana. An ANC surveillance Survey in 2004 confirmed the picture provided by an analysis of PMTCT data from ANC Centers around the country.

The PMTCT program was initiated in 2001 at 11 pilot sites and has since grown to 56 sites in 8 of the 10 geographical regions of the country by the end of 2005. Since November 2001, more than 21,000 women have been offered testing and more than 18,000 have accepted testing. In 2002, there was a 67% uptake and since then this has increased to 94.6% in 2005. During 2000, almost 3,000 women accepted testing for HIV. This increased to 4,800 in 2004 and has exceeded 7,000 in 2005. With about 16,000 deliveries on an annual basis, this translates to almost 50% of pregnant women having access to PMTCT in Guyana.

Program Uptake_2002- Sept 2005





Behavioral and Attitudinal Characteristics of the population remain major challenges in the prevention and management of HIV/AIDS in Guyana and it is imperative that programs to effect behavior changes become an integral part of the response to HIV/AIDS. Guyana has recently (2004/2005) completed both a BSS and an AIDS Indicator Survey (AIS). While these surveillance tools have shown improvement in behavior and attitudes, the surveys also indicate that the population is at significant risk because of certain behavior and attitudinal patterns.

There is still too wide a gap in comprehensive knowledge of the methods for prevention of HIV among the population, especially among the young people. Table 2.1.4 demonstrates that there are still between 14% and 38% of In-school and out-of-school youths who lack a comprehensive knowledge of the methods of prevention for HIV. Male has less knowledge of the prevention methods than female. More than 50% of the rural population, more than 30% of CSW and MSM and 15% of the uniform services lack this knowledge.

TABLE 2.1.4_COMPREHENSIVE KNOWLEDGE OF THREE (3) METHODS OF HIV PREVENTION – ABSTINENCE, FAITHFULNESS AND CONDOM USE

POPULATION	BSS		AIS	
In School Youths (% who knew all three methods)	62.0		75.9	
Out of School Youths (% who knew all three methods)	71.1		85.6	
Age Group 15 -24	M	F	M	F
In and Out-of School (% who knew all three methods)			47.3	52.6
Age group 15-19 (% who knew all three methods)	59.5	63.7	42.5	50.3
Age group 20-24 (% who knew all three methods)	67.8	74.0	54.3	55.3
GUYSUCO Workers - (% who knew all three methods)	75.3		Not done	
Female Sex Workers - (% who knew all three methods)	63.1			
MSM - (% who knew all three methods)	67.1			
Uniform Services - (% who knew all three methods)	84.0			
Region 5 - (% who knew all three methods)			M	F
Region 6 - (% who knew all three methods)			22.1	49.1
				43.2

Risky sexual practices constitute a major challenge in Guyana's prevention efforts. The sexual experience and sexual attitudes of young people and of some vulnerable groups, especially in the debut age for sex, the involvement in pre-marital sex, number of sex partners, involvement with CSWs and in the use of condoms, place the population at great risk for HIV. A good example is to look at the uniform services personnel, a group considered to be an at-risk group. Condom use by uniform personnel with non-regular partner is only 48% of the time. Table 2.1.5 shows that the sexual practices of the population place the population at great risk for HIV.

TABLE 2.1.5_SEXUAL EXPERIENCE, CONDOM BEHAVIOR AND STI AWARENESS OF THE POPULATION

SEXUALLY ACTIVE POPULATION	BSS		AIS	
	M	F	M	F
In School Youths – Sexually Active (%) [30.6]	43.5	22.3		
Mean Age of First Sex (Years)	14.2	15.0	18.0	18.4
Mean age of first sex partner	14.8	19.9	17.8	18.4
% Sexually active who had sex in last 12 months	59.9	68.1	61.3	56.1
Mean number of non-commercial sex partners last 12 months	2.5	1.2	-	-
Mean number of commercial sex partners last 12 months	0.89	0.34	0.8	-
% Who have had sex with a CSW last 12 months	29.6	18.7	0.8	-
% Male who have had sex with another male	1.9	-	-	-
% Aware where to obtain condoms	89.6	64.2	91.4	80.3
% Who used a condom at first sex	51.0	64.1	-	-
% Used condom with a non-commercial partner last sex	75.7	69.3	-	-
% Used condom every time with non-commercial partner	57.4	47.5	-	-
% Who has used condom with a CSW at last sex	55.0	50.0	84.6	-
% Used condom every time with CSW last 12 months	57.1	14.3	84.6	-
% Think condoms have holes and do not work	40.1	45.5	-	-
% Awareness of STDs	72.8	74.9	-	-
% With abnormal discharge last 12 months	4.5	9.7	-	-
% Sexually active with genital ulcer last 12 months	7.4	8.5	-	-
Age Group	**15-19**	**20–24**	**15-19**	**20-24**

Continued from p25

TABLE 2.1.5_SEXUAL EXPERIENCE, CONDOM BEHAVIOR AND STI AWARENESS OF THE POPULATION

OUT-OF SCHOOL YOUTHS –	M	F	M	F	M	F	M	F
% Sexually Active [58.7 of total]	52.6	39.9	84.8	73.5	37.5	26.2	80.3	56.1
Mean Age (years) of First Sex [All – 15.98]	14.9	15.9	16.1	17.1	-	-	17.8	18.4
Mean age (years) of first sex partner [All- 18.6]	15.6	20.6	16.9	21.5	-	-	-	-
% Sexually active who had sex in last 12 months [72.8]	64.3	73.4	77.6	76.1	75.7	55.5	79.6	78.7
Mean number of non-commercial sex partners last 12 months	-	-	-	-	-	-	-	-
Mean number of commercial sex partners last 12 months	-	-	-	-	-	-	-	-
% Who have had sex with a CSW last 12 months [3.0]	2.7	0.7	6.8	1.2	0.9	-	1.4	-
% Male who have had sex with another male [1.2]	2.0	-	0.6	-	-	-	-	-
% Aware where to obtain condoms [81.4,M=90.5 F=72.8]	-	-	-	-	87.6	77.4	96.9	-
% Who used a condom at first sex [60.7]	59.3	71.8	59.5	54.0	68.3	51.0	45.9	83.7
% Used condom with a non-commercial partner last sex	72.8	47.8	53.7	34.5	75.8	70.0	64.7	
% Used condom every time with non-commercial partner	70.0	68.8	69.8	58.9	-	-	-	89.1
% Who has used condom with a CSW at last sex	75.0	100	91.7	50.0	100.0	-	100.0	56.7
% Used condom every time with CSW last 12 months	100	100	90.9	-	-	-	-	-
% Think condoms have holes and do not work	-	-	-	-	-	-	-	-
% Awareness of STDs [90.1, M-90.2 F=90.1]	-	-	-	-	-	-	-	-
% With abnormal discharge last 12 months [2.4]	-	-	-	-	1.5	4.3	1.2	1.6
% Sexually active with genital ulcer last 12 months [1.1]	-	-	-	-	0.3	0.9	0.7	1.4

GUYSUCO EMPLOYEES	M	F
% Sexually active	90.8	90.8
Mean Age of First Sex (Years)	17.0	19.3
Mean age of first sex partner	-	-
% Sexually active who had sex in last 12 months	92.3	78.7
Mean number of non-commercial sex partners last 12 months	-	-
Mean number of commercial sex partners last 12 months	0.08	0
% Who have had sex with a CSW last 12 months	2.4	0

Continued from p26

TABLE 2.1.5_SEXUAL EXPERIENCE, CONDOM BEHAVIOR AND STI AWARENESS OF THE POPULATION

GUYSUCO EMPLOYEES	M	F
% Male who have had sex with another male	2.6	-
% Aware where to obtain condoms	85.8	-
% Who used a condom at first sex	-	-
% Used condom with a non-commercial partner last sex	-	-
% Used condom every time with non-commercial partner	-	-
% Who has used condom with a CSW at last sex	51.4	-
% Used condom every time with CSW last 12 months	25.8	-
% Think condoms have holes and do not work	52.4	59.6 93.3
% Awareness of STDs	91.7	
% With abnormal discharge last 12 months	2.6	0.9
% Sexually active with genital ulcer last 12 months	-	-
UNIFORM SERVICES: - % SEXUALLY ACTIVE	**MALE**	**FEMALE**
Mean Age of First Sex (Years)	97.6	97.5
Mean age of first sex partner	16.6	17.7
% Sexually active who had sex in last 12 months	92.0	84.7
Mean number of non-commercial sex partners last 12 months	0.56	0.58
Mean number of commercial sex partners last 12 months	0.04	0.03
% Who have had sex with a CSW last 12 months	1.7	-
% Male who have had sex with another male	97.3	91.6
% Aware where to obtain condoms	19.4	13.3
% Who used a condom at first sex	10.7	7.8
% Used condom with a regular partner last sex	100.0	-
% Used condom every time with a regular partner	87.5	-
% Who has used condom with a CSW at last sex	48.5	47.7
% Used condom every time with CSW last 12 months		
% Think condoms have holes and do not work		

Continued from p27

TABLE 2.1.5_SEXUAL EXPERIENCE, CONDOM BEHAVIOR AND STI AWARENESS OF THE POPULATION

UNIFORM SERVICES: - % SEXUALLY ACTIVE	MALE	FEMALE
% Awareness of STDs	96.3	98.1
% With abnormal discharge last 12 months	2.0	1.3
% Sexually active with genital ulcer last 12 months	1.8	1.3
FEMALE COMMERCIAL SEX WORKERS	**MALE**	**FEMALE**
Mean Age of First Sex (Years)		
Mean age of first sex partner		
% Sexually active who had sex in last 12 months		
Mean number of non-commercial sex partners last 12 months		
Mean number of commercial sex partners last 12 months		
% Who have had sex with a CSW last 12 months		
% Male who have had sex with another male		94.0
% Aware where to obtain condoms		-
% Who used a condom at first sex		72.7
% Used condom with a non-commercial partner last sex		-
% Used condom every time with non-commercial partner		-
% Who has used condom with a CSW at last sex		-
% Used condom every time with CSW last 12 months		44.0
% Think condoms have holes and do not work		93.8
% Awareness of STDs		8.2
% With abnormal discharge last 12 months		11.0
% Sexually active with genital ulcer last 12 months mean age of FCSW		28.6
Mean Duration of sex work (years)		4.35
Median number of sex partners in the past week		3.0
Use of condom with last paying partner		89.3
Use of condom with non paying partner		68.6

Continued from p28

TABLE 2.1.5_SEXUAL EXPERIENCE, CONDOM BEHAVIOR AND STI AWARENESS OF THE POPULATION	
MEN WHO HAVE SEX WITH MEN (MSM):	**M**
Mean Age of First Sex (Years)	
Mean age of first sex partner	-
% Sexually active who had sex in last 12 months	-
Mean number of non-commercial sex partners last 12 months	2.18 (0-20)
Mean number of commercial sex partners last 12 months	4.20 (0-58)
% Who have had sex with a CSW last 12 months	-
% Male who have had sex with another male (anal)	92.4
% Aware where to obtain condoms	97.0
% Who used a condom at first sex	-
% Used condom with a non-commercial partner last sex	80.7
% Used condom every time with non-commercial partner	50.5
% Who has used condom with a CSW at last sex	83.8
% Used condom every time with CSW last 12 months	66.2
% Think condoms have holes and do not work	50.8
% Awareness of STDs	94.9
% With abnormal discharge last 12 months	17.8
% Sexually active with genital ulcer last 12 months	-

Too few people know their HIV status and many people are unaware of the availability of ARV treatment: There are too few people who have taken advantage of free VCT across the country. Further, most people still are unaware that treatment is available. The result of this contributes to the low level of the population that have tested for HIV (Table 2.1.6).

TABLE 2.1.6: TOO FEW PEOPLE KNOW THEIR HIV STATUS AND KNOW OF TREATMENT AVAILABILITY			
% WOMEN AND MEN WHO HAVE TESTED AND RECEIVED RESULTS	**BSS**	**AIS**	
		M	**F**
Age Group 15-19: Ever tested and received results	17.6	5.4	14.6
Tested and received results in last 12 months		4.2	9.0
% Know of treatment availability (In-school youths)	41.6		
% Know of treatment availability (Out-of-school youths)	12.9		

Continued from p29

TABLE 2.1.6: TOO FEW PEOPLE KNOW THEIR HIV STATUS AND KNOW OF TREATMENT AVAILABILITY

% WOMEN AND MEN WHO HAVE TESTED AND RECEIVED RESULTS	BSS	AIS	
		M	F
Age Group 20-24: Ever tested and received results		26.8	36.3
Tested and received results in last 12 months		16.0	17.8
Age Group 25-29: Ever tested and received results		25.6	36.9
Tested and received results in last 12 months		16.5	14.9
Age Group 30-39: Ever tested and received results		23.0	30.0
Tested and received results in last 12 months		11.4	11.2
Age Group 40-49: Ever tested and received results		19.9	19.4
Tested and received results in last 12 months		7.0	6.9
Married: Ever tested and received results		22.2	28.3
Tested and received results in last 12 months		11.6	11.6
Formerly married: Ever tested and received results		28.1	37.4
Tested and received results in last 12 months		8.8	14.2
Never married: Ever tested and received results		14.8	19.5
Tested and received results in last 12 months		8.9	9.7
Urban: Ever tested and received results		29.5	38.5
Tested and received results in last 12 months		15.1	16.3
Rural: Ever tested and received results		15.5	21.3
Tested and received results in last 12 months		8.3	9.1
GUYSUCO: Ever tested and received results	?		
Tested and received results in last 12 months	?		
% Know of treatment availability	32.2		
Uniform Services: Ever tested and received results	48.2		
Tested and received results in last 12 months	48.2		
% Know of treatment availability	63.3		
CSW: Ever tested and received results	85.2		
Tested and received results in last 12 months	64.3		
% Know of treatment availability	70.8		
MSM: Ever tested and received results	43.8		
Tested and received results in last 12 months	87.6		
% Know of treatment availability	66.5		

Stigma and Discrimination are two factors that influence the spread of HIV in any country and both stigma and discrimination are important factors in the Guyana HIV epidemic. Table 2.1.7 shows that despite aggressive awareness and education programs in the last five years, stigma and discrimination are still significant factors.

TABLE 2.1.7: MEASURING PERCEPTIONS OF THE POPULATION			
POPULATION	BSS	AIS	
		M	F
Would buy food/goods from an infected shopkeeper			
• % of In-School Youths	21.4	37.7	50.9
• % of Out-of-School Youths	23.7	51.1	51.0
• % of GUYSUCO Workers	26.1		
• % of Uniform Services Personnel	24.0		
• % MSM	37.2		
• % of CSW	30.5		
Perception of personal risk (none/low)			
• % of In-School Youths			
• % of Out-of-School Youths			
• % of GUYSUCO Workers	91.4		
• % of Uniform Services Personnel	82.9		
• % MSM	59.5		
• % of CSW	59.5		
Persons with HIV should be quarantined			
• % of In-School Youths			
• % of Out-of-School Youths	28.8		
• % of GUYSUCO Workers	50.3		
• % of Uniform Services Personnel	76.5		
• % MSM	31.7		
• % of CSW	38.1		

Practices in the health sector constitute potential risks: Blood safety, safe injection and waste management practices are potential barriers in attempts to prevent the transmission of HIV/AIDS. Although practices in Guyana tend to comply with safe practices, there are still areas for strengthening. For example, a recent survey showed that:

- Written procedures for PEP were found in only 14% of surveyed sites.
- PEP prophylactic drugs were available in only 8 of the 39 surveyed sites
- Needle stick injuries were reported by 21% of health care providers, but these were not reported and documented
- Only 16% of the surveyed sites had a formal ledger for the documentation of these injuries
- Safety boxes are not routinely available

2.2_THE IMPACT OF HIV/AIDS

Socio-economic impact

The potential socio-economic impact of HIV/AIDS has already manifested itself in several African countries where HIV prevalence rates are high. The potential that the socio-economic impacts of HIV/AIDS seen in countries like Botswana, Swaziland, South Africa, Kenya etc. can also be seen in Guyana is very real since Guyana is a country where:

- HIV prevalence is already relatively high (2.5%)
- Poverty rate of approximately 35% is significant

- Migration restricts the pool of professional and skilled personnel eg A recent USAID study estimated that 85% of qualified Guyanese migrate annually
- High vacancy rate (greater than 40%) exists in the public sector
- The economy is still largely dependent on labour-intensive industries such as agriculture, mining and forestry which, as seen in African countries, are particularly vulnerable to prolong and repeated periods of absenteeism due to chronic illness, disability and death due to HIV/AIDS. In addition, the situation can be worsened as carers stay home to look after ill relatives suffering from HIV/AIDS.

The mortality pattern in Guyana clearly demonstrates that the burden is greatest in the 20-45 year age group. This is the economically active group in the country, which is expected to make significant contributions to the state economy and support for the dependent population.

The BSS study clearly demonstrates that whilst knowledge is high amongst all professional groups in the armed forces, teachers etc, little behaviour change has resulted. Whilst the prevalence of HIV/AIDS is not known in these groups, the lack of behaviour change and expressed risky behaviour amongst these groups in an environment where the mortality is high in the economically active age group clearly demonstrates the impact that HIV/AIDS can have in Guyana.

The social burden from HIV/AIDS is already present. A study addressing the needs of orphans and vulnerable children supported by UNICEF conducted in 2004 estimated that there are at least 7,000 orphans and vulnerable children in Guyana. This number does not necessarily relate only to children who are orphaned as a result of HIV/AIDS but due to other reasons. It will be expected that if the epidemic is not controlled, the number will significantly increase as more children become orphaned by HIV/AIDS or they become more vulnerable as parents who are ill from HIV/AIDS become increasingly unable to support their children. The study clearly demonstrates that of the children studied, many are in urgent need of social support as they are looked after by relatives who are unable to provide the care which is needed to give these children an opportunity in life. Establishment of mechanisms to address these issues pose a significant burden on the social services support systems.

The costs of providing social safety nets to vulnerable groups, loss of economy and the costs of provision of health services will be significant. Thus, unless the epidemic in Guyana is reversed, morbidity and mortality associated with HIV/AIDS would significantly impact on:

- **The Economy**: This scenario has not yet manifested itself in Guyana. But it has been seen in several African countries and the potential of this scenario becoming manifested in Guyana is very real. HIV/AIDS is the leading cause of death in working age people (15 to 44 years) already in Guyana. Its effects are devastating, leading to increasing poverty, as breadwinners die leaving their families struggling to make ends meet and many children parentless. The end result is that the economy suffered from diminishing productivity.
- **National Demography**: Countries with high HIV prevalence and deaths due to HIV/AIDS, especially among young people are likely to suffer losses in life-expectancy which in turns affects population growth. The overall structure (population pyramid), is shifted towards the very young and the old. Such shifts have become dramatic in several African countries and has already began to manifest it self in Guyana.

- **Health:** The National Health System, in countries with high HIV prevalence face significant financial, infrastructure and human resource challenges in their HIV/AIDS responses. Countries have been forced to shift resources to meet specific HIV/AIDS response needs. This has manifested itself already and although Guyana has benefited from finical assistance by partners, the human resources and infrastructural needs are becoming severe constraints as both have began to be diverted away from other health problems to HIV/AIDS.
- **Orphans and vulnerable children:** Already Guyana has seen an increase in the number of children categorized as OVC because of the direct impact of HIV/AIDS.

The Government of Guyana has long recognized the potential negative impact of HIV/AIDS and it is in this context that Guyana's Poverty Reduction Strategy Paper (PRSP), endorsed by the World Bank (WB) and the International Monetary Fund (IMF), identified HIV/AIDS as a priority PRSP response.

2.3_DETERMINANTS AND DYNAMICS OF THE EPIDEMIC

Amongst the issues affecting the spread of HIV/AIDS in Guyana are stigma and discrimination, poverty, risky behaviour, gender roles and relations, cultural and social norms and differences among different generations. Stigma and discrimination play a significant role in driving the epidemic underground in certain marginalised sub-groups such as MSMs, prison inmates and CSWs. Many male-female relationships are still male dominated leaving women and girls in a weaker position when it comes to determining their sexual relations, thus making them more vulnerable to HIV infection. In order to survive, poor and marginalised groups sometimes indulge in risk-taking behaviours which also make them more susceptible to HIV infection. Amongst these groups are the indigenous peoples who, while they live in largely isolated rural communities, are amongst the poorest and do not easily access services. In addition, as the economy continues to grow and work in the hinterland develops, travel and communication will create opportunities for the spread of the epidemic if interventions and strategies are not put in place.

Determinants: The various significant determinants can be grouped as follows:

1. Behavioural

- **MULTIPLE SEX PARTNERS:** The BSS (2004/2005) demonstrated clearly that the practice of multiple sex partners in Guyana is significant and this clearly establishes a major risk for HIV/AIDS.
- **INCONSISTENT USE OF CONDOMS:** The 2004/2005 BSS showed that even though there is high knowledge about the usefulness of condoms in reducing the risk for HIV/AIDS large numbers of persons did not comply with advice to use condoms in risky situations.
- **SEX WITH CSWS:** The 2004 surveillance among CSW demonstrated that the prevalence rate for HIV among CSWs remain high (>25%). The BSS shows continued practice of sex with CSWs and non-use of condoms.
- **SUBSTANCE ABUSE AND HIV (ALCOHOL AND GANJA):** Thus far, this has not been a strong determinant in Guyana. But there is growing risk in the Guyana context with excessive us of alcohol and increasing concerns about substance abuse with ganja and cocaine.

[6] *World Bank HIV/AIDS Prevention & Control Project appraisal document for the Republic of Guyana, March 2004.*

- **LACK OF PERCEPTION OF PERSONAL RISK:** The BSS and the AIS both showed that Guyanese young people still have a perception of low risk and thus places themselves in harms way.
- **INCONSISTENCY BETWEEN KNOWLEDGE AND BEHAVIOUR MODIFICATION CHANGE:** The BSS and the AIS show that while public awareness programs have led to relatively high knowledge about HIV and its transmission, this knowledge has not resulted in behaviour change.
- **MYTHS ON TRANSMISSION:** There is still significant level of misinformation pertaining to HIV transmission. For example, almost 25% of respondents in the BSS believe that HIV could be transmitted by mosquitoes.
- **DISCUSSION OF SEX IS STILL TABOO:** There needs to be greater openness in discussing subjects around sex. Much of the discussion about sex among young people occurs in ad hoc and uninformed settings.

2. Economic

- **INADEQUATE ECONOMIC GROWTH:** Guyana has a GDP of approximately $US900 per capita. While this represents almost a tripling of the GDP since 1990, Guyana remains as one of the poorest countries in the Americas.
- **UNEMPLOYMENT AND UNDEREMPLOYMENT:** Employment opportunities are limited still, even though significant improvements have been made in employment for young people.
- **RURAL/URBAN MIGRATION:** Because of several factors, including access to higher education and access to certain kinds of employment, there is a continued growth of migration from rural to urban settings.
- **MOBILE POPULATION IN SEARCH OF ECONOMIC OPPORTUNITIES (MINERS, LOGGERS, TRUCK DRIVERS ETC.):** There has been impressive growth in the mining and forestry industries. This has resulted in increased movement of people to the hinterland and within the hinterland.
- **INCREASE IN CROSS BORDER TRAVEL, AND INTERNATIONAL TRAVEL:** Guyana tourism industry has grown, but there has also been increased international travel into and out of Guyana. In addition, movement across the borders with Brazil, Suriname and Venezuela has intensified.

3. Tourism

- **PROSTITUTION:** With an increase of people from other countries supporting the service industries in Guyana, CSWs have found a large market for their services.

4. Social and cultural

- **DISCRIMINATION AND STIGMATIZATION:** This is a major barrier in the universal access to prevention, care and treatment

5. Gender

- Inequalities in male/female relationship
- Trans generational gaps (sugar daddy syndrome) older men younger women
- Domestic violence

SECTION 3

RESPONDING TO HIV/AIDS CHALLENGE IN GUYANA: EXPERIENCES AND LESSONS LEARNT

3.1_INSTITUTIONAL STRUCTURES FOR THE RESPONSE

After the first case of HIV/AIDS was diagnosed in 1987, the GOG responded by establishing, within the Ministry of Health a National AIDS Programme in 1989 that comprised of the GUM Clinic, the National Laboratory for Infectious Disease (NLID), the National Blood Transfusion Service (NBTS), and the National AIDS Programme Secretariat (NAPS). The NLID was responsible for carrying out all HIV testing done in the public sector.

A National AIDS Committee (NAC) was also established to make recommendations and advise the MOH on HIV/AIDS policy advocacy issues, with representatives from other ministries, NBOs, PLWHA, FBOs, and the private sector. A national AIDS the Regional Advisory Committees (RAC), were also organised to carry out an HIV/AIDS advisory role at the Regional Level.

3.2_POLITICAL LEADERSHIP, DEVELOPMENT POLICIES, RESOURCES, MANAGEMENT STURCTURE AND MULTI SECTORIAL

National leadership

Political commitment and leadership in Guyana have grown over the years to the point where Guyana is a good example of strong political leadership. Initially, the response was led by the Ministry of Health which has provided and continues to provide invaluable technical advice and leadership in the HIV/AIDS response. But now leadership can also be seen at the highest level from the Office of the President through the establishment of the Presidential Commission on HIV/AIDS.

The National AIDS Committee (NAC), a multi-sectoral body, advises the MOH on all aspects of the response to HIV/AIDS. The United Nations Theme Group (UNTG) on HIV/AIDS also provides advice to the PCHA in resource mobilisation, strengthening, institutional capacity, promoting and applying national policy and coordinating donor support.

In 1998, after a review by the HIV/AIDS/STI surveillance system and the work of the Legal and Ethical Committee of the National AIDS Programme, a National HIV Policy was developed and approved by Cabinet and later adopted by Parliament as Government policy. This policy was revised in 2003 to reflect changes to the NAPS and to allow for the delivery of free care and

treatment for people living with HIV/AIDS. During that year, Cabinet also approved the NSP 2002-2006 which focused on a more expanded response involving the ministries, NGOs, Faith Based Organisations (FBOs), the private sector and funding agencies.

Management structure – the presidential commission on HIV/AIDS (PCHA)

In order to strengthen the implementation and coordination of the multi-sectorial response on HIV/AIDS, the GOG established the PCHA in 2004 under the aegis of the Office of the President. The commission is chaired by His Excellency, the president of Guyana The composition of the PCHA include key Ministries, the Attorney General, the chair of the United Nations Theme group (UNTG) on HIV/AIDS, and the Head of the Presidential Secretariat.

The GOG response to HIV/AIDS is supported by the activities of numerous NGOs, CBOs, FBOs, the private sector, and civic organizations. The primary responsibility of the PCHA is to coordinate, oversee, and support the national response to HIV/AIDS. Key functions of the PCHA include the following:

- Supporting the implementation of the National Strategic Plan;
- Mobilizing multi-sector support for the national response;
- Coordinating, preparing and assisting in the implementation of the line ministries' work program;
- Advising the Cabinet on HIV/AIDS policies and strategies;
- Mobilizing resources (national and international) for HIV/AIDS programming;
- Presenting annual and quarterly reports on the progress of the national response;

The PCHA is intended to meet on a quarterly, wherein each Ministry is required to present on key HIV/AIDS-related activities. The PCHA is to issue a report to the public annually.

The Multi-Sector Approach

The Ministry of Health has a pivotal role to play in the comprehensive response to HIV/AIDS. But the implementation of a multi-sector approach is critical in the fight against HIV/AIDS. All Government Ministries and agencies must become involved, with each sector taking responsibility for some aspects of the response, using their own resources. But the response must also involve sectors outside of Government, including businesses, civil society organizations (including FBOs, CBOs and NGOs), communities, PLWHA, those affected by HIV/AIDS. The HIV/AIDS National Strategy 2007-2011 seeks to tap the comparative advantages of each partner so that Guyana can truly mount a comprehensive and effective response against HIV/AIDS.

Guyana's National Response has always embraced the multi-sector approach in the fight against HIV/AIDS. However, the previous HIV/AIDS National Strategies have always been mainly formulated as a National Health Response. The National HIV/AIDS Strategy 2007-2011 is different from the previous strategies in that it is designed as a comprehensive multi-sector response and is intended to guide all Government Ministries and Agencies, International Agencies and partners and civil society in designing and implementing programs as part of the national response in the fight against HIV/AIDS.

The Guyana Government joined other governments from around the world in 2001 in the Declaration of Commitment at United Nations General Assembly Special Session on HIV/AIDS and agreed ***"to ensure the development and implementation of a multi-sectoral national strategies and financing plans for combating HIV/AIDs"***.

The Commonwealth Ministers of Health at their meeting in New Zealand in 2001 and the Commonwealth Heads of Government in the Coolum Declaration in 2002 further committed to these principles. A Commonwealth Think Tank Meeting in London in 2001 defined a multi-sector approach as follows:

> *A multi-sectoral response means involving all sectors of society – governments, business, civil society organizations, communities and people living with HIV/AIDS, at all levels – pan-Commonwealth, national and community – in addressing the causes and impact of the HIV/AIDS pandemic. Such a response requires action to engender political will, leadership and coordination, to develop and sustain new partnerships and ways of working, and strengthen the capacity of all sectors to make an effective contribution.*

Some Guiding Principles for the Multi-Sector Response:

- A comprehensive and effective response demands leadership and coordination by the Government of Guyana in fostering a supportive environment for a multi-sector response, providing a framework for planning and implementing actions by all sectors.
- The response must be linked to Guyana's international commitments, such as the MDGs and UNGASS 2001.
- The response must take cognizance of the direct and indirect causes of the HIV/AIDS epidemic. The response must consider efforts at behaviour change, but must also address the vulnerability factors such as fear, denial, stigma and discrimination, gender equality and power differentials, poverty and livelihood insecurity, internal migration for employment purposes, social-cultural norms, values and practices, and the national legislative and policy environment.
- It is imperative that there be a linkage of HIV/AIDS response to Guyana's PRSP.
- People living with HIV/AIDS (PLWHA) are central to the overall response, they need to be empowered to enable them to take effective action themselves and with others.
- Society at large needs to be mobilized to break the silence about HIV/AIDS, reduce discrimination and stigma, protect human rights of PLWHA, provide effective programs to prevent, treat, care for and mitigate the impact of HIV/AIDS, and mobilize and make available resources for civil society organizations engaged in prevention and care.
- Recognizes the special needs of adolescents and young people, especially girls.
- Recognizes the special needs of OVC.
- Recognizes the special needs of other vulnerable and disadvantaged groups, such as women, those living in poverty, street children, the disabled, migrants, sex workers, prisoners, men who have sex with men.
- Ensures 100% access to PMTCT.
- Ensures that the needs of those caring for PLWHA are taken into account.
- Empower communities to take effective action themselves and in collaboration with others to prevent HIV transmission and to improve the quality of life of PLWHA.

- Facilitate partnerships among Government Ministries and agencies (local and national), international partners, civil society, FBOs and the private sector.
- Expand efforts and improve access to programs for prevention, treatment and care, including provision of testing and drugs, not only for HIV/AIDS, but also for TB and STIs.
- Mobilize and train members of the community, FBOs, CBOs, NGOs and the private sector to provide complementary services to add to those provided by health care providers in counseling and testing and in general awareness programs for HIV/AIDS, TB and STIs.

FRAMEWORK FOR GUYANA'S MULTI-SECTOR RESPONSE

	GOVERNMENT	INTERNATIONAL PARTNERS	BUSINESS	CIVIL SOCIETY
Actors	• President • Ministers • MPs • Other Political Leaders • Mayors and Municipalities • Local Government Leaders • Civil Servants	• UNDP • UNAIDS • PAHO/WHO • UNICEF • UNFPA • UNDCP • UNESCO • ILO • USAID • CDC • PEPFAR • Global Fund • World Bank • CIDA • EU • Red Cross • PANCAP	• Chief Executives • Managing Directors • Boards of Directors	• University of Guyana • PLWHA • FBOs • CBOs • NGOs • Trade Union Leaders • Professional org • Women and Youth Leaders • Vulnerable groups
Sectors	• Health • Education • Labor and social security • Finance • Water and Housing • Local Government • Home Affairs • Defense • Youth, Sports and Culture • Agriculture • Tourism • Gender and Children	• Health • Education • Donor/Financing • Service	• GUYSUCO • Rice • Bauxite • Mining • Forestry • Beverage • Banking • Insurance • Construction • Human Resources • Manufacturing • Service Industry • Retailing	• Charitable Org. • Professional Bodies • Religious Org. • Cultural org • Service • Community • Media • Prominent personalities
Resources	• Political will • Coordination • Mandates • Human Resources • Physical infra • Technology • Funds	• Clout • Human Resources • Physical infra • Technology • Funds	• Human Resources • Physical infra • Technology • Funds	• Human resources, families, friends • Moral suasion • Volunteers

3.3_FINANCING THE RESPONSE TO HIV/AIDS IN GUYANA

Over the last two years Guyana has been successful in mobilising substantial external resources to fund their 2002 – 2006 National Strategic Plan. However, even though the country has been able to scale up the response certain gaps still remain in terms of human and technical capacity. This will affect the ability to operationalized programme activities. A challenge that presents itself is the number of donors who are now part of the response to HIV/AIDS and the co-ordination that that requires in order guaranteeing the optimum use of resources. It is crucial that the country develops the capacity to harmonise and align its national strategic plan with the donors' programme areas. Detailed annual operational plans translated from the NSP must be developed to improve donor and partner alignment, coordination and harmonisation.

The international community that has placed the GOG in a powerful position to confront HIV includes multilateral and bilateral organizations.

PARTNER MATRIX		
DONOR/PARTNER	**MAJOR AREA OF ASSISTANCE**	**ESTIMATED FUNDING**
UNAIDS	Coordinate HIV/AIDS activities of the UN Theme Group; strengthen capacity to UNGASS reporting	Ongoing
UNDP	Limited activities; policy development	Ongoing
UNICEF	Strengthen coordination and M&E of PMTCT services; support knowledge of women, children and health care workers; support care treatment and support for HIV positive children; youth friendly health services	$1.5 (est) (2006-10)
PAHO/WHO	Chair UNAIDS Theme Group; technical assistance for HIV/AIDS prevention, TB, and malaria control; small grants scheme management; surveillance and laboratory support	Ongoing
CIDA	HIV/AIDS prevention; communicable disease control; public health management system; stigma and discrimination; TB prevention and malaria	CN$5 mil (2003-07)
EU	Strengthen national capacity to respond to HIV/AIDS	Limited
Work Bank	Grant for HIV/AIDS program; support institutional capacity strengthening; monitoring, evaluation and research	US$10 mil (2004-08)
UNFPA-OPEC Fund	Caribbean-Central America project HIV prevention among youth as a part of adolescent health program	US$450,000 (2004-08)
GFATM	Multifaceted support for HIV/AIDS prevention, treatment, care and support; training; HMIS; upgrade laboratory capacity; strengthen surveillance system; quality care for persons living with HIV/AIDS; expand care and treatment; reduce stigma and discrimination; condom social marketing	US$27.2 mil (2004-08)

Continued from p39

PARTNER MATRIX		
DONOR/PARTNER	MAJOR AREA OF ASSISTANCE	ESTIMATED FUNDING
IDB	Regional Support for HIV/AIDS	US$6.7 mil (2004-08)
JICA	Small Grant for HIV/AIDS	Limited
GATC	HIV/AIDS project targeting commercial sex workers, including condom social marketing campaign	Limited
The Emergency Plan (US)	Coordinated, comprehensive HIV/AIDS support for care and treatment, prevention, and laboratory support. Main partners are CDC and USAID.	US$34 mil (2004-08)

3.4_BUILDING A COMPREHENSIVE PREVENTION, CARE AND TREATMENT PROGRAMME

Guyana was one of the first developing countries to announce universal care and treatment for people living with HIV/AIDS. The programme started in December 2001 with the MOH providing drugs manufactured in Guyana. The programme aims to combine the synergies of prevention, care, treatment and support on a continuum combining PMTCT, care and treatment, a focus on orphans and vulnerable children, behaviour change communication and support counselling. Through the "Me to You: Reach One Save One Campaign" each Guyanese is encouraged to get tested to know their status. Home-based and palliative care and the involvement of NGOs, CBOs and FBOs to promote the reduction of stigma and discrimination in the community are also part of the initiative.

In the mid-1990's the MOH adopted the syndromic approach for the management of STIs. Since then a number of interventions has occurred to strengthen the programme. The TB programmes have also been enhanced where all TB patients are now also offered HIV testing.

With continued political commitment and support GOG will strive to provide the following in their care and treatment programme:

1_Increasing access to services to diagnose and manage STIs.
2_Strengthening services to diagnose and treat HIV/AIDS and related opportunistic and concurrent infection such as TB.
3_Increasing access to antiretroviral treatment and to other advanced HIV related treatments.
4_Providing a continuum of care from home to health facility, supported by a system of client referral (e.g to nutritional support, psychosocial support and palliative care)[7].

Summary of Achievements

- The establishment of the PCHA demonstrates the Government's strong political support and leadership to HIV/AIDS.
- A multi-sectoral response is being achieved but the coordinating structure needs strengthening in order to become operational.

[7] *WHO, Global Health-Sector Strategy for HIV/AIDS, Providing a Framework for Partnership and Action 2003-2007.*

- External and internal resources have been mobilized to support the implementation of the National HIV/AIDS response but the Presidential Commission and its Secretariat must ensure that the optimal use is made of these resources to avoid duplication.
- The PMTCT Programme has been expanded to new Regions and the HIV prevalence rate has declined from 7% prior to 2001 among the antenatal population to 2.4% in 2004.
- The VCT services have been expanded into other Regions.
- Expansion of care and treatment to seven government and two private site. HIV treatment is available nationally and almost 1,000 persons are receiving ARV treatment.
- The TB programme has been enhanced where by all TB patients are offered HIV testing and all HIV clients are offered TB testing.
- There has been greater involvement of NGOs, CBOs and FBOs over the last two years in the delivery of HIV/AIDS prevention and care activities.
- First Behavioural Surveillance Surveys and AIDS Indicator Survey have been completed.

3.5_CHALLENGES FOR THE FUTURE

- Limited trained/qualified staff to fill the positions still poses a problem to providing and implementing HIV/AIDS programmes and services. As Guyana's economy faces more challenges many qualified professionals have migrated to seek employment and better wages. This "brain drain" causes significant human resource constraints for the GOG and undermines ability to provide quality health, education and social services and impedes government administration and management. In some instances, some of the more qualified personnel have been recruited by donors.
- Insufficient training opportunities – no structured training, inadequate continuing education (internal and external). Although training has been provided in the past from various sources, there is a high turn over of trained personnel. Trained staff is always seek better opportunities elsewhere, leaving a constant void in services.[8]
- Donor environment is very complex, with many reporting procedures and requirements.- Many of these agencies have different administrative requirements for the approval and the monitoring and approval of funds. This also complicates the delivery of activities for persons working in the field, in the clinics, RAC, NGOs, CBOs, and other sectors. They also conduct multiple planning and assessment missions, in most cases calling on the same in-country staff members for assistance in the process.
- Work plans of the Donor agencies overlap in some places and this could lead to duplication of efforts and an inefficient use of resources. If efforts are not made to harmonise and streamline the workplans it could affect the rate at which the response can be scaled up, and HIV/AIDS activities and services implemented.
- Creating an environment free from stigma and discrimination
- Weakening of other health sector responses
- Psychosocial counselling requirements for PLWHA and those affected
- Long term sustainability of the National HIV/AIDS Response Guyana has already integrated HIV/AIDS in its PRSP as an element of sustainable development in the interest of scaling up its response. Guyana has also taken the initiative to accelerate implementation by building a comprehensive multi-sectoral programme that combines prevention, care and treatment. To

[8] *CHRC- Evaluation of the National HIV/AIDS Programme of Guyana.*

sustain this approach, Guyana has adopted the UNAIDS sustainable strategies that emphasise sufficient resources to finance the response and where these resources are used effectively to reverse the spread and impact of AIDS[9].

To remove the bottlenecks that can develop in scaling up the response the following areas must be addressed: empowering inclusive national leadership and ownership; building human capacity harmonising and aligning the workplans of the donor agencies; strengthening the multi-sectoral response; and ensuring proper accountability and oversight.

[9] *UNAIDS, Resource Needs for an Expanded Response to AIDS in Low and Middle Income Countries,* Discussion Paper, '*Making the Money Work' The Three Ones in Action London, United Kingdom, 9 March 2005.*

SECTION

4 STRATEGIC FRAMEWORK

4.1_GENERAL REVIEW OF PREVIOUS PLANS 1999-2001, 2002-2006

The CHRC assessment report stated[10] that the successes of the implementation of the 1999-2001 Medium Term Plan, as identified in its successor 2002-2006 Plan, include the following: increased awareness of HIV/AIDS through information, education and communication (IEC); increased availability of voluntary counselling and testing (VCT) services; provision of safe blood through careful screening of donors; increased availability of condoms and condom social marketing for high risk groups; provision of treatment for sexually transmitted infections (STIs) through syndromic management; provision of treatment for opportunistic infections; limited provision of antiretroviral (ARV) therapy; greater involvement of NGOs and private enterprises; and introduction of the prevention of mother to child transmission (PMTCT) programme.

The assessment went on to outline the following limitations: insufficient human, technical and financial resources; inadequate emphasis on coordination and management of programme by the NAPS which focused mainly on implementation; lack of involvement of other sectors—the Ministry of Labour, and the Ministry of Education were the only other two entities from the public sector with some involvement in the response; stigmatisation and discrimination of HIV infected persons; and limited geographical reach.

4.2_THE STRATEGIC PLANNING PROCESS

This Plan is a product of two distinct steps that were inextricably linked but separated in execution.

The first step

In 2004, a number of participatory consultations involving a wide cross section of stakeholders involving NGOs, CBOs, FBOs, representatives from other government and private sectors, occurred during the development of certain key HIV/AIDS funding proposals. The information gathered during the formulation of these proposals is still relevant and provides insight into the achievements and challenges faced by the National AIDS Programme.

In 2005, the MOH in consultation with other partners, requested the Pan American Health Organization (PAHO/WHO) to coordinate the Strategic Planning Process. They took the lead in coordinating a series of small consultations on various components within the HIV/AIDS Programme between April and August of 2005. These consultations were built on the earlier consultations that occurred in 2004 and covered the following areas: care and treatment, home based care (HBC), prevention of mother to child transmission (PMTCT), voluntary counselling

[10] *CHRC Assessment Report of the National HIV/AIDS Programme of Guyana, 2004, prepared under "Strengthening the Intuitional Response to HIV/AIDS/STIs in the Caribbean" Project managed by the Caribbean Community and Common Market (CARICOM) Funded by the European Union (EU).*

and testing (VCT), behaviour change communication, orphans and vulnerable children (OVC) and laboratory diagnosis and blood safety. Key stakeholders from various sectors were invited to participate in these consultations and asked to provide feedback on previous and current conditions, conduct a SWOT analysis, a gap analysis, and outline some objectives and next steps.

The second step involved:

- An in-depth review of the National HIV/AIDS Strategic Plan 2002-2006 that outlines the overall strategic objective, the programme components and the activities
- A review of national reports, the epidemiological data, the policies, programmes and interventions currently being implemented by the National AIDS Programme Secretariat and Government Partners.
- A review of the findings of the assessment of the National HIV/AIDS Programme of Guyana that was conducted by the Caribbean Health Research Council (CHRC) in 2004. This review was conducted by assessing data from written documentation, analysis of data from quantitative indicators in key programme areas that were available at the time and interviews with selected key informants who were knowledgeable with various components of the National Response.
- A review of international project agreements that outlined programme goals, objectives and targets for the next four years to which the country had already made a commitment, such as, the World Bank Project Appraisal Document 2004-2008, The Global Funds Project Document-Guyana 2004-2008, and the President's Emergency Plan for AIDS Relief 2004-2008 Strategy. The formulation of these documents involved a process of consultation with stakeholders in Guyana during 2004.
- A review of reports on selected programme areas such as AN ASSESSMENT: The Situation of Children made Vulnerable or Orphaned in Guyana, Ministry of Labour, Human Services and Social Security/ UNICEF, October 2004; The National Behaviour Change Communication Strategy of Guyana USAID/GHARP, 4th August, 2005;
- A review of the reports from the consultations/workshops conducted in step 1;
- Consultations with key individuals either by telephone or in person;
- Presentation of the draft at a National Consensus meeting for comments and feedback;

The document is also developed in accordance with the principles outlined by WHO/UNAIDS "3 by 5" Initiative and the "Three Ones" as guiding principles for improving the coordination of the country's response. This Plan falls under the First 'One' Principle: One agreed AIDS action framework that provides the basis for coordinating the work of all partners.

4.3_GUIDING PRINCIPLES

The successful implementation on the plan is to be guided by a set of principles:

- Ensuring strong political commitment at the highest level;
- Continuing to strengthen and expand the coordinated and mulit-sectoral approach recognising HIV/AIDS as a development, society, education, security, economic, cultural issues, in addition to being a health issue;

- Mainstreaming HIV/AIDS into al government programmes to generate an effective response;
- Continuing to build the political support and commitment incorporating the line ministries, NGOs, CBOs, FBOs and the private sector;
- Empowering PLWHA to become involved in planning and implementing the response;
- Creating an enabling environment for PLWHAs and other vulnerable groups, free from stigma and discrimination;
- Promoting respect for human rights and ensuring confidentiality at all levels;
- Strengthening and accelerating efforts to prevent new infections, including all aspects of behaviour changes, safe sex and blood injections safety as well as vertical transmission;
- Expanding efforts in prevention, care and support for orphans and vulnerable children;
- Strengthening and expanding workplace, school and out-of-school education and common social marketing programmes;
- Expanding access to an availability of care and treatment services for all people living with HIV/AIDS in Guyana.

4.4_PRIORITY OBJECTIVES AND STRATEGIES

The objectives and strategies of the NSP address the challenges faced by Guyana in controlling the epidemic. They reflect Government's policy, as previously stated and international commitments such as the MDGs and the UNGASS Commitments.

As stated, the overall goal of the NSP 2007 -2011 is:

> *"To reduce the social and economic impact of HIV and AIDS on individuals and communities, and ultimately the development of the country".*

The strategic objective is to reduce the spread of HIV and increase the quality of life of persons living with HIV/AIDS.

This will be achieved through four broad strategic priorities:

1_Strengthening the national capacity to implement and coordinate a multi-sectoral approach to HIV/AIDS in Guyana.
2_Ensure all citizens, especially those most vulnerable, have access to information, preventative services such as counselling and testing and live free of stigma and discrimination in order to reduce transmission of HIV/AIDS.
3_Ensuring access to care and treatment for persons living with HIV/AIDS.
4_Strengthening of the surveillance system and monitoring and evaluation mechanisms to pro. vide timely information for project management.

The specific objectives for each priority area are as follows:

1_Strengthening the national capacity to implement and coordinate a multi-sectroal approach to HIV/AIDS in Guyana

- Strengthen institutional capacity to effectively coordinate the multi-sectoral response through implementation of the Three Ones Principles (One Coordinating Body, One National Strategy and One National Monitoring and Evaluation plan).
- Strengthen human capacity to effectively coordinate and manage the mulit-sectoral response.
- Strengthen regional capacity to implement and manages HIV/AIDS interventions

2_Ensure all citizens, especially those most vulnerable, have access to information, preventative services such as counselling and testing and live free of stigma and discrimination in order to reduce transmission of HIV.

- Decrease misconceptions and discriminatory behaviours and increase knowledge and access to prevention services.
- Reduce sexual transmission of HIV infection with a focus on most at-risk populations and their partners through delayed sexual debut, reduced partner change and number, increase condom use.
- Ensure universal access to prevention of mother-to-child-transmission services.
- Reduce the risk for transmission in medical settings.
- Reducing the socio-economic impact of HIV/AIDS on children and increase protection for OVCs.
- Ensure universal access to counselling and testing services.

3_Ensuring access to care and treatment for all persons living with HIV/AIDS.

- Ensure universal access to quality diagnostic, care and treatment and support in an enabling environment for all persons infected with HIV/AIDS, including access to ARVs and quality home based care services.
- Expand comprehensive care for opportunistic infections, especially with greater links with the TB control and monitoring.
- Design and implement training programmes for HIV/AIDS treatment care and support for services providers.
- Ensure continued access to ARVs and other treatments supplied through improved procurement and commodities management.
- Established national public health reference laboratory.

4_Strengthening of the surveillance system and monitoring and evaluation mechanisms to provide timely information for project management.

- Strengthening of the HIV/AIDS surveillance system and the national health information system.
- Ensure one national system for monitoring and evaluating the response to HIV/AIDS.
- Improve strategic information on HIV/AIDS by strengthening local capacity and identifying priority studies and surveys.

PRIORITY	SPECIFIC OBJECTIVES
1_STRENGTHENING THE NATIONAL CAPACITY TO IMPLEMENT A COORDINATED, MULTI-SECTORIAL RESOURCE	1. Strengthen institutional capacity to effectively coordinate the multi-sectoral response through implementation of the Three Ones Principles 2. Strengthen human capacity to effectively coordinate and manage the multi-sectoral response 3. Strengthen regional capacity to implement and manage HIV/AIDS interventions
2_REDUCING RISK VULNERABILITY TO HIV INFECTION	1. Decrease misconceptions and discriminatory behaviors and increase knowledge and access to prevention services 2. Reduce sexual transmission of HIV infection with a focus on most at-risk populations and their partners through delayed sexual debut, reduced partner change and number, increase condom use, and promotion of treatment adherence 3. Reduce mother-to-child transmission of HIV infection 4. Ensure universal access to counseling and testing services 5. Reduce the risk for transmission in medical settings 6. Reducing the socio-economic impact of HIV/AIDS and increase protection for OVCs
3_CLINICAL AND DIAGNOSTIC MANAGEMENT AND ACCESS TO CARE, TREATMENT AND SUPPORT	1. Increase access to diagnostic management and comprehensive treatment, care, and support in an enabling environment 2. Strengthen the service delivery system to provide uninterrupted supply of medications and commodities (Comprehensive care includes the scaled up coverage and access to care, provision of antiretroviral drugs, needed psychosocial care for those infected and affected, the option of home based care and treatment for OIs including TB and STIs.)
4_STRATEGIC INFORMATION	1. Increase local capacity to design and implement surveillance, monitoring and evaluation, special studies, surveys and research on HIV/AIDS according to national and international guidelines. 2. Strengthen capacity at the national and regional levels for the collection and use of data for decision making, planning, implementing, monitoring, and evaluating the local response to HIV/AIDS

PRIORITY #1_STRENGTHENING THE NATIONAL CAPACITY TO IMPLEMENT A COORDINATED, MULTI-SECTORAL RESPONSE			
BROAD STRATEGIC PROGRAMME AREAS	**INDICATORS**	**STRATEGIC ACTIVITIES**	**LEAD AGENCY AND STRATEGIC PARTNER(S)**
1.1 PCHA, HSDU & NAPS empowered to coordinate Guyana's National HIV/AIDS multi-sectoral response	Number of meetings of PCHA and reports produced by HSDU and NAPS	1.1.1 Strengthen the leadership and programme management capacity of the PCHA, HSDU and NAPS	MOH/HSDU/WB/GF/UNAIDS/PAHO
	Develop/Updated TORs for PCHA, HSDU, NAPS	1.1.2 Define functions, roles, responsibilities and reporting relationships between HSDU, NAPS and PCHA, as well as Health Theme Group/ Partnership Forum	MOH/HSDU/WB/GF/UNAIDS
	Number of NGOs represented on NAC/RACs	1.1.3 Review/update TORs, and membership of the NAC and RACs in light of the scaled up response	MOH/HSDU/WB/GF
1.2 Integrate HIV/AIDS into the programmes and services offered by other Ministries	Number and percent of line ministries with HIV work plans and budgets	1.2.1 Provide technical assistance in programme management to the line ministries to develop their annual sectoral work plans	HSDU/WB/UNAIDS/PEPFAR
	Reports from Ministry of Amerindian Affairs	1.2.2 Support the implementation of the HIV/AIDS Strategy for the Amerindian population	Ministry of Amerindian Affairs / WB
1.3 Harmonise and align resources to ensure efficient use of donor funding	Donor Coordination Committee functioning	1.3.1 Establish/strengthen mechanism to streamline the allocation of resources from the donor agencies	HSDU/WB
	Number of reports produced	1.3.2 Monitor and evaluate the utilisation of resources	HSDU/WB/GF/UNAIDS/PAHO

PRIORITY #1_STRENGTHENING THE NATIONAL CAPACITY TO IMPLEMENT A COORDINATED, MULTI-SECTORAL RESPONSE			
BROAD STRATEGIC PROGRAMME AREAS	**INDICATORS**	**STRATEGIC ACTIVITIES**	**LEAD AGENCY AND STRATEGIC PARTNER(S)**
1.3 Harmonise and align resources to ensure efficient use of donor funding *(continued)*	Number of International partners involved in implementing the Three Ones and GTT recommendations	1.3.3 Implement the recommendations for Three Ones implementation and of the Global Task Team on Improving AIDS Coordination among Multilateral Institutions and International donors	HSDU/UNAIDS
	Number of partners involved	1.3.4 Effectively provide surveillance, GOG and donor program planning, and key activities using Electronic Resource Center (ERC).	MOH/HSDU/PEPFAR
1.4 Increase the involvement of civil society organisations and the private sector in the scaled up response	Workplace policy developed Number of private sector companies implementing the workplace policy	1.4.1 Provide technical assistance with the development of workplace policies with a focus on stigma and discrimination	WB/ILO/GFATM/UNAIDS/ PEPFAR/PAHO/Ministry of Labour
	Number of workplace programmes supported	1.4.2 Provide technical assistance with the development of workplace programs for prevention, care and support	WB/ILO/NAPS/PEPFAR
	Number of groups trained	1.4.3 Provide training in programme management for these groups to strengthen the capacity of their organisations to respond	WB/ILO/NAPS/PEPFAR
	Number of new CSOs involved	1.4.4 Expand the number of civil societies organizations involved in implementing HIV/AIDS activities in the regions	WB/PEPFAR/GF/UNAIDS/PAHO

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PRIORITY #1_STRENGTHENING THE NATIONAL CAPACITY TO IMPLEMENT A COORDINATED, MULTI-SECTORAL RESPONSE			
BROAD STRATEGIC PROGRAMME AREAS	**INDICATORS**	**STRATEGIC ACTIVITIES**	**LEAD AGENCY AND STRATEGIC PARTNER(S)**
1.4 Increase the involvement of civil society organisations and the private sector in the scaled up response	Number of NGOs trained	1.4.5 Build capacities of newly formed NGOs to develop proposals and access funding	HSDU/UNAIDS/UNDP/ PEPFAR
1.5 Advocate for a legal and policy environment that protects the rights of people living with HIV/AIDS and vulnerable groups	National Composite Policy Index Na-tional Composite Policy Index	1.5.1 Revise existing legal framework, National HIV/AIDS Policy and prepare new health legislation to combat all aspects of discrimina-tion relative to HIV/AIDS	MOH/Ministry of Legal Affairs,/WB/ PANACP/UNAIDS
	Amount of national funds spent on HIV/AIDS	1.5.2 Create mechanisms to stimulate advocacy by informing senior decision makers of the social and economic impact of HIV/AIDS on National Development	GOG/WB
1.6 Review the National Response to HIV/AIDS	Mid-term review report available	1.6.1 Conduct mid term review of the National Strategic Plan	HSDU/UNDP/UNAIDS/PAHO
	Participatory review available	1.6.2 Conduct a Government-led partici-patory review of the National AIDS Response	HSDU/NAPS/UNAIDS and all partners

PRIORITY #2_REDUCING RISK AND VULNERABILITY TO HIV INFECTION: Strategic Objectives			
BROAD STRATEGIC PROGRAMME AREAS	**INDICATORS**	**STRATEGIC AREAS**	**LEAD AGENCY AND STRATEGIC PARTNER(S)**
2.1 Design and implement Communication Programme on HIV/AIDS	Percentage of people aged 15-49 years expressing accepting attitudes towards people with HIV/AIDS	2.1.1 Develop and implement National behaviour change strategy to reduce stigma and discrimination related to HIV/AIDS	GOG/NGOs/GFATM/ PEPFAR/PAHO
	Percentage of people aged 15-24 who correctly identify ways of preventing the sexual transmission of HIV and who reject two major misconceptions about HIV transmission	2.1.2 Use available data to develop mass media campaign to ensure that all members of society have information on prevention, care and treatment services	GOG/GFATM/PEPFAR/PAHO
		2.1.3 Encourage the participation of NGOs, CBOs and other partners in the development and implementation of the behaviour change interventions	GOG/PEPFAR/PAHO
	Average age at first sex (by gender)	2.1.4 Conduct assessment and test messages targeted towards general and high risk populations	GOG/PEPFAR/NGO/PAHO
		2.1.5 Train staff to conduct health promotion activities	GOG/PAHO
2.2 Develop and implement targeted behaviour change interventions to increase positive sexual practices and encourage early STI/HIV diagnosis and treatment among most vulnerable groups		2.2.1 Define and prioritise populations to be targeted	GOG/MOH/PEPFAR/UNAIDS/ UNFPA/PAHO

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PRIORITY #2_REDUCING RISK AND VULNERABILITY TO HIV INFECTION: Strategic Objectives			
BROAD STRATEGIC PROGRAMME AREAS	**INDICATORS**	**STRATEGIC AREAS**	**LEAD AGENCY AND STRATEGIC PARTNER(S)**
	Percentage of people aged 15-49 years reporting use of a condom during last sexual intercourse with non-regular partner	2.2.2 Use available data to develop targeted behaviour change interventions for selected high risk groups	MOH/PEPFAR/UNAIDS/UNFPA/ PAHO
		2.2.3 Use messages designed to increase the use of VCT services and early treatment-seeking for STIs and HIV/AIDS	MOH/PEPFAR/PAHO
		2.2.4 Develop "friendly" services for youth and most at risk populations	MOH/UNICEF/UNFPA/PAHO/ PEPFAR
		2.2.5 Develop peer education programmes for high risk youth, CSWs and MSMs	NGO/PEPFAR/UNFPA/PAHO
		2.2.6 Develop mass and small media interventions to promote the use of risk-reduction sexual health practices	MOH/Line Ministry/PEPFAR
2.3 Implement prevention education and behaviour change reinforcement activities		2.3.1 Implement HFLE at primary and secondary levels	MOE/UNICEF/PAHO
		2.3.2 Develop peer education programmes for youth	MOE/NGO/Ministry of Culture/PEPFAR

PRIORITY #2_REDUCING RISK AND VULNERABILITY TO HIV INFECTION: Strategic Objectives			
BROAD STRATEGIC PROGRAMME AREAS	**INDICATORS**	**STRATEGIC AREAS**	**LEAD AGENCY AND STRATEGIC PARTNER(S)**
		2.3.3 Continue to implement the Abstinence and Faithful programs	MOH/FBOs/PEPFAR
		2.3.4 Develop and implement serial communication programs reinforced with community-level education.	MOH/PEPFAR/PAHO
2.4 Expand condom social marketing programme	Percentage of people aged 15-49 years reporting use of a condom during the last sexual intercourse with a non-regular partner	2.4.1 Review and implement strategy and expand program	MOH/WB
		2.4.2 Increase the number of non-traditional outlets targeting high risk populations	MOH/Private Sector/PEPFAR
	Total number of condoms distributed in past 12 months	2.4.3 Develop monitoring and evaluation plan to assess impact of the interventions	MOH/WB
2.5 Scale up the PMTCT Program	Number of public facilities that offer PMTCT services	2.5.1 Strengthen service delivery capacity of PMTCT sites and expand geographic coverage at primary care facilities	MOH/PEPFAR/UNICEF/ UNFPA
	Number of pregnant women who receive HIV counseling and testing for PMTCT	2.5.2 Strengthen community mobilization and referral networks to include PMTCT	NAPS/UNICEF

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PRIORITY #2_REDUCING RISK AND VULNERABILITY TO HIV INFECTION: Strategic Objectives			
BROAD STRATEGIC PROGRAMME AREAS	**INDICATORS**	**STRATEGIC AREAS**	**LEAD AGENCY AND STRATEGIC PARTNER(S)**
	Number of health care workers trained in the provision of PMTCT	2.5.3 Develop standardised system for monitoring and tracking	NAPS/UNICEF
	Percent of babies born to HIV positive women who are tested before age 18 months	2.5.4 Increasing the involvement of NGOs and CBOs in the PMTCT response	NAPS/UNICEF
	Percentage of women who receive a complete course of ARV prophylaxis as part of PMTCT	2.5.5 Strengthening PMTCT service delivery at labor and delivery wards	NAPS/UNICEF
2.6 Reduce the vulnerability of OVC to HIV/AIDS	Number of persons trained in caring for OVCs	2.6.1 Mobilise additional CBO's NGO's to become involved in providing support to OVCs	Min of Labour/ UNICEF/PEPFAR
		2.6.2 Expedite and enact the legislation that protects the rights of the most vulnerable children and approve national policy	GOG/UNICEF/Min of Labour
	Percent of OVCs enrolled in schools	2.6.3 Encourage the participation of key stakeholders from all sectors to ensure the provision of essential services, education, health care, birth registration etc.	WB/UNICEF
		2.6.4 Involve children and youth as partners in designing and implementing HIV/AIDS interventions	UNICEF

PRIORITY #2_REDUCING RISK AND VULNERABILITY TO HIV INFECTION: Strategic Objectives			
BROAD STRATEGIC PROGRAMME AREAS	**INDICATORS**	**STRATEGIC AREAS**	**LEAD AGENCY AND STRATEGIC PARTNER(S)**
	Percent of OVC whose household received free of cost external support in caring for the child	2.6.5 Strengthen the care and coping capacities of families and the community	NAPS/WB/UNICEF
2.7 Expand the VCT services	Number of persons receiving test results in last twelve months between ages 15-49	2.7.1 Design and implement operational strategy	MOH/PEPFAR
		2.7.2 Increase availability to a greater proportion of the population, with a special focus on service centers delivering care to high risk groups	NAPS/NGO/PAHO
		2.7.3 Increase service uptake through community mobilization	NAPS/WB/NGO
		2.7.4 Improve QC and referral system	NAPS
	Number of individuals trained in the provision of VCT according to national guidelines	2.7.5 Continually train and update skills for health care providers and laboratorians according to National Guidelines	NAPS/CIDA/PAPFAR/PAHO
2.8 Reduce the vulnerability to HIV/AIDS through identification and treatment of STI/OIs	Percent of men and women with STIs at health centers who are appropriately diagnosed, treated and counseled	2.8.1 Increase the use of STI/OI services and early treatment-seeking for STIs and HIV/AIDS	MOH/CIDA/PEPFAR/PAHO
	Number of persons trained in management of STIs according to National guidelines	2.8.2 Train health care providers STI/OI management according to national guidelines	NAPS/CIDA

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PRIORITY #2_REDUCING RISK AND VULNERABILITY TO HIV INFECTION: Strategic Objectives			
BROAD STRATEGIC PROGRAMME AREAS	**INDICATORS**	**STRATEGIC AREAS**	**LEAD AGENCY AND STRATEGIC PARTNER(S)**
2.9 Ensure safe blood supply	Percent of transfused blood units in the last twelve months that have been screened for HIV according to national guidelines	2.9.1 Maintenance of safe blood supply	MOH/PEPFAR/PAHO
2.10 Implement plan to reduce health worker and community risk of HIV transmission through contaminated sharps	Number of persons trained in injection safety and waste management	2.10.1 Provide a national policy to oversee injection safety in the public and private sector	MOH/PEPFAR
	Number of curative injections Per person	2.10.2 Build competency of health workers to provide injections and dispose of sharps according to standards	NAPS
		2.10.3 Build competency of waste handlers to dispose of waste according to safe waste management standards	NAPS
		2.10.4 Advocate for rational use of injections	NAPS
		2.10.5 Reduce demand for injections among patients and community members	NAPS

PRIORITY #3_CLINICAL AND DIAGNOSTIC MANAGEMENT AND ACCESS TO CARE, TREATMENT AND SUPPORT			
BROAD STRATEGIC PROGRAMME AREAS	**INDICATORS**	**STRATEGIC AREAS**	**LEAD AGENCY AND STRATEGIC PARTNER(S)**
3.1 Expand access to ARV treatment to scale up the response	Percent of persons with advance HIV infection receiving ART	3.1.1 Strengthen existing treatment sites and expand the number of treatment	MOH/GFATM/PEPFAR /PAHO
	Number of regions with health facilities that have the capacity to provide HIV/ AIDS care, treatment, and support	3.1.2 Standardise guidelines and protocols for care and treatment	MOH/GFATM/PEPFAR /PAHO
	Number of health care providers trained to deliver ART services according to national guidelines	3.1.3 Strengthen technical capacity of health care workers in delivering comprehensive care to PLWHAS	MOH/GFATM/PEPFAR/PAHO
	Number of persons receiving ART	3.1.4 Establish public-private partnership in treatment and care	MOH/GFATM/PEPFAR/PAHO
		3.1.5 Establish network of PLWHA Support groups	HSDU/PEPFAR/UNAIDS
		3.1.6 Develop National Treatment and Care communications strategy	MOH/PAHO
		3.1.7 Strengthen human capacity to scale up the care and treatment response	MOH/PAHO/PEPFAR
		3.1.8 Develop and implement national adherence strategy	MOH/PAHO/PEPFAR
3.2 Create Centre of Excellence at the GUM clinic and GPHC		3.2.1 Upgrade the facility to provide specialized care and serve as a referral centre	MOH/PEPFAR
		3.2.2 Design and implement Continuous Quality Improvement (CQI)programme for the Centre	MOH/ PEPFAR

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PRIORITY #3_CLINICAL AND DIAGNOSTIC MANAGEMENT AND ACCESS TO CARE, TREATMENT AND SUPPORT			
BROAD STRATEGIC PROGRAMME AREAS	**INDICATORS**	**STRATEGIC AREAS**	**LEAD AGENCY AND STRATEGIC PARTNER(S)**
		3.2.3 Upgrade technical capacity of the multidisciplinary team to provide specialized care in HIV/AIDS	MOH/ PEPFAR
3.3 Establish a quality home based and palliative care programme providing support to PLWHA and those affected by HIV/ AIDS	Number of regions with outlets that provide HPC	3.3.1 Develop and implement a national HBC strategy for PWLHA and those affected by HIV/AIDS.	MOH/GFATM/NGO(G+)
	Number of outlets that provide HPC	3.3.2 Strengthen and expand home-based care services for PLWHA and those affected by HIV/AIDS	MOH/GFATM/NGO(G+)
		3.3.3 Establish network of home-based care volunteers	MOH/GFATM/NGO(G+)
		3.3.4 Establish public private partnership in home base care	MOH/GFATM/NGO(G+)
		3.3.5 Strengthen the technical capacity of HBC workers in providing quality care	MOH/GFATM/NGO(G+)
		3.3.6 Establish National referral system for Home base care	MOH/GFATM/NGO(G+)
		3.3.7 Strengthen the capacity of the volunteers in providing HBC services	MOH/GFATM/NGO(G+)
3.4 Provide psychosocial care and support to PLWHA and those affected		3.4.1 Increase the number of social service programmes available to PLWHA and those affected	Other Line Ministries

PRIORITY #3_CLINICAL AND DIAGNOSTIC MANAGEMENT AND ACCESS TO CARE, TREATMENT AND SUPPORT			
BROAD STRATEGIC PROGRAMME AREAS	**INDICATORS**	**STRATEGIC AREAS**	**LEAD AGENCY AND STRATEGIC PARTNER(S)**
		3.3.2 Establish referral network for psychosocial support	MOH/PEPFAR
		3.4.3 Encourage public private partnership	
3.5 Design and implement institution training programmes for HIV/ AIDS treatment, care and support		3.5.1 Develop and implement curriculum for pre-service HIV training programme and post-graduate training programmes at central and regional levels for the multi-disciplinary team	MOH/PEPFAR
		3.5.2 Review, revise and implement curriculum of graduate training programmes	MOH
3.6 Expand comprehensive care for opportunistic infections		3.6.1 Strengthen clinical care for opportunistic infections at present sites and expand to new sites	MOH/GFATM/PAHO
		3.6.2 Revise/review protocols for opportunistic infections	MOH/GFATM/PAHO
		3.6.3 Develop national communication campaign for treatment and care	MOH/GFATM
3.7 Strengthen the link between the TB and HIV/AIDS/STI control programmes		3.7.1 Support increased screening for TB among HIV positive patients	MOH/GFATM/PAHO

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PRIORITY #3_CLINICAL AND DIAGNOSTIC MANAGEMENT AND ACCESS TO CARE, TREATMENT AND SUPPORT			
BROAD STRATEGIC PROGRAMME AREAS	**INDICATORS**	**STRATEGIC AREAS**	**LEAD AGENCY AND STRATEGIC PARTNER(S)**
		3.7.2 Improve training programme for staff	MOH/GFATM/PAHO
		3.7.3 Improve facilities and logistical support	MOH/GFATM
		3.7.4 Support increased screening for HIV among patients with TB	MOH/GFATM
3.8 Implement activities to increase use of quality STI/HIV/AIDS diagnostic and treatment services	Percent of persons with STIs who are diagnosed, treated, and counseled at treatment sites according to national guidelines	3.8.1 Strengthen STI services to provide comprehensive care and syndromic management for STI	MOH/HSDU/GFATM
	Number of persons trained in the management of STIs using national guidelines	3.8.2 Expand the pool of health care workers trained in sydromic management	MOH/HSDU/GFATM/PEPFAR)
		3.8.3 Review, update and disseminate guidelines, protocols and training, material for STI management in both the public and private sectors	MOH/HSDU/GFATM/PEPFAR
3.9 Upgrade laboratory capacity to diagnose and monitor HIV/AIDS and associated opportunistic infections	Percent of patients on ARVs who receive CD4 testing following national ARV treatment guidelines	3.9.1 Upgrade GPHC's facility to undertake additional laboratory test for HIV, haematological, TB, STI, Biochemical, immunological markers and diagnosis of opportunistic infections	GPHC/WB/ PEPFAR/PAHO
	Number of persons trained to conduct CD4 testing	3.9.2 Strengthen regional labs to conduct quality diagnosis of HIV and opportunistic infections and for treatment and monitoring	PEPFAR/PAHO

PRIORITY #3_CLINICAL AND DIAGNOSTIC MANAGEMENT AND ACCESS TO CARE, TREATMENT AND SUPPORT			
BROAD STRATEGIC PROGRAMME AREAS	**INDICATORS**	**STRATEGIC AREAS**	**LEAD AGENCY AND STRATEGIC PARTNER(S)**
	Number of regional labs with capacity to do CD4	3.9.3 Finalise and implement Lab Strategic Plan	PEPFAR/CAREC
		3.9.4 Enhance GPHC's capacity to serve as a QA/ QC/QI site for tests	PEPFAR
		3.9.5 Train laboratory staff to use specialised methods for diagnosis and monitoring of HIV/AIDS and related issues at the post graduate level	MOH/GFATM
3.10 Establish National Public Health Reference Laboratory		3.10.1 Construct national reference laboratory	MOH/ PEPFAR
		Strengthen the capacity of the quality assurance monitoring committee	
		3.10.2 Review/update systems for certification	
3.11 Procurement and distribution of care and treatment supplies improved (commodities management)		3.11.1 Establish inter-agency collaboration to expedite the process of procurement through the MMU	MMU/GF/WB/PEPFAR
		3.11.2 Strengthen the management and monitoring capacity of the MMU (Commodities Management)	MMU/GF/WB/PEPFAR

PRIORITY #4_STRATEGIC INFORMATION			
BROAD STRATEGIC PROGRAMME AREAS	**MEANS OF VIRIFICATION**	**STRATEGIC AREAS**	**LEAD AGENCY AND STRATEGIC PARTNER(S)**
4.1 Strengthen the HIV/AIDS surveillance systems	- Number of surveillance guidelines issued - Number of staff trained in surveillance - Number of regions with capacity to conduct surveillance - Number of reports disseminated	4.1.1 Review and update existing protocols and guidelines for HIV/AIDS surveillance	HSDU/MOH/GFATM/WB/PAHO
		4.1.2 Employ and train staff at national and regional levels to conduct HIV/AIDS surveillance	HSDU/MOH/GFATM/WB/PAHO
		4.1.3 Regionalize the HIV/AIDS surveillance system	HSDU/MOH/GFATM/WB/PAHO
		4.1.4 Conduct regular sessions for the review of surveillance and other data with key stakeholders	HSDU/MOH/GFATM/WB/PAHO
		4.1.5 Prepare and disseminate regular reports of the results of HIV/AIDS surveillance	HSDU/MOH/GFATM/WB/PAHO
4.2 Develop and implement a system for monitoring and evaluating the response to HIV/AIDS	- National plan for M&E - # of staff employed to conduct M&E - # of persons trained in M&E - National agreed upon database	4.2.1 Develop and disseminate a national M&E Plan	MOH/WB/GAFTAM/PAHO/UNAIDS
		4.2.2 Identify at the national level a unit which will be responsible for M&E related to HIV/AIDS	MOH/WB/GAFTAM/PAHO/UNAIDS
		4.2.3 Develop and disseminate national guidelines on system and tools for the monitoring the response to HIV/AIDS	MOH/WB/GAFTAM/PAHO/UNAIDS

PRIORITY #4_STRATEGIC INFORMATION			
BROAD STRATEGIC PROGRAMME AREAS	**MEANS OF VIRIFICATION**	**STRATEGIC AREAS**	**LEAD AGENCY AND STRATEGIC PARTNER(S)**
		4.2.4 Identify priorities, develop and disseminate guidelines for measuring outcomes and impact of intervention related to HIV/AIDS	MOH/WB/GAFTAM/PAHO/UNAIDS
		4.2.5 Employ and train staff at the national and regional levels for monitoring and evaluation	MOH/WB/GAFTAM/PAHO/UNAIDS
		4.2.6 Identify and establish a national system for the storage of data for monitoring and evaluating the national response to HIV/AIDS	MOH/WB/GAFTAM/PAHO/UNAIDS
4.3 Design, implement and disseminate results of special surveillance surveys and studies in selected groups	- # of surveys conducted - # of reports disseminated - # of persons trained to conduct special surveys	4.3.1 Conduct HIV/AIDS risk assessment surveys to collect information on attitudes, behaviours, sexual mixing patterns, health facilities utilisation, and perceived intervention needs among defined target groups and the general population	MOH/HSDU/PEPFAR
		4.3.2 Conduct behavioural surveillance surveys in selected groups (in and out-of school youths), sugar workers; uniformed services personnel	MOH/PEPFAR
		4.3.3 Conduct biological and behavioural surveillance surveys among MSM and CSW	MOH/PEPFAR
		4.3.4 conduct and disseminate results of needs assessment – PLWHAs and orphans	MOH/PEPFAR

PRIORITY #4_STRATEGIC INFORMATION			
BROAD STRATEGIC PROGRAMME AREAS	**MEANS OF VIRIFICATION**	**STRATEGIC AREAS**	**LEAD AGENCY AND STRATEGIC PARTNER(S)**
		4.3.5 Assess capacity of health facilities in both the public and private sector to provide services related to HIV/AIDS	MOH/PEPFAR
4.4 Strengthen local capacity to undertake research related to HIV/AIDS	- # of studies supported - # of studies conducted - # of persons trained in research	4.4.1 Establish a multi-disciplinary HIV/AIDS Research Unit	HSDU/MOH/GFATM and other partners
		4.4.2 Establish and support an HIV/AIDS Research Agenda	MOH/GFATM
		4.4.3 Develop a cadre of persons with appropriate skills to undertake research related to HIV/AIDS	MOH/GFATM/PEPFAR
		4.4.4 Conduct operations and cost-effectiveness research relevant to HIV/AIDS and disseminate findings	MOH
4.5 Strengthen the Health Information System	- # of staff hired - # of persons trained in HMIS - # of regions with functional HMIS	4.5.1 Develop and disseminate national guidelines on system and tools for a national HMIS	MOH/CSIH/PAHO
		4.5.2 Hire and train staff at the national and regional levels for the operation and maintenance of the network	MOH/PAHO
		4.5.2 Establish and interconnect networks at the national and regional levels	MOH/CSIH/PAHO

SECTION 5

MONITORING AND EVALUATION

To fully realize the strategic leadership of the GoG in reducing the spread of HIV/AIDS and increasing the quality of life for PLWHA, a national monitoring and evaluation (M&E) plan has been developed that will harmonise M&E efforts and ensure that the impact of the HIV/AIDS epidemic and the effectiveness of the NSP are adequately monitored.* A set of core national indicators that cut across all sectors and program areas has been established and will form the basis of monitoring the national response to HIV/AIDS in Guyana.

The general purpose of the monitoring and evaluation plan is to:

- Provide a framework that will be used to monitor and evaluate the coordinated national response to HIV/AIDS;
- Ensure consistent use of all indicators and appropriate linkages between all initiatives supported by the GoG, partners, and key stakeholders;
- Ensure appropriate and sustainable linkages between data collection efforts by different stakeholders.

The core indicators are summarized below in tabular form by program area. Consistent with the NSP, the indicators have been grouped into the four key priority areas: Strengthen National Capacity to Implement a Coordinated, Multi-Sectoral Response; Clinical and Diagnostic Management and Access to Care, Treatment, and Support; Reducing Risk and Vulnerability to HIV Infection; and Surveillance and Research.

LEVEL & AREA	INDICATORS	REF	DATA SOURCE
IMPACT			
	Proportion of all deaths attributable to AIDS	Imp1	Vital registration system and program reports
	Percentage of adults and children with HIV alive and known to be on treatment 12 months after initiation of ART	Imp2	Vital registration system and program reports
	HIV prevalence among women aged 15-24	Imp3	Sentinel surveillance at ANC sites
	HIV prevalence among most-at-risk populations	Imp4	BSS/AIS with HIV testing and sentinel surveillance at STI and TB sites
	Percent of infants born to HIV-infected mothers who are infected	Imp5	Program reports and facility surveys

* *The national M&E plan is published as a separate document and is entitled the "National Monitoring and Evaluation Plan for the Multi-Sectoral Response to HIV/AIDS in the Co-operative Republic of Guyana."*

LEVEL & AREA	INDICATORS	REF	DATA SOURCE
PROGRAM OUTPUTS			
Priority 1: Strengthen National Capacity to Implement a Coordinated, Multi-Sectoral Response			
Policy Formation	National composite policy index	Nc1	NCPI questionnaire
Policy Formation	Percent of schools with teachers who have been trained in life-skills based HIV/AIDS education and who taught it during the last academic year	Nc2	School survey
Partnerships/Multi-sectoral Response	Number of line ministries with HIV work plans and budgets	Nc3	Special survey of Line Ministries
Priority 2: Clinical and Diagnostic Management and Access to Care, Treatment, and Support			
Access to ART	Percent of persons with advanced HIV infection receiving ART	Cts1	Program reports and facility surveys
	Number and percent of regions with at least one service outlet providing ART services following national standards	Cts2	Program reports and facility surveys
VCT	Percent of the general population aged 15-49 receiving HIV test results in the past 12 months	Cts4	AIS
	Number of individuals trained in the provision of VCT according to national guidelines	Cts5	Program reports and facility surveys
Home and Palliative Care (HPC)	Number of regions with service outlets that provide HPC	Cts6	Program reports and facility surveys
	Number of service outlets that provide HPC	Cts7	Program reports and facility surveys
	Number of persons trained to provide HPC according to national guidelines	Cts8	Program reports and facility surveys
	Number of persons who receive HPC following national guidelines	Cts9	Program reports and facility surveys
OIs and STIs	Percent of men and women with STIs at health care facilities who are appropriately diagnosed, treated, and counseled	Cts10	Program reports and facility surveys

LEVEL & AREA	INDICATORS	REF	DATA SOURCE
OIs and STIs	Number of persons trained in the management of STIs according to national guidelines	Cts11	Program reports and facility surveys
Tuberculosis	Percent of HIV-positive registered TB patients given ART during TB treatment	Cts12	Program reports and facility surveys
	Percent of registered TB patients tested for HIV	Cts13	Program reports and facility surveys
Lab Support	Percent of patients on ARVs who receive regular CD4 monitoring following national ARV treatment guidelines	Cts14	Program reports and facility surveys
	Number of regional labs with the capacity to perform CD4 tests following national standards	Cts15	Program reports and facility surveys
	Number of persons trained to conduct CD4 testing according to national guidelines	Cts16	Program reports and facility surveys
Priority Area 3: Reducing Risk and Vulnerability to HIV infection			
IEC/BCC	Percent of never-married youth aged 15-24 who ever had sex	Pv1	BSS & MICS
	Percent of youth aged 15-24 reporting use of a condom during last sexual intercourse with a nonregular partner	Pv2	BSS & AIS & MICS
	Percent of people aged 15-49 expressing accepting attitudes toward people with HIV/AIDS	Pv3	BSS & AIS & MICS
	Percent of people aged 15-24 who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	Pv4	BSS & AIS & MICS
	Number of condoms distributed in the past 12 months	Pv5	Program reports and facility surveys
PMTCT	Number of service outlets that offer PMTCT services	Pv6	Program reports and facility surveys
	Number of pregnant women who receive HIV counseling and testing for PMTCT and received their results	Pv7	Program reports and facility surveys

LEVEL & AREA	INDICATORS	REF	DATA SOURCE
PMTCT	Percent of HIV-infected pregnant women who receive a complete course of ARV prophylaxis as part of PMTCT	Pv8	Program reports and facility surveys
	Number of health workers trained in the provision of PMTCT according to national guidelines	Pv9	Program reports and facility surveys
	Percent of babies born to HIV-positive women who are tested before age 18 months	Pv10	Program reports and facility surveys
OVC	Percent of OVC whose households receive free, basic external support in caring for the child	Pv11	MICS
	Number of providers trained in the provision of care for OVC	Pv12	Program reports and facility surveys
	Ratio of current school attendance among orphans to that among non-orphans aged 10-14	Pv13	AIS
Priority Area 4: Surveillance and Research			
	Percent of service outlets with record-keeping systems to monitor HIV/AIDS care and treatment	Sr1	SPA
	Number of persons trained in strategic information (monitoring and evaluation and/or surveillance and/or HMIS)	Sr2	Program reports and facility surveys

SECTION 5

NEXT STEPS – THE WAY FORWARD

To make this plan a reality and move the process forward a detailed workplan with its attendant budget needs to be developed in partnership with the representatives from the various ministries, the donors and other stakeholders. This document is crucial since the National Strategic Plan will be of limited use until the donors can align their financial resources with the strategic priorities. Once this occurs, then implementation can begin and the beneficiaries will receive the support needed for their programmes and intervention activities. For Guyana to achieve its goal and to achieve the optimum use of resources in support of the programme, harmonisation has to occur at the national level with respect to the coordination and alignment of activities. Co-ordination among partners is also essential to ensure the smooth implementation of the Strategic Plan.

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