Country Report

UNGASS COUNTRY PROGRESS REPORT

Republic of Guyana

Reporting period: January 2008 - December 2009

Presidential Commission on HIV and AIDS

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FOREWORD

This Report for the United Nations General Assembly Special Session on HIV and AIDS provides an opportunity for us to determine how well we in Guyana have done in relation to achieving the Declaration of Commitment on HIV and AIDS. The Declaration remains a powerful tool that is helping to guide and secure action, commitment, support and resources for the HIV response.

This 2008-2009 Progress Report provides concrete evidence of the significant progress that we have made in our response to HIV in Guyana. The improved surveillance system has enabled us to identify the decreasing trend in our epidemic, particularly among the general population. Taken together, the prevalence studies conducted among women attending antenatal clinic, programmatic data from antenatal clinic and blood banking and prevalence studies among most-at-risk groups, such as commercial sex workers and men who have sex with men provide a clearer picture of the Guyanese epidemic than any of them viewed alone.

We have been able to put more people on treatment. There were 2,832 persons actively receiving antiretroviral therapy at the end of 2009, compared to 942 persons on treatment in 2005. Prophylaxis treatment provided to pregnant women has reduced mother-to-child-transmission from 16.0 percent in 2005 to 3.8 percent in 2008. The number of TB-HIV co-infected persons has declined from over 30.0 percent in 2005 to 23.0 percent in 2009. Prevalence among blood donors has declined steadily from 0.9 percent in 2005 to 0.16 percent in 2009.

We are beginning to see encouraging signs with regard to reducing the HIV prevalence among most-at-risk populations, particularly female sex workers among whom HIV prevalence declined from 26.6 percent in 2005 to 16.6 percent in 2009. The proportion of all deaths attributable to AIDS has also declined from 9.5 percent in 2002 to 4.7 percent in 2008. Our aggressive "know your status" campaign has seen a progressive increase in the number of persons being counselled and tested over the last six years, from 16,065 persons in 2005 to 85,554 persons in 2009. More recently we have seen a significant increase in the number of men coming forward to be tested.

We have experienced tremendous growth in the number and quality of services we provide. We have established a National Public Health Reference Laboratory in 2008 with the capacity to perform CD4 testing, viral load monitoring, DNA PCR for HIV-exposed infants among other diagnostics and have decentralised the delivery of laboratory services through training and provision of laboratory equipment. We have established quality assurance monitoring within our treatment and care programme and are in the process of expanding to other programmes. We have made significant strides towards achieving the goal of 100.0 percent voluntary blood donation. Voluntary non-remunerated blood donation has increased sharply from 22.0 percent in 2005 to 68.0 percent in 2009.

However, despite these achievements and the massive investment there are still measurable gaps in our response. We believe there are still persons who are in need of treatment who are not in our treatment and care programme. We must continue to explore new strategies to find those persons who require treatment. I believe that the restrictive protocol of using CD4 cut-offs for eligibility for ARV treatment is a backward protocol and an immoral one and we should pursue earlier treatment with ARVs. It is still my wish to place persons who are HIV positive on ARV treatment as early as possible.

Although we have made progress in the prevention response, and although there are genuine success stories, such as the prevention of mother-to-child-transmission, there are gaps in the prevention response. The continued presence of poor awareness and knowledge about HIV in small pockets around the country must be compelling reasons to expand our IEC and awareness programmes around the country.

Sexual intercourse is the main means of transmission of HIV, but there is evidence that people, particularly young people, still engage in sexual behaviour that leave them at great risk. For example, only marginal improvement has been noted in the use of condoms. We have made no dent in the age for sexual debut.

Predisposing factors, such as alcohol use, continue to be major social determinant that need to be more seriously addressed. It is clear, therefore, that changing the behaviour of the individual must be the key strategy of preventing infections. We must develop new and innovative strategies and we must do so quickly.

We have achieved impressive national coverage in relation to the provision of prevention, treatment and care, and support services. Yet there are pockets of non-coverage. And we do need to ask if we are reaching the most vulnerable among us. We must direct our attention more aggressively to ensuring equity in our services.

Stigma and discrimination remain barriers to access to prevention, treatment and care, and support services. We must adopt strategies that not only target people with mass media anti-stigma information. We must acknowledge that stigma and discrimination are complex and require multipronged strategies that include interpersonal communication at individual, family and community level.

We have continually struggled with the human resource constraints. We must therefore continue to invest in training and the utilisation of our health care providers while continuing to strengthen our health systems since the weaknesses and gaps in those systems constrain the achievement of improved outcomes in reducing the burden of AIDS and other diseases. We must also recognise that a good health information system has the potential for a paradigm shift in health outcomes.

This Progress Report not only measures our achievements against the UNGASS indicators but presents us with a situation analysis. The analysis suggests that we have done very well in relation to broadening and widening the scope of our response. We must celebrate our successes. However, the analysis brings into sharp focus the work that is yet to be done if we are to remain on this path of success.

We must commit ourselves to securing and building on the gains of the last six years. We shall be held accountable by the people of Guyana and we must therefore demonstrate that we are good stewards of the massive resources we have available to us to roll back this epidemic. We can, and we must stop the spread of HIV in Guyana.

Honourable Dr. Leslie Ramsammy
Minister of Health

ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
AIS	AIDS Indicator Survey
ANC	Antenatal Clinic
ART	Anti-retroviral Therapy
ARV	Anti-retroviral
BCC	Behaviour Change Communication
CHPC	Community Home and Palliative Care
BSS	Behavioural Surveillance Survey
BBSS	Biological and Behavioural Surveillance Survey
CBOs	Community-based Organisations
CCM	Country Coordinating Mechanism
CDC	US Centers for Disease Control and Prevention
CIDA	Canadian International Development Agency
COATS	Coordinating AIDS Technical Support
CHAT	Country Harmonisation and Alignment Tool
CRIS	Country Response Information System
CRS	Catholic Relief Services
CSO	Civil Society Organisation
DHS	Demographic Household Survey
DNA	Deoxyribonucleic Acid
FBO	Faith-based Organisation
FSWs	Female Sex Workers
FXB	Francois Xavier Bagnaud
GDP	Gross Domestic Product
GBoS PHC	Guyana Bureau of Statistics, Population and Housing Census
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GHARP	Guyana HIV/AIDS Reduction and Prevention Project
GoG	Government of Guyana
GSIP	Guyana Safer Injection Project
GUM	Genito-Urinary Medicine
HFLE	Health and Family Life Education
HBC	Home-Based Care
HIV	Human Immuno-deficiency Virus
HSDU	Health Sector Development Unit
HTLV	Human T-Lymphotropic Virus
IEC	Information, Education, Communication
IPED	Institute for Private Enterprise Development
MARPs	Most At-Risk Populations
M&E	Monitoring and Evaluation
MICS	Multi-Indicator Cluster Survey
MoLHS&SS	Ministry of Labour, Human Services and Social Security
MoH	Ministry of Health
MSM	Men Who Have Sex with Men
MTCT	Mother-to-Child-Transmission
MTR	Mid-Term Review
NAC	National AIDS Committee

NAP	National AIDS Programme
NAPS	National AIDS Programme Secretariat
NCTC	National Care and Treatment Centre
NCPI	National Composite Policy Index
NGOs	Non Governmental Organisations
NLID	National Laboratory for Infectious Disease
NSP	National Strategic Plan
NBTS	National Blood Transfusion Service
OIs	Opportunistic Infections
OVC	Orphans and Vulnerable Children
PAHO-WHO	Pan American Health Organisation-World Health Organisation
PANCAP	Pan Caribbean Partnership against HIV/AIDS
PCHA	Presidential Commission on HIV and AIDS
PCR	Polymerase Chain Reaction
PEP	Post Exposure Prophylaxis
PEPFAR	President Emergency Plan for AIDS Relief
PLHIV	Persons Living with HIV
PMTCT	Prevention of Mother-to-Child Transmission
PRSP	Poverty Reduction Strategy Paper
RACs	Regional AIDS Committees
SCMS	Supply Chain Management Systems
STIs	Sexually Transmitted Infections
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNDP	United Nations Development Programme
UNESCO	United Nations Education Scientific and Cultural Organisation
UNFPA	United Nations Population Fund
UNICEF	United Nations Children Fund
UNV	United Nations Volunteers
USAID	United States Agency for International Development
VCT	Voluntary Counselling and Testing
WBMAP	World Bank Multi-country AIDS Programme

1. STATUS AT A GLANCE

1.1 Inclusiveness of stakeholders in report preparation

The National Composite Policy Index (NCPI) interviews provided a unique opportunity for key stakeholders to contribute to writing this report. Stakeholders provided candid feedback on the progress towards the development and implementation of national HIV policies and strategies, and remained engaged throughout the review process. Additionally, Civil Society was represented on the UNGASS Report Preparation Team throughout the preparation and review processes. Key stakeholders were invited to a participatory workshop to ensure consensus on the content of the report.

1.2 Status of the Epidemic

The analysis of the available epidemiological evidence suggests that the HIV prevalence has been progressively decreasing among the general population over the last six years and there are encouraging signs that the HIV prevalence among most-at-risk populations is beginning to decline. Concomitantly, the proportion of deaths attributed to AIDS has progressively decreased.

A detailed overview of the epidemic is presented in Section 2. The following section summarises the latest data on the epidemiology of HIV in Guyana and demonstrates the continued improvement in the national HIV surveillance system. Key elements of the epidemic are as follows:

1. Antenatal Clinic (ANC) Surveys, routine prevention of mother-to-child-transmission (PMTCT) programme data provide evidence that HIV prevalence among the general population has been progressively decreasing since 2004. ANC surveys have revealed a reduction in HIV prevalence from 2.3 percent in 2004 to 1.55 percent in 2006 and routine PMTCT programme data showed HIV prevalence of 3.1 percent in 2003, 2.5 percent in 2004, 2.2 percent in 2005, 1.6 percent in 2006, 1.3 percent in 2007, 1.15 percent in 2008 and 1.11 percent in 2009. There has also been a decreasing trend in the HIV prevalence among blood donors; 0.9 percent in 2005, 0.42 percent in 2006, and 0.29 percent in 2007, 0.46 percent in 2008 and 0.16 percent in 2009 (Blood Bank Programme data).

2. Data from the 1st National Day of Testing conducted in November 2007 revealed an HIV prevalence of 1.01 percent among 4,504 persons tested. Data from the highly successful Week of Testing conducted in November 2008 and 2009 revealed HIV prevalence of 0.66 percent among 15,489 persons tested in 2008 and 0.5 percent among 28,360 persons tested in 2009 (NAPS Programme Reports).

3. Although the epidemic is generalised, sub-populations are known to have higher HIV prevalence. The Biological and Behavioural Surveillance Survey (BBSS) 2009 revealed decreases in HIV prevalence among female sex workers (FSWs), and men who have sex with men (MSM), compared to the 2005 BBSS. A sharp decrease (10%) has been observed in the HIV prevalence among FSWs, from 26.6 percent (BBSS, 2005) to 16.6 percent (BBSS, 2009). In contrast only a slight decrease has been observed among MSM, from 21.2 percent (BBSS, 2005) to 19.4 percent (BBSS, 2009). A national BBSS conducted among security guards in 2008 revealed an HIV

prevalence of 2.7 percent. In 2007 a national BBSS among prisoners revealed an HIV prevalence of 5.24 percent.

4. There is increasing feminisation of the disease particularly between 2000 and 2008, when the annual number of reported cases of HIV has been consistently higher among females. The sex ratio (male to female) changed from 1.16 in 2000 to 0.91 in 2008 (MOH Statistics Unit). In 2009 the sex ratio (male to female) was 1.05 (MOH Statistics Unit).

5. The available data for 2009 revealed that the 20-44 age-group is the most affected, accounting for 71.59 percent (842/1176) of all cases of HIV in 2009 (MOH Statistics Unit). There was a total of 10 HIV cases reported among children aged 0-4. The highest number of reported HIV cases occurred in the 30-34 age-group during 2009 as well as in 2007. Persons 50 years and above accounted for 8.75 percent of all reported HIV cases in 2009 compared to the 1.0 percent in 2006 (MOH Statistics Unit).

6. Data on HIV cases revealed that Region Four accounted for 56.29 percent (662/1176) of all HIV cases in 2009, and 51.16 percent of all AIDS cases for the same year (MOH Statistics Unit). In contrast, the region only accounts for 41.3 percent of the total population.

7. The proportion of all deaths attributable to AIDS has also been declining since 2002, when it was 9.5 percent, to 6.86 percent in 2005, 5.9 percent in 2006, 5.7 percent in 2007 and 4.7 percent in 2008. The actual number of AIDS related deaths has significantly declined from 475 in 2002, to 360 in 2005, 298 in 2006, 289 in 2007 and 239 in 2008 (MOH Statistics Unit).

1.3 Policy Response

The National Policy on HIV and AIDS was first approved by Parliament in 1998. This policy was revised in 2003 to reflect changes within the National AIDS Programme and to demonstrate a policy of universal access to prevention, treatment and care. Additional policy provisions, such as those prohibiting stigmatisation or discrimination when applying for social benefits and universal access to VCT and PMTCT, have also been integrated into the most recent revision of the National Policy in 2006.

The National Workplace HIV and AIDS Policy was launched in March 2009 and is being promoted as the minimum standard for the development of HIV and AIDS workplace policies.

An adequate and safe blood supply is a crucial element of a national strategy to control HIV. In light of this a National Blood Policy was developed and approved. A draft Orphan and Vulnerable Children (OVC) Policy was prepared and approved by the Ministry of Labour, Human Services and Social Security (MOLHS&SS).

Draft HIV legislation was developed and is currently being finalised by the Attorney General's Chambers for tabling in Parliament. The draft HIV legislation addresses a range of issues including the protection of PLHIV from discrimination. A final draft of the Blood Transfusion Legislation has been developed.

1.4 Programmatic Response

The period under review saw significant strengthening of all major programme areas and expansion of prevention services particularly to vulnerable populations. The major programmatic developments during the reporting period are outlined below.

Prevention efforts have been significantly scaled-up and intensified with the full collaboration and commitment of all key stakeholders during the last six years. BCC campaigns have been strengthened and expanded during 2008 and 2009 to target vulnerable populations and promote community involvement in prevention, treatment and care, and support. This period saw an increase in the availability of both male and female condoms. National Prevention Guidelines and a Prevention Technical Working Group were established during the reporting period.

The VCT programme has expanded to increase access and geographic coverage. The period under review saw an increased from 62 sites in 2008 to 70 sites in 2009 compared to 44 sites in 2007 and 27 sites in 2005. Nine of the 10 administrative regions now have fixed sites while Region One is served by one of the three mobile teams that deliver services to hinterland locations thereby ensuring national coverage (NAPS Programme Report). A total of 63,876 persons (37,028 females and 26,848 males) received counselling and testing in 2008 and this was increased to 85,554 persons (48,042 females and 37,512 males) in 2009 (NAPS Programme Report).

Uptake and coverage of PMTCT services have improved substantially over the last six years. Concomitantly, HIV prevalence among antenatal women has declined over the years, from 3.1 percent in 2003 to 1.3 percent in 2007, 1.15 percent in 2008 and 1.11 in 2009 (PMTCT Programme Reports). The national PMTCT programme was expanded and strengthened thus ensuring that PMTCT services are available in both the public and private sectors. At the end of 2009, there were 157 facilities including antenatal clinics, delivery wards and four of the six private hospitals. This compares to 135 facilities in 2008, 110 in 2007 and 57 in 2005. Routine programme data revealed a 95.5 percent acceptance rate among 16,473 pregnant women offered testing in 2008 and 89.8 percent in 2009 (see table 8 for explanation). There was 97.8 percent acceptance rate in 2007, and 97.6 percent in 2006.

The access to a safe blood supply was expanded through the establishment of a Hospital Blood Bank at Guyana's largest hospital, Georgetown Public Hospital in December 2008. Efforts to ensure the appropriate clinical use of blood and blood products saw the development and launch of guidelines on clinical use of blood in April 2009 and the establishment of Hospital Transfusion Committees in five administrative regions serving a significant proportion of the population (Regions Two, Three, Four, Six and Ten). Capacity has been increased to screen for transmissible and transfusible infections through the introduction of Chagas Disease testing capabilities to the National Blood Bank in December 2008. Additional capacity building efforts were directed to achieving the national goal of 100.0 percent voluntary blood donation by 2010 and enhancing quality control systems. Voluntary blood donation increased to 55.0 percent (4021/7360) in 2008 and 68.0 percent (5236/7700) in 2009, compared to 47.0 percent in 2007 and 22.0 percent in 2005 (Blood Bank Programme Reports).

Substantial work has been completed to ensure safe injections and minimise the risk of needle stick injury. Emphasis was placed on training of health care workers, procurement of safe injection commodities and facilitating access to safe disposal options. A total 744 health care workers were

trained in injection safety during 2008 and 2009. A total of 276 facilities which represents 76.0 percent of all eligible hospitals, health centres and health posts benefited from interventions to ensure injection safety in these facilities. National coverage is expected to reach 95.0 percent during the first quarter of 2010.

The 2005 and 2009 BBSS targeted key Most-at-Risk Populations (MARPS); female sex workers, and MSM, among others. The MoH directed efforts at training MARPS outreach workers to build their capacity in education and counselling as a means of strengthening interpersonal communication and strategies, and monitoring the delivery of peer education among these groups. In-school and out-of-school youth were also targeted.

The Guyana HIV treatment and care programme increased to 16 sites in 2008, compared to 14 sites in 2007 and eight sites in 2005 (NAPS Programme Report). This programme ensures the provision of comprehensive treatment and care, and support for all persons living with HIV (PLHIV). Both first and second line treatments are available free of charge since 2002 and 2006 respectively. A total of 2,832 persons were actively receiving antiretroviral therapy (ART) at the end of 2009, and 2,473 persons were receiving ART in 2008, compared to 1,965 in 2007, and 942 in 2005. The National Patient Monitoring System is fully functional at all care and treatment sites.

The period under review saw the implementation of the HEALTHQUAL Guyana Project, the development of HIV Drugs Resistance Monitoring Protocol and Country Operational Plan, the revision of the National Guidelines for the Management of HIV Exposed Infants and Infected Adults and Children, the conduct of training, and the provision of equipment to perform viral load testing.

Referrals between tuberculosis (TB) treatment sites and antiretroviral treatment sites were strengthened in response to the priority need to reduce the transmission of TB and the burden of the disease among HIV positive persons. A total of 400 new TB cases were detected in 2009 and placed on Directly Observed Treatment Strategy (DOTS) and 71 TB/HIV co-infected patients were placed on highly active antiretroviral treatment (HAART). There was a TB incidence rate of 79 per 100,000 in 2009 compared to 83 per 100,000 in 2008. Tuberculin skin testing has been integrated into the package of services provided at the ART sites through training of nurses, counsellor-testers and DOTS workers in the placement and reading of Mantoux tests.

The diagnostic capacity of the treatment and care programme has been significantly enhanced with the establishment of an operational National Public Health Reference Laboratory (NPHRL) in 2008. The NPHRL provides CD4 testing for the national treatment programme. The CD4 testing capability has been decentralised to two regional laboratories in New Amsterdam, Region Six, and Linden, Region Ten. With effect from January 2010 the country will have the capacity to provide early infant diagnosis through DNA PCR testing, and viral load monitoring for the national programme. A National Care and Treatment Centre was also established in 2008.

Eight hundred and twenty-six (826) new persons were enrolled onto the Home-Based Care (HBC) programme in 2009 compared to 790 enrolled in 2008 (NAPS Programme Report). This programme was launched in 2005 and served 1,026 persons in 2006 and 1,223 persons in 2007. Some 4,000 persons were served through the Community Home and Palliative Care Programme (CPHC) during 2008 and 2009 (PEPFAR FY 2009 Report). Palliative care training has extended beyond the nurses at treatment sites to all categories of nurses within the health sector.

Social and economic support was provided to PLHIV through a number of empowerment sessions which have enabled them to be more proactive in their health care and utilise the vocational skills acquired to generate incomes and accessed small loans. PLHIV support groups have also been established at each treatment site and at NGOs. The Food Bank was officially launched in April 2007 to provide temporary and critical nutritional support to persons living with and affected by HIV. Two thousand and seventy-five (2,075) food hampers were distributed to 805 persons in 2008 and 3,983 food hampers were distributed to 1,129 persons in 2009. The number of local businesses that provided financial or material support to the Food Bank increased significantly from 11 private sector entities in 2008, to 25 entities in 2009.

A National Workplace Policy on HIV and AIDS was launched in March 2009. The Ministry of Labour and the labour unions are actively involved in advocacy to increase uptake of workplace policies. Through the ILO Workplace Programme 13 enterprises developed workplace policies in 2008 and this increased to 31 at the end of 2009.

The Private Sector Partnership Programme which initially comprised a small group of companies in 2005 was transformed into a strong coalition of private sector organisations that are actively engaged in helping the GoG reach its goals of preventing and reducing HIV in Guyana. This 43-member body, Guyana Business Coalition on HIV/AIDS, was officially launched in May 2008. It is designed to serve as a central coordinating mechanism, linking companies to in-house workplace and peer education training, VCT, PMTCT, treatment and care, support for OVC and PLHIV.

Table 1: Overview of UNGASS Indicator Data

UNGASS or UNGASS-related Indicator	Data Origin	Period	Value
NATIONAL COMMITMENT AND ACTION			
1. Domestic and international AIDS spending by categories and financing sources	-	-	Not available
2. National Composite Policy Index	Key informant interviews	2009	See Annex 2
NATIONAL PROGRAMME			
3. Percentage of donated blood units screened for HIV in a quality assured manner ***Note:*** *Public sector only*	National Blood Transfusion Service routine data	2008 2009	100.0% 100.0%
4. Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy ***Note:*** *The projected estimate of Adult ART need for 2009 modelled in the 2006 ANC Survey was used as the denominator for 2009 in the absence of UNAIDS 2009 estimate.*	NAPS Programme Reports	2008 2009	72.7% 83.5%
5. Percentage of HIV-positive women who received antiretroviral to reduce the risk of mother-to-child transmission ***Note****: Numerator is actual number of pregnant women uptaking ART. Denominator used is the number of women*	ANC Programme Report	2008 2009	80.45% 84.4%

giving birth multiplied by the estimated HIV prevalence rate among pregnant women (i.e., 1.15% in 2008 and 1.11% in 2009)			
6. Percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV ***Note:*** *Denominator: WHO estimated number of incidence TB cases in people living with HIV* *WHO estimate unavailable for 2009, therefore the 2008 estimate was reused as the denominator in 2009*	Chest Clinic Programme Reports	2008 2009	94.2% 93%
All Females	Chest Clinic Programme Reports	2008 2009	91.1% 94.7%
All Males	Chest Clinic Programme Reports	2008 2009	93.3% 92.8%
Less than 15 years	Chest Clinic Programme Reports	2008 2009	3.7% 2.5%
More than 15 years	Chest Clinic Programme Reports	2008 2009	96.2% 9.75%
7. Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and who know their results	DHS	2009	24.8%
All Females	DHS	2009	27.0%
All Males	DHS	2009	21.6%
8. Percentage of most-at-risk populations who received an HIV test in the last 12 months and who know their results ***Note****: This indicator is not defined in the same way in the 2009 BBSS. The indicators actually used in the BBSS are presented here as a proxy.*			Indicator relevant but data not available (see note)
Percent tested within last 12 months (**FSW**)	BBSS	2009	87.9%
Percent ever had an HIV test (**FSW**)	BBSS	2009	78.5%
Percent returned to receive results – from any test ever taken (not necessarily within past 12 months) (**FSW**)	BBSS	2009	93.0%
Percent tested within last 12 months (**MSM**)	BBSS	2009	87.1%
Percent ever had an HIV test (**MSM**)	BBSS	2009	77.7%
Percent returned to receive results – from any test ever taken (not necessarily within past 12 months) (**MSM**)	BBSS	2009	100.0%
9. Percentage of most-at-risk populations reached with HIV prevention programmes	-	-	Indicator relevant but data not available

***Note**: This indicator is not defined in the same way in the 2009 BBSS. The indicators actually used in the BBSS are presented here as a proxy.*			(see note)
Percent who know of place in community to access HIV test (**FSW**)	BBSS	2009	61.4%
Percent who know of place in community to access HIV test (**MSM**) ***Note:** This indicator was not measured for MSM in the 2009 BBSS therefore the 2005 value was reused.*	BBSS	2005	16.0%
10. Percentage of orphaned and vulnerable children aged 0-17 whose households received free basic external support in caring for the child	-	-	Not required to report since national prevalence is below 5%
11. Percentage of schools that provided life skills-based HIV education in the last academic year	MOE HFLE Survey	2008	61.6%
Nursery School	-	-	100.0%
Primary School	-	-	73.9%
Secondary School	-	-	23.8%
KNOWLEDGE AND BEHAVIOUR			
12. Current school attendance among orphans and among non-orphans aged 10-14	-	-	Indicator relevant but data not available
13. Percentage of young women and men aged 15-24 who both correctly identified ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	BBSS	2009	45.5%
13.1 Percentage who correctly identify that the risk of HIV transmission is reduced by having sex with one non- infected partner	BBSS	2009	86.0%
13.2. Percentage who correctly reported that consistent condom use reduces the risk of HIV transmission	BBSS	2009	90.50%
13.3. Percentage who correctly reported that a healthy looking person can have HIV	BBSS	2009	95.7%
13.4. Percentage who correctly reported that HIV cannot be transmitted through mosquito bites	BBSS	2009	73.3%
13.5 Percentage who correctly reported that HIV cannot be transmitted through sharing a meal with an infected person	BBSS	2009	78.6%
14. Percentage of most-at-risk-populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject misconceptions about HIV transmission ***Note:** Data presented separately for FSWs and MSMbelow:*		-	-

FSW	BBSS	2009	35.0%
MSM	BBSS	2009	46.8%
FSW **14.1** Percent who has knowledge of HIV prevention methods (defined as: correctly identified abstinence, faithfulness, and consistent condom use as ways that HIV cannot be transmitted) ***Note:*** *The specific indicators for a faithful partner and use of condoms are reported separately immediately below*	BBSS	2009	74.9%
14.1.1 Percent who identify that having one faithful uninfected partner can reduce the risk of HIV transmission (**FSWs**)	BBSS	2009	82.0%
14.1.2 Percent who identify that consistently using a condom correctly can reduce the risk of HIV transmission (**FSWs**)	BBSS	2009	95.4%
FSWs **14.2** Percent with no incorrect beliefs about HIV (correctly rejected three most common local misconceptions: mosquito bites, sharing a meal with infected persons and healthy looking persons) ***Note:*** *The specific indicators for the above misconceptions are reported separately immediately below*	BBSS	2009	50.6%
14.2.1 Percent with knowledge that mosquitoes cannot transmit HIV (**FSWs**)	BBSS	2009	71.3%
14.2.2 Percent with knowledge that sharing a meal cannot transmit HIV (**FSWs**)	BBSS	2009	74.7%
14.2.3 Percent with knowledge that a healthy looking person can transmit HIV (**FSWs**)	BBSS	2009	93.8%
MSM **14.1** Percent who has knowledge of HIV prevention methods (defined as: correctly identified abstinence, faithfulness, and consistent condom use as ways that HIV can be transmitted) ***Note:*** *The specific indicators for a faithful partner and use of condoms are reported separately immediately below:*	BBSS	2009	68.2%
14.1.1 Percent who identify that having one faithful uninfected partner can reduce the risk of HIV transmission (**MSM**)	BBSS	2009	82.9%
14.1.2 Percent who identify that consistently using a condom correctly can reduce the risk of HIV transmission (**MSM**)	BBSS	2009	94.5%
MSM **14.2** Percent with no incorrect beliefs about HIV (correctly rejected three most common local	BBSS	2009	64.5%

misconceptions: mosquito bites, sharing a meal with infected persons and healthy looking persons) ***Note:*** *The specific indicators for the above misconceptions are reported separately immediately below:*			
14.2.1 Percent with knowledge that mosquitoes cannot transmit HIV (**MSM**)	BBSS	2009	81.8%
14.2.2 Percent with knowledge that sharing a meal cannot transmit HIV (**MSM**)	BBSS	2009	80.6%
14.2.3 Percent with knowledge that a healthy looking person can transmit HIV (**MSM**)	BBSS	2009	96.4%
15. Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15	DHS	2009	13.6%
All females	DHS	2009	10.1%
All males	DHS	2009	18.9%
16. Percentage of women and men aged 15-49 who have had sexual intercourse with more than one partner in the last 12 months	DHS	2009	4.9%
All Females	DHS	2009	1.3%
All Males	DHS	2009	9.9%
Females 15 – 19	DHS	2009	1.1%
Females 20 – 24	DHS	2009	1.5%
Females 25 – 49	DHS	2009	1.4%
Males 15 – 19	DHS	2009	8.0%
Males 20 – 24	DHS	2009	18.4%
Males 25 – 49	DHS	2009	8.5%
17. Percentage of women and men aged 15-49 who had more than one sexual partner in the past 12 months reporting the use of a condom during their last sexual intercourse ***Note****: Fewer than 25 unweighted cases for females 15-19 and 20-24, and has been suppressed in DHS report.*	DHS	2009	62.7%
All Females	DHS	2009	47.9%
All Males	DHS	2009	65.4%
Females 15 -19	-	-	-
Females 20 – 24	-	-	-
Females 25 – 49	DHS	2009	47.9%
Males 15-19	DHS	2009	85.8%
Males 20-24	DHS	2009	70.4%
Males 25-49	DHS	2009	57.7%
18. Percentage of female and male sex workers reporting the use of a condom with their most recent client *Note- Only Female sex workers*	BBSS	2009	61.4
19. Percentage of men reporting the use of a condom	-	-	-

the last time they had anal sex with a male ***Note**: The BBSS indicator is the same, except that it distinguishes between 3 classes of partners as specified below.*			
Regular partner	BBSS	2009	79.9%
Non-regular partner	BBSS	2009	75.0%
Commercial partner	BBSS	2009	84.2%
20. Percentage of injecting drug users reporting the use of a condom the last time they had sexual intercourse	-	-	2009 BSS findings suggest that this is not a major population
21. Percentage of injecting drug users reporting the use of sterile injecting equipment the last time they injected	-	-	2009 BSS findings suggest that this is not a major population
IMPACT			
22. Percentage of young women and men aged 15 – 24 who are HIV infected *Note: ANC programme data reported as a proxy. Data not disaggregated by age group*	ANC Programme Data	2008 2009	1.12% 1.11%
23. Percentage of most-at-risk populations who are HIV infected *Note: Data not disaggregated by age group*	-	-	-
FSW	BBSS	2009	16.6%
MSM	BBSS	2009	19.4%
24. Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy ***Note**: This is the average survival values of 12 cohorts after 12 months on treatment. The cohorts cover the period January to December 2008.*	Patient Monitoring System (NAPS)	2008	72.18%
All Females	PMS (NAPS)	2008	74.6%
All Males	PMS (NAPS)	2008	69.67%
<15 years	PMS (NAPS)	2008	65.2%
>15 years	PMS(NAPS)	2008	72.51%
25. Percentage of infants born to HIV-infected mothers who are infected	-	-	Will be modelled at UNAIDS from data

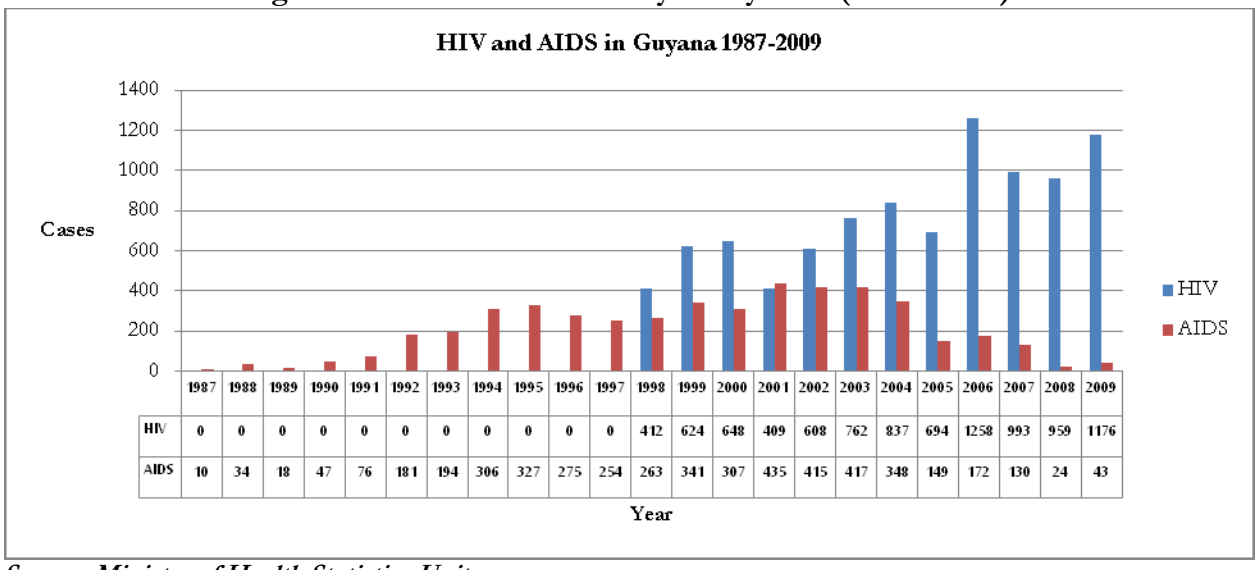
			reported at indicator 5

2. OVERVIEW OF THE HIV EPIDEMIC

Guyana has a population of 751,223 with a landmass of 215,000 km^2 extending along the north-eastern coast of South America. It is the only English-speaking country in South America and is joined by Suriname as the only South American members of the Caribbean Community (CARICOM). According to the 2002 Census of the Guyana Bureau of Statistics (GBoS), most of the population (86%) is concentrated in the coastal areas and 71.6 percent of the population lives in rural communities.

Guyana is divided into ten administrative regions, with three coastal regions (Three, Four, and Six) collectively accounting for 72.0 percent of the total household population. Per capita GDP is US$1,233.60 (GBoS, 2008) and the country is ranked 114th in the Human Development Index (HDI) 2009 Report.
The first case of AIDS was reported in a male homosexual in 1987 and there has been a progressive increase in the number of reported cases. The epidemic in Guyana is considered generalised, as an HIV prevalence of greater than one percent has been consistently found among pregnant women attending antenatal care clinics. A cumulative total of 14,146 HIV and AIDS cases (9,380 cases of HIV and 4,766 cases of AIDS) have been officially reported to the Ministry of Health by the end of 2009 (Ministry of Health Statistics Unit). The number of new AIDS cases has progressively decreased since 2004. The number of HIV and AIDS cases by year is illustrated in Figure 1.

Figure 1: HIV and AIDS in Guyana by Year (1987 – 2009)



	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
HIV	0	0	0	0	0	0	0	0	0	0	0	412	624	648	409	608	762	837	694	1258	993	959	1176
AIDS	10	34	18	47	76	181	194	306	327	275	254	263	341	307	435	415	417	348	149	172	130	24	43

Source: Ministry of Health Statistics Unit

National HIV estimates for 2008

Leading up to the UNAIDS Bi-annual Estimation Workshop held in Barbados in June 2009, a pre-estimation workshop was held with key data providers in Guyana to review all data required for the

estimation workshop and to arrive at consensus on data sets. Following the June 2009 regional Estimation Workshop where the Guyana National AIDS programme was represented, a Consensus Meeting was convened in Guyana and the new estimates were presented to key data providers. New estimates were on (i) HIV+ population; (ii) new adult infections; (iii) total adult incidence; (iv) mothers in need of ART and (v) adult HIV prevalence. The following are the National HIV estimates for 2008:

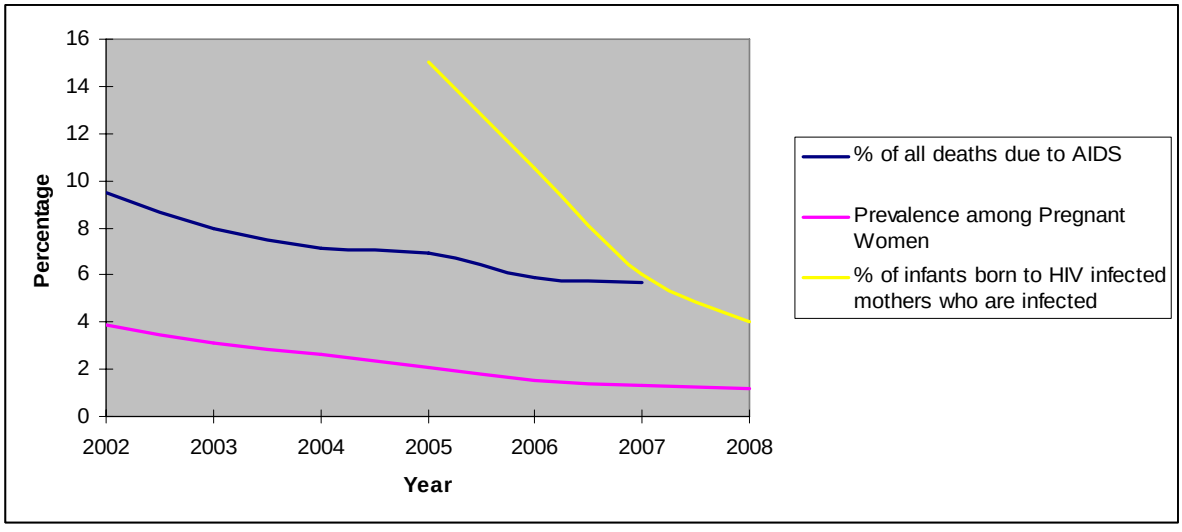
- Estimated HIV positive population 15+ 8,900 Males/Females 8000
- New adult infections for Males and Females <500
- Incidence for Adult Males and Females age 15-49 <.15 percent
- Estimated mothers needing ART <500
- Estimated HIV prevalence 1.9 percent

Trends in the HIV epidemic

Significant progress has been made with decreasing the overall progression of the HIV epidemic in Guyana (Guyana HIV AIDS Strategy 2007-2011 Mid-term Review Report, 2009). The following are some key achievements:

- Prevalence among pregnant women decreased steadily from 5.6 percent in 2000 to 2.6 percent in 2004 to 1.55 percent in 2006, 1.3 percent in 2007, 1.15 percent in 2008 and 1.11 percent in 2009;
- The proportion of deaths attributed to AIDS has decreased from 9.5 percent in 2002 to 4.7 percent in 2008;
- The percentage of HIV infected infants born to HIV infected mothers is down to 3.8 percent in 2008.

Figure 2: Percentage of all deaths due to AIDS, HIV prevalence among pregnant women and percentage of HIV infected infants born to HIV infected mothers



Source: Guyana HIV/AIDS Strategy 2007-2011 Mid-term Review Report, 2009

A similar pattern of decreasing prevalence among key populations is illustrated in Table 2. Improved screening of potential donors would have also contributed to the decreasing pattern observed among blood donors. The gains observed among most-at-risk population, particularly among female sex workers are encouraging given that the national response has only recently began to develop activities to aggressively engage these populations with prevention information and services. Such activities need to be intensified.

The trend over the last five years shows that the co-infection prevalence among TB-HIV patients is decreasing as illustrated in Table 2.

Gender Distribution of Reported Cases

While HIV appears to have initially been most prevalent among males, the disease has been transmitted to increasing numbers of women. By 2003, the annual number of reported cases of HIV was higher among females and has remained so until 2008 as shown in Table 3. Trends in the male to female ratio are also shown in Table 3. The 2008 male to female ratio for HIV cases is 0.91, down from 1:2.8 in 1989. This is consistent with a true heterosexual epidemic where males and females are equally affected. Overall, the number of AIDS cases in males outnumbers the number of cases in females, except within the younger age group (15-24), where there are more female than male cases.

Table 2: HIV Prevalence among Key Populations in Guyana

POPULATION	SEX	YEAR	PREVALENCE	REMARKS
Pregnant Women	Female	2004	2.3	ANC Survey
		2006	1.55	ANC Survey
		2003	3.1	PMTCT Prog. Report
		2004	2.5	PMTCT Prog. Report
		2005	2.2	PMTCT Prog. Report
		2006	1.6	PMTCT Prog. Report
		2007	1.35	PMTCT Prog. Report
		2008	1.12	PMTCT Prog. Report
		2009	1.11	PMTCT Prog. Report
Blood Donors	All	2004	0.7	Blood Bank Progamme Reports
		2005	0.9	
		2006	0.42	
		2007	0.29	
		2008	0.46	
		2009	0.16	
Sex Workers	Female	1997	45.0	Special Survey
		2005	26.6	BBSS
		2009	16.6	BBSS
MSM	Male	2005	21.25	BBSS
		2009	19.4	BBSS
TB Patients	All	1997	14.5	Clinic Records
		2003	30.2	

		2004	11.2 (52% tested)	
		2005	30.24 (82% tested)	
		2006	33.2(83% tested)	
		2007	35.32	
		2008	22.0	
		2009	23.0 (89% tested)	
Miners	Male	2000	6.5	Special Survey One mine study
		2003	3.9	Special Survey 22 mines study
Security Guards	All	2008	2.7	BBSS
Prisoners	All	2008	5.24	BBSS

Source: National AIDS Programme Secretariat, 2009

Table 3: Trends in Reported Cases of HIV and AIDS by Gender

CLASSIFIC -ATION		2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
HIV	Male	348	174	301	339	368	325	591	422	446	600
	Female	300	226	268	368	408	421	626	531	490	567
	Unknown	0	9	39	55	61	36	41	40	23	9
	Total	648	409	608	762	837	809	1,258	993	959	1,176
	Sex Ratio	**1.16**	**0.77**	**1.12**	**0.92**	**0.90**	**0.77**	**0.94**	**0.79**	**0.91**	**1.05**
AIDS	Male	175	232	243	232	117	58	99	80	14	21
	Female	132	185	146	163	204	77	68	49	8	21
	Unknown	0	18	26	22	27	7	5	1	2	1
	Total	307	435	415	417	348	142	172	130	24	43
	Sex Ratio	**1.33**	**1.25**	**1.66**	**1.42**	**0.57**	**0.75**	**1.46**	**1.63**	**1.75**	**1.0**
TOTAL HIV/AIDS		955	844	1,023	1,179	1,185	951	1,430	1,123	1002	1,219

Age Distribution

In 2009 there was a total of 10 HIV cases reported among children, aged 0-4 (Ministry of Health Statistics Unit, 2009). This represented 0.85 percent of the total HIV cases reported in 2009 and is significantly lower than the 25 cases reported in 2006 that represented 1.7 percent of the total HIV and AIDS cases for 2006 among the same age group (Ministry of Health Statistics Unit). These results are significant and provide evidence of the success of the aggressive implementation of the national PMTCT programme. The vast majority of the remaining HIV cases occurred in the active labour force and has potential implications for long-term productivity. The highest number of reported HIV cases occurred in the 30-34 age-group (17.34%) during 2009 as illustrated in Table 4. Although a lower number of HIV cases were reported among the elderly (age 50 and above), some 8.75 percent of HIV cases occurred within this group during 2009. This result provides justification for increased monitoring and interventions among this age group.

Table 4: Distribution of HIV Cases by Age Group 2009

Age group	Total	Distribution by age group
<1 yr	1	0.08
1yr to 4 yr	9	0.76
5yr to 14 yrs	14	1.19
15-19	71	6.03
20-24	136	11.56
25-29	161	13.69
30-34	204	17.34
35-39	198	16.83
40-44	143	12.15
45-49	105	8.92
50-54	48	4.08
55-59	30	2.55
60+	25	2.12
Unknown	31	2.63
Total	**1,176**	**100.0%**

Source: Ministry of Health Statistics Unit

In contrast to HIV cases the highest number of AIDS cases occurred in the 35-39 age-group during the same period (Table 5). Of note is that persons within the 20-24 age-group accounted for 16.27 percent of all reported AIDS cases for 2009. These results suggest a need for more targeted programmes aimed at reducing young people's risk to HIV.

Table 5: Distribution of AIDS Cases by Age Group 2009

Age group	Total	Distribution by age group
5yr to 14 yrs	1	2.32
15-19	1	2.32
20-24	7	16.27
25-29	4	9.3
30-34	5	11.62
35-39	8	18.6
40-44	6	13.95
45-49	6	13.95
50-54	3	6.97
55-59	1	2.32
Unknown	1	2.32
Total	**43**	**100.0%**

Source: Ministry of Health Statistics Unit

Spatial Distribution of HIV and AIDS

Data on HIV and AIDS cases for 2009 indicate that Region Four accounts for a disproportionate amount of reported HIV cases, 56.29 percent (662/1176), and AIDS cases, 51.16 percent (22/43) (Ministry of Health Statistics Unit). The region accounts for 41.3 percent of the total population of Guyana. In contrast, most of the other regions had a lower proportion of reported HIV cases relative to their population distribution during this period. These spatial patterns constitute an important criterion for allocating resources to control the epidemic. The spatial pattern of HIV and AIDS cases in 2009 relative to population distribution and gender is analysed in Table 6.

Table 6: HIV and AIDS Distribution by Region and Gender (2009)

Region	Population	HIV	AIDS

	Total	%	Male	Female	Unknown	Total	Regional %	Male	Female	Unknown	Total	Regional %
1	24,275	3.2	6	5	0	11	0.93%	1	0	0	1	2.32%
2	49,253	6.6	19	12	0	31	2.63%	0	0	0	0	0%
3	103,061	13.7	64	60	1	125	10.62%	2	2	0	4	9.30%
4	310,320	41.3	317	341	4	662	56.29%	12	9	1	22	51.16%
5	52,428	7.0	21	11	0	32	2.72%	1	4	0	5	11.62%
6	123,695	16.5	64	50	3	117	9.94%	2	2	0	4	9.30%
7	17,597	2.3	19	10	0	29	2.46%	0	0	0	0	0%
8	10,095	1.3	2	4	0	6	0.51%	0	0	0	0	0%
9	19,387	2.6	0	0	0	0	0%	0	0	0	0	0%
10	41,112	5.5	18	18	0	36	3.06%	2	3	0	5	4.65%
Unknown	-	-	70	56	1	127	10.79%	1	1	0	2	4.65%
Total	**751,223**	**100**	**600**	**567**	**9**	**1,176**	**100%**	**21**	**21**	**1**	**43**	**100%**

Source: Ministry of Health Statistics Unit

AIDS-Related Mortality

The proportion of all deaths attributable to AIDS has declined from 9.5 percent in 2002 to 4.7 percent in 2008 (Ministry of Health Statistics Unit). The actual number of AIDS-related deaths has also generally declined as illustrated in Table 7 below.

Table 7: Annual Number and Proportion of AIDS-Related Deaths

Year	% of AIDS Related Deaths	No. of AIDS Related Deaths
2002	9.5	475
2003	8.0	399
2004	7.1	356
2005	6.86	360
2006	5.9	298
2007	5.7	289
2008	4.7	237

***Source**: Ministry of Health Statistics Unit*

2005 and 2009 BSS Comparisons

Comparisons of selected indicators from 2005 and 2009 for the target populations allow analyses of two time periods. The indicators selected for comparison between BSS 2005 and BSS 2009 were chosen based on UNGASS standard indicators as well as the Guyana Ministry of Health National Monitoring and Evaluation Plan.

The BSS 2009 analysis suggests that the proportion of respondents having ever been tested for HIV showed the highest number of significant positive outcomes in four populations for which comparisons were possible (military, police, out-of-school youth and in-school youth).

Three populations (military, out-of-school youth and in-school youth) showed statistically significant increases in the proportion receiving results of their HIV tests.

There was a significant increase in reported condom use at last sex with a regular partner among the following groups: military, police, and out of school youth.

The proportion of respondents correctly identifying three methods of HIV prevention similarly showed mixed results; the military and the out-of-school youth stayed the same whereas the police and the in-school-youth had significantly decreased.

The mean age at first sex decreased significantly and the proportion of those having had sex before the age of 15 increased significantly for two out of four of the populations compared (military and in-school youth).

The military showed the most positive gains of any population (that is, significant changes in four indicators examined in the analysis), with significant positive changes in the proportions using a condom at last sex with a regular partner, using a condom at last sex with a non-regular partner, ever having been tested for HIV, and receiving the results of the HIV test.

2005 and 2009 BBSS Comparisons

Comparison of 2005 and 2009 BBSS conducted among sex workers revealed a significant reduction in HIV prevalence among this group. HIV prevalence was down 10.0 percent, from 26.6 percent in 2005 to 16.6 percent in 2009.

3. NATIONAL RESPONSE TO THE AIDS EPIDEMIC

2010 UNGASS provides optimism – a transformation of the hopelessness of 2001 to one where the world can be optimistic and we as human beings are prepared to confront HIV successfully. - Honourable Dr. Leslie Ramsammy, Minister of Health

3.1 National Commitment

Following the first diagnosed case of AIDS in Guyana in 1987, the Government of Guyana being cognisant of the devastating effects of the disease, responded quickly as did other countries, with a medical approach.

In 1989, the Government of Guyana established the National AIDS Programme (NAP) under the Ministry of Health (MoH), which resulted in the development of the Genito-Urinary Medicine (GUM) Clinic, the National Laboratory for Infectious Diseases (NLID) and the National Blood

Transfusion Service (NBTS). In 1992, the National AIDS Programme Secretariat (NAPS) was established and charged with the role of coordinating the national response to the AIDS epidemic. The National AIDS Committee (NAC) was also established in 1992 with responsibility for developing and promoting HIV and AIDS policy and advocacy issues, advising the Minister of Health and assessing the work of the National AIDS Programme Secretariat. The NAC also encourages the formulation of Regional AIDS Committees (RACs) and networking amongst NGO involved in the HIV response. The government's response is complemented by the activities of various civil society organisations, whose approach focused primarily on prevention (disseminating information, education and communication initiatives).

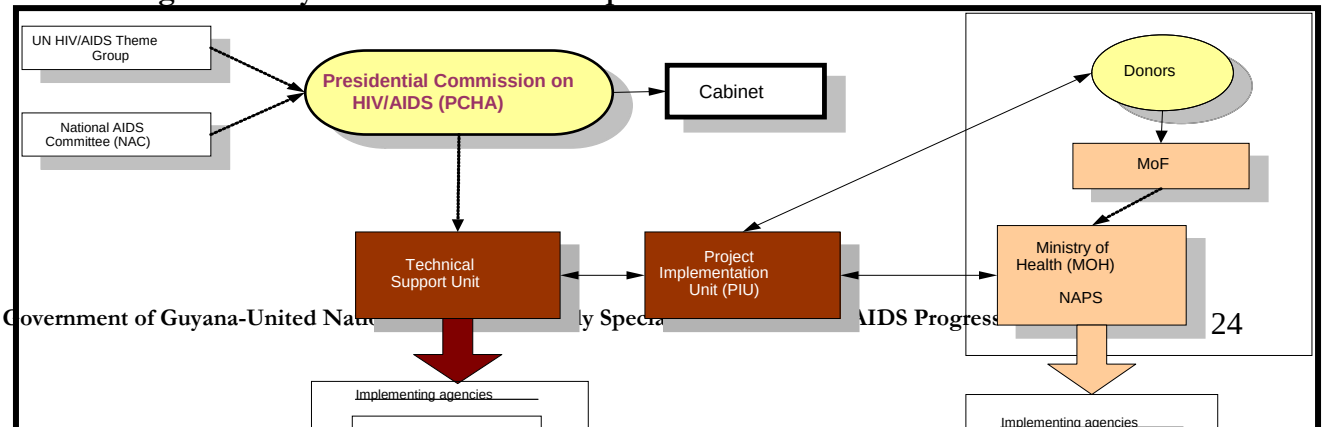
The management and coordination of the National AIDS Programme were strengthened over the last six years with the construction of a modern and spacious National AIDS Programme Secretariat building, recruitment of key technical and administrative staff and the delivery of key prevention, and care and support services. This period has also seen improvement in surveillance, health information systems, laboratory capacity, safe blood systems, supply chain and bio-safety.

Over the six years, the Government of Guyana, with substantial support from development partners, has built a strong political commitment in the leadership of the national response. The following are milestones in Guyana's commitment to the HIV response:

- Establishment of a National HIV and AIDS Policy;
- Development of a multi-sectoral response;
- Development of a multisectoral strategy for HIV and AIDS;
- Development of a Monitoring and Evaluation Plan;
- Development of an Education Sector School Health, Nutrition, and HIV and AIDS Policy;
- Development of line ministries work plans in support of the National Strategic Plan for HIV and AIDS;
- Development National Blood Policy;
- Development of a National HIV and AIDS Workplace Policy;
- Development and implementation of Workers Occupational Safety Policy and Guidelines;
- Passed legislation in Parliament empowering the Ministry of Health to establish an Institutional Review Board (IRB) "for all medical research involving human subjects".

Political commitment was further demonstrated by the establishment of the Presidential Commission on HIV and AIDS (PCHA) in 2005 under the aegis of the Office of the President to strengthen the implementation and coordination of the various components of the National Strategic Plan (NSP) across all sectors. The Commission is chaired by the President of Guyana and coordinates all HIV activities nationally. Figure 3 below illustrates the Guyana multi-sectoral response mechanism for HIV and AIDS.

Figure 3: Guyana multi-sectoral response mechanism for HIV and AIDS



Forty two (42) key informants representing government (16), civil society organisations (18), and donor agencies (8), drawn from Regions Two, Three, Four, Six, Seven and Ten, were interviewed for the National Composite Policy Index (NCPI) survey, compared to 24 key informants interviewed in 2007. The main objective of the NCPI is to evaluate and note Guyana's progress in relation to the National Strategic Planning process and to garner stakeholders' feedback on the extent to which progress has been made in achieving national commitments on HIV and AIDS. The questionnaire comprised six sections:

- Strategic Plan and Political Support
- Human Rights
- Prevention
- Care and Support Section
- Civil Society
- Monitoring and Evaluation

All key respondents of the National Composite Index (NCPI) survey agreed that the Government of Guyana has ensured full and active participation, and involvement of civil society in the development of the Guyana HIV and AIDS Strategy, 2007-2011, and has developed plans to strengthen its health systems, including infrastructure, human resources capacity, and logistical systems to deliver antiretrovirals. In contrast, only half of the respondents agreed that cross cutting issues such as poverty and gender empowerment and gender equality are addressed in the strategy. Half of the respondents expressed the belief that the populations with the greatest need for HIV interventions, as well as the specific needs of MSM and SWs were addressed in the strategy.

The analysis of key informant interviews suggests that HIV and AIDS are not comprehensively taken into account in national development plans. Whilst all respondents agreed that there is support for HIV integration in the National Development Strategy, the Common Country Assessment Plan, and the Poverty Reduction Strategy, only half of them agreed that there was support for HIV integration in the sector wide approach.

All respondents reported satisfaction with the public leadership demonstrated by the political directorate in rolling out the national response to HIV. Half of the respondents agreed that the National AIDS Programme Secretariat (NAPS) is the national mechanism that promotes interaction between government, people living with HIV, civil society and the private sector in implementing HIV and AIDS strategies/programmes.

A majority of respondents disagreed that Guyana has laws and regulations that protect PLHIV against discrimination, including both general non discrimination provisions and provisions that specifically mention HIV. Respondents stated that existing laws are primarily general non discrimination provisions. An example cited is the Prevention of Discrimination Act, Article 149 D, 149F, 149E and 154A of the Constitution of Guyana. Half of the respondents agreed that there are no non discrimination laws or regulations which specify protections for most-at-risk populations (MARPS) and other vulnerable sub populations. The majority reported that there are still laws that criminalised buggery and sex work.

The majority of respondents reported that the promotion of human rights is explicitly mentioned in the National HIV and AIDS policy as a cross cutting theme. Conversely a majority of respondents agreed that there is no mechanism to record, document and address cases of discrimination experienced by PLHIV, most-at-risk and other vulnerable sub populations.

The majority of respondents agreed that the government involved PLHIV, most-at-risk and other sub-populations in national HIV policy design and programme implementation. Examples cited included the development of the National HIV and AIDS Strategy, the 2009 Detailed HIV and AIDS Work Plan and Budget, and the Country Coordination Mechanism (CCM) for the Global Fund.
The majority of respondents agreed that Guyana has a policy of free services for HIV prevention, ARV treatment and care, and support. The majority reported that Guyana has a policy prohibiting HIV screening for general employment. A majority also reported that Guyana has a policy to ensure equal access for women and men to HIV prevention, treatment and care, and support services. In contrast a majority reported that this was not the same for most-at-risk populations.

Half of the respondents reported that Guyana has a policy to ensure that HIV research protocols involving human subjects are reviewed and approved by a national/ethical review committee. Respondents stated that Guyana has an Institutional Review Board (IRB) for all research involving human subjects which is not specific to HIV and AIDS.

The majority of respondents reported that there is an independent national institution for the promotion and protection of human rights, which considers HIV-related issues within its work. However, in contrast a majority reported that HIV and AIDS Focal Points within the line ministries do not monitor HIV-related human rights abuses and discriminations. Most respondents agreed that members of the judiciary had not been trained or sensitised during the last two years to HIV and human rights issues that may arise within the context of their work.

The majority of respondents reported that there is no legal aid specifically for HIV case work. Most respondents agreed that private sector law firms and university based centres did not provide free or reduced cost for legal services provided to PLHIV. More than half of the respondents reported that there were programmes to raise awareness and educate PLHIV concerning their rights.

The majority of respondents reported that there are programmes in place to reduce HIV-related stigma and discrimination through the media, school education, and use of celebrities. Honourable Dr. Leslie Ramsammy, Minister of Health was singled out for his untiring effort in this regard.

A majority of respondents reported that there were no performance indicators or benchmarks for compliance with human rights standards in the context of HIV.

3.2 Prevention

3.2.1 Behaviour Change Communication (BCC)

Prevention efforts have been significantly scaled-up and intensified with the full collaboration and commitment of all key stakeholders during the last six years. Links have been forged with other programmes and services delivered through workplace interventions, trade unions, non-governmental organisation, faith-based organisations, community groups, women's and youth organisations and people living with HIV. Behaviour Change Communication strategies have focused on the individual, couples, families, peer groups and networks, institutions and communities. The reduction of stigma and discrimination is a cross cutting theme among all BCC strategies employed by the prevention programme.

Guyana developed a Behavioural Change Communication (BCC) Strategy and subsequently developed and launched a markedly strengthened BCC campaign in 2005 aimed at:

1. Promoting abstinence and being faithful;
2. Promoting safer sexual practices;
3. Reducing stigma and discrimination;
4. Encouraging early HIV testing; and
5. Increasing community involvement in HIV and AIDS treatment and care.

In 2006 and 2007, new campaigns were developed to build upon the 2005 campaign. These campaigns were targeted at:

1. Controlling opportunistic infections;
2. Encouraging treatment adherence;
3. Empowering women to successfully negotiate condom use; and
4. Reaching high risk groups (FSWs, MSM and youths in and out of school).

During 2008 and 2009 emphasis was placed on strengthening and expanding the 2006 – 2007 campaign to include new strategies. The 2008 – 2009 campaign adopted the following strategies:

1. Promoting early diagnosis and treatment of opportunistic infections;
2. Promoting early HIV testing, specifically targeting MARPS;
3. Promoting adherence among PLHIV;
4. Promoting women's empowerment, particularly around condom negotiation;
5. Promoting early testing among the general population;
6. Promoting treatment and care;
7. Providing general HIV and AIDS information;

8. Promoting correct and consistent condom use among the general population.

The BCC programme comprised a variety of activities during 2008-2009:

- One hundred and sixty eight thousand two hundred and eighty (168,280) information, education and communication (IEC) materials that sought to promote the reduction of stigma and discrimination, early HIV testing, correct and consistent condom use, and treatment and care were distributed in 2008 (NAPS Progamme Report). An additional 241,981 IEC materials were distributed in 2009 to promote the reduction of stigma and discrimination, early HIV testing, correct and consistent condom use, treatment and care, women's empowerment, adherence to treatment, community involvement, safer sexual practices, and to highlight the human dimension of AIDS.

- Posters, television and radio advertisements, including a series of half-hour television documentaries on HIV were produced. Some 98,116 radio and television spots were aired in 2008 and 153,337 were aired in 2009. Two hundred and eight (208) 15-minute episodes of the twice-weekly BCC radio serial drama, Merundoi, were aired during 2008 and 2009. Merundoi was launched in October 2006 with accompanying community-based reinforcement activities. During 2008 and 2009 57,100 persons were reached in the ten administrative regions of Guyana with abstinence, faithfulness, correct and consistent condom use, positive parent and child communication, alcohol reduction and prevention, access to quality HIV and STIs services, reduction of stigma and discrimination, suicide prevention, and domestic violence information.

- A significant achievement for 2009 was the completion of the Guyana National Prevention, Principles, Standards, and Guidelines for HIV. This is a tool to help improve the quality of prevention efforts in Guyana through adherence to internationally accepted standards and practices. A Prevention Technical Working Group was also established during the reporting period.

- The National AIDS Programme collaborated with the Ministry of Culture, Youth and Sport in the Caribbean Festival of Creative Arts (Carifesta) X Village hosted in 2008. This event attracted thousands of youth and provided opportunity for the national programme to interact and gain greater insights into this vulnerable population. The NAPS booth was divided into five sections; Youth Movie Zone (movies on HIV, alcohol use, substance abuse and others); Colour Splash (painting of HIV messages on T-shirts, face painting, condom demonstration); Computer games (lets have sex and test your knowledge, game of the world); Positives Vibes (rapping, free style dancing, choreographed dancing, singing); and Real Talk TV (Live show hosted by young people for young persons who discussed issues related to teenage pregnancy, bullying in school, and peer pressure among others).

- Increased emphasis on promoting abstinence and faithfulness resulted in outreach work within all administrative regions, including distant interior regions such as Regions One, Seven, Eight, and Nine, that are not easily accessed. Community outreach efforts were also active within previously unserved hinterland communities in Regions One and Nine. In order to better reflect local community and gender sensitivities, the HIV education curricula were modified and a format which allowed for candid discussions of issues among both males and females was used.

- At the regional level sales promoters in Regions Two, Three, Four, Five, Six, Seven, and Ten promoted condom use through interpersonal communication. More than 1000 condom service outlets are currently in existence. This network of outlets served as the hub of "roadshow" outreach activities spearheaded by the MOH-NAPS for the "Put It On" national prevention campaign aimed to promote and increase correct and consistent condom use. Preliminary data indicates that the campaign has increased short-term demand for condoms in many of these locations.

- This period saw an increase in the availability of both male and female condoms. A total of 2,329,858 male condoms were distributed in 2008 and 3,300,000 in 2009 through a focused effort on increasing access to condoms for most-at-risk populations with the strategic placement of condom vending machines at high traffic locations, for example, bars and clubs. Commercial sale of condoms is critical in ensuring MARPs and other groups especially in mining locations have access to condoms. The Ministry of Health is currently advocating for the removal of Value Added Tax (VAT) on branded condoms.

- In 2008, 12 agencies including Government ministries, and NGOs received 48,400 second generation female condoms from UNFPA for distribution. These agencies made commitments to conduct activities aimed at female condom education, demonstration, and promotion among their target groups. The target groups included people living with HIV, family planning clients, sex workers, STI clients, young people, and a mix of the foregoing. An analysis of the feedback forms found that respondents had high knowledge (86.0%) in relation to the extent in which they accurately identified the benefits of using condoms, and 47.0 percent of those who reported high knowledge about the female condom actually used it. Some 65.0 percent of respondents who indicated that they ever used the female condom also reported an intention to sustain its use.

- The training of youth and community opinion leaders as peer educators continued in 2008 and 2009. Training was also extended to MSM, FSWs, sports men and women, media operatives, and faith leaders in 2009. A total of 234 peer educators, 83 community leaders and 45 FSWs were trained in 2009. A one-hour dramatic production addressing the issues of peer pressure and its consequences was staged. National Peer Education standards will be developed in 2010.

- For the first time a conference was convened in 2008 for 100 Rastafarians to address HIV and other health related issues.

- A National Conference on "Faith and HIV," was held at the end of 2008 aimed at establishing a national coalition of faith leaders of all denominations in Guyana to address HIV-related stigma and discrimination. Some 120 faith leaders from the Hindu, Christian, Islamic, Rastafarian and Baha'i faiths agreed to move from commitment and rhetoric to action, by endorsing the 'Guyana Faith and HIV Declaration.' The outcome of this conference was the establishment of the Guyana Faith-based Coalition on HIV and AIDS in December 2008.

- A national hotline programme was initiated during February 2005 to fulfil information requests and provide psychosocial support for the public. A total of 1,637 calls were received in 2008, of which 59.8 percent were placed by females and 38.9 percent from males. The majority of calls

(88.6%) originated in Georgetown. Hotline facilitators were trained in HIV/AIDS/STI information, Domestic Violence, and Home and palliative care.

The majority of NCPI respondents agreed that Guyana has a policy or strategy that promotes information, education and communication (IEC) on HIV to the general population, compared to 2007 when all agreed. A majority also agreed that Guyana has a policy or strategy promoting HIV related reproductive and health education for young people particularly in secondary schools and that there was an education strategy for out-of-school youth.

The perception regarding national coverage for information education and communication (IEC) services varied significantly among respondents. All respondents were in agreement that specific messages were developed for prevention components such as condom use, HIV testing and counselling. In contrast respondents reported that not enough is being done with regards to developing appropriate messages to address stigma and discrimination, school based education, HIV prevention for out-of-school youth, and prevention for positives among PLHIV and sexual minority communities.

3.2.2 Prevention of Mother-to-Child-Transmission (PMTCT)

The prevention of mother-to-child-transmission programme is an integral part of the overall strategy to prevent and control the spread of HIV. With a consistently generalised epidemic among pregnant women in Guyana it was clear that a strong national programme had to be developed to prevent HIV-infected women from infecting their newborn babies. Beginning in November 2001, a pilot phase of the programme was initiated at 11 sites in two regions. By the end of 2005, the programme had expanded to 57 sites in eight regions. The PMTCT Programme was subsequently integrated into the Maternal and Child Health Unit of the Ministry of Health.

During 2008 and 2009, the focus continued to be on expanding and strengthening the national PMTCT programme. Some of the achievements in PMTCT include:

- PMTCT services were increased from 135 facilities in 2008 to 157 in 2009 compared to 110 facilities in 2007 (PMTCT Programme Reports). These services are available in all regions of the country and include four private hospitals that have initiated HIV testing of pregnant women.

- In 2006, an ANC survey conducted at 137 ANCs revealed an HIV prevalence of 1.55 percent among pregnant mothers. Routine programme data revealed an HIV prevalence of 1.3 percent among pregnant women in 2007, 1.15 percent in 2008 and 1.11 in 2009. These proxy data may represent a possible decrease in HIV prevalence among this population.

- Uptake of VCT services among pregnant women was 89.8 percent in 2009, compared to 95.5 percent in 2008, 97.6 percent in 2007 and 93.8 percent in 2005 (see explanation regarding 2009 update data at the bottom of table 8 below).

- In 2008, 80.45 percent of HIV positive pregnant women received ART to prevent mother-to-child-transmission and 82.5 percent received ART in 2009, compared to 66.92 percent in 2006 and 31.66 percent in 2005 (PMTCT programme data).

- Coverage of live births receiving the necessary ARVs to reduce mother-to-child-transmission has significantly improved to 98.0 percent in 2008, compared to 69.0 percent of babies who received ARVs at the inception of the programme in 2001 (PMTCT programme data).

- Babies born to HIV-positive mothers were provided with early HIV diagnosis through DNA PCR testing conducted in South Africa with support from The Clinton Foundation. In 2008, 3.8 percent (9/234) of babies born to HIV positive mothers were infected with HIV and 6.1 percent (8/130) were infected in 2009 when compared to 6.0 percent (7/116) in 2007 (PMTCT programme data). It should be noted that in 2009, 228 samples were drawn however results were only received for 130 samples. The remaining 98 samples were either rejected or results were not received. Effective January 2010 DNA PCR testing will be conducted at the National Public Health Reference Laboratory in Guyana.

- Expansion of the PMTCT programme was facilitated through the training of 217 health care workers in 2008 to offer PMTCT services including counselling and testing of pregnant mothers, referrals for treatment and preparation of dried blood spots (DBS) for Polymerase Chain Reaction (PCR) testing of HIV-exposed infants. A total of 132 health care workers were trained in 2009 to offer PMTCT services and 32 health care workers were trained in HIV rapid testing. A rapid assessment of the national PMTCT programme was conducted in 2009 to identify programme weaknesses and strengths to inform technical assistance. Key recommendations focused on treatment regimens, partner testing, and receipt of treatment and prophylaxis.

- Priorities for the PMTCT programme in 2010 will be to conduct a formative data quality assessment for ANC surveillance purposes and improve male partner involvement through the antenatal clinics.

Major trends in the PMTCT programme are illustrated in Table 8 below.

Table 8: Major Trends in the PMTCT Programme (2003 – 2009)

CATEGORY	2003	2004	2005	2006	2007	2008	2009
No. of Sites with PMTCT	23	37	57	92	110	135	157
Total Births	17,209	16,676	15,123	14,990	15.114	15,076	NA
ANC mothers tested for HIV	3,279	4,741	9,675	13,041	12,004	12,587	11,776
Uptake of VCT among pregnant women (%)	84.9	86.3	93.8	97.8	97.6	95.5	89.8%*
No. of HIV positive mothers	103	118	212	215	176	189	130
Prevalence of HIV (%)	**3.1**	**2.5**	**2.2**	**1.6**	**1.3**	**1.12**	**1.11**
Exposed live infants who received ARVs	71	99	148	174	210	222	206**

Adapted from MCH 2008 Annual Report, Birth data from Statistical Unit and PMTCT Preliminary 2009 Annual Report (Min. of Health)

**** Note:*** *In 2008, uptake was calculated using the number of pregnant mothers who accepted HIV testing as the numerator and the number of pregnant mothers who were pre-test counselled as the denominator. In 2009, The PMTCT programme has calculated uptake using the number of first time attendees who accepted an HIV test for the first time as the numerator and the number of new admissions at the clinic as the denominator. The PMTCT programme has changed the data forms in 2010. Effective 2010, the uptake will be calculated as the number of first time attendees who received an HIV test as the numerator and the number of new admissions at the clinic as the denominator. (The number of first time visits who had their blood drawn for HIV is not available on the 2009 data forms, and will be added on the 2010 data forms. Because more women accept an HIV test than those who have their blood drawn for an HIV test, the 2009 uptake rate may be a slight overestimate of the actual uptake rate).*

***** Note*** *Between 2007 and 2009 the number of exposed live infants who received ARVs exceeded the number of HIV positive mothers due to*

some women having multiple births.

3.2.3 Voluntary Counselling and Testing

The VCT programme has expanded to increase access and geographic coverage. The period under review saw an increased from 62 sites in 2008 to 70 sites in 2009 compared to 44 VCT sites in 2007 and 27 sites in 2005. Nine of the ten administrative regions now have fixed sites while Region One is served by one of the three mobile teams that deliver services to hinterland locations thereby ensuring national coverage (NAPS Programme Report). National VCT Guidelines prepared during the period 2006-2007 ensure that all VCT sites adhere to these guidelines, which address issues such as the age of consent for access to testing. As the programme scales-up, increasing attention is being given to quality control nationally.

- VCT services are provided by a range of Community Services Organisations (CSOs), private facilities, and public health care facilities. These CSOs were supported in developing strategies to increase access by members of most-at-risk populations and underserved populations including miners and loggers, MSM and FSWs. Mobile populations of miners, loggers and FSWs were targeted in hard to reach interior regions of Guyana through the outreach efforts of non-governmental organisations. A quality assurance model which will allow for the identification and improvement of quality issues related to the implementation of counselling and testing services was also developed.

- Training of health care providers to offer HIV counselling and testing services continued over the last two years. One hundred and twenty-five (125) persons were trained as counsellor testers in 2008 and 137 were trained in 2009 from the 10 administrative regions. Some 319 persons received refresher's training; 92 in 2008 and 227 in 2009. Thirty (30) nurses/health care providers from Adolescent Health and Wellness Unit, 32 staff from the Berbice Regional Health Authority, 30 staff from the TB programme, and 45 persons from the 10 administrative regions were trained as HIV and AIDS counsellors in 2009. Additionally, mentoring and coaching activities were conducted during training sessions for newly trained counsellor trainers attached to the Ministry of Health.

- Several workplaces have introduced counselling and testing as a regular activity conducted twice a year on work premises. Workplaces are also moving towards incorporating counselling and testing services into overall health and wellness programmes offered to their workers.

- The demand for HIV testing which was stimulated by a strong social marketing campaign that commenced during the period 2006-2007, was significantly increased during the period under review. A total 63,876 persons were counselled and tested in 2008, and 85,554 persons in 2009, compared to 48,578 persons counselled and tested in 2007, 25,063 persons in 2006 and 16,065 persons in 2005 (NAPS Programme Reports). This rapid increase in the number of persons accepting VCT is clear evidence that the programme is generating the desired results.

- The National Day of Testing initiated in 2007 was expanded to a National Week of testing in 2008 in response to the great demand for testing during this period. Compared to the National Day of Testing conducted in 2007 in which 1,198 persons were counselled and tested with an HIV prevalence of 1.01 percent, the November 2009 Week of Testing received an overwhelming response which resulted in 28,360 persons being counselled and tested and an HIV prevalence of 0.5 percent among them. These national campaigns were each preceded by massive promotions. It is clear that the national testing events are contributing to raising awareness of the importance of knowing one's status and increasing men's uptake of VCT services.

- A pilot intervention was initiated in 2007 to enhance the linkage between VCT and treatment programmes. This intervention used case navigators to follow up on persons who were referred from the VCT sites to the treatment and care sites to ensure that they followed through. This intervention continued during the period under review.

3.2.4 Blood Safety

Generally, high standards are followed for laboratory control and blood screening at the National Blood Transfusion Service (NBTS), which includes proficiencies in the National External Quality Assessment Scheme for blood transfusion laboratory practice. The Caribbean Regional Standards for Blood Banks was adopted and a National Blood Policy was established by Guyana in 2006. The national blood supply is routinely screened for Hepatitis B and C, Syphilis, HTLV, Malaria, Micro Filaria, HBV, HBC, and Chagas Disease.

There have been significant achievements in blood safety over the last two years and these include:

- The access to a safe blood supply was expanded through the establishment of a hospital blood bank at Guyana's largest hospital, Georgetown Public Hospital in December 2008. Efforts to ensure the appropriate clinical use of blood and blood products saw the development and launch of guidelines on clinical use of blood in April 2009 and the establishment of Hospital Transfusion Committees in five administrative regions serving a significant proportion of the population (Regions Two, Three, Four, Six and Ten).

- The capacity to screen for transmissible and transfusable infections was increased with the introduction of Chagas Disease testing capabilities to the National Blood Bank in December 2008. Staff capacity to detect the disease was enhanced through the training of National Blood Bank staff in clinical recognition and laboratory screening; standard operating procedures were also developed for Chagas testing.

- Capacity building of staff has been conducted in an effort to achieve the national goal of 100.0 percent voluntary blood donation by 2010. Quality control systems have also been enhanced. To this end, more than 180 persons were trained in recruitment and retention of voluntary blood donors, clinical use of blood, Chagas disease testing and quality systems.

- This period also saw intense training in quality assurance and greater focus on blood donor recruitment which resulted in a substantial increased in voluntary blood donation, from 55.0 percent (4021/7360) in 2008 to 68.0 percent (5236/7700) in 2009, compared to 47.0 percent in 2007 and 22.0 percent in 2005.

- The National Blood Transfusion Service reported 100.0 percent screening of donated blood in a quality assured manner in 2008 and 2009. Some 7,360 units were screened in 2008 and 7,700 units in 2009.

3.2.5 Safe Injections

For some time now, Guyana has been promoting the use of safe injections, with special emphasis on using a new syringe and needle for each new patient, as well as disposing used syringes and needles in a safety disposal box. In 2004, a concerted intervention was initiated with the goal of reducing the number of unnecessary and unsafe injections. The strategy emphasises preventing the transmission of blood borne diseases through contaminated sharps, since needle stick injuries are the primary cause of blood borne transmission among health care workers.

Complementary interventions include improving the national system for the management and disposal of medical waste, sustainable procurement of required safety supplies, raising national awareness of the risks and preventative measures for medical transmissions of blood borne diseases, and enhancing worker safety with pre-exposure vaccinations and Post Exposure Prophylaxis (PEP). At the clinical level an implementation plan was developed to address referrals for Post Exposure Prophylaxis (PEP) by local police departments, and administration of PEP and reporting by hospital emergency departments.

The following were some of the main achievements during the reporting period:

- A total of 276 facilities (76.0%) of all eligible hospitals, health centres and health posts have been reached and 744 health care workers have been trained in safe injection practices. Three hinterland regions (Regions One, Eight and Nine) require additional input to reach 60.0 percent completion on the key indicators during 2010. The year 2010 will be used to strengthen practices, supervision and monitoring and waste management in all regions.
- Nationally, the Worker Safety Policy was used by the Ministry of Health to build commitment to compliance at the regional and facility level. At the facility level, efforts to ensure the worker safety policy is followed have been monitored. This included vaccination uptake, needle stick documentation and analysis and provision of post exposure prophylaxis (PEP), consumption data recording and timely re-ordering for bin liners, injection supplies and personal protective equipment (PPE).

- Thirty-one (31) additional health facilities developed facility waste management plans to guide waste disposal which is an important aspect of ensuring safe disposal of medical waste. A pilot certification programme was implemented at five health facilities to address quality of injection safety practices. This approach is intended to institutionalise safe injection practices, ensure ownership of efforts and promote community confidence.

- Capacity building efforts focused on the introduction of refresher training, increasing the number of community health workers (CHW) and enhancing outreach staff support to incorporate injection safety messages into their communication and counselling activities, and training pharmacy staff in medication counselling.

- All regions have benefited from a package of support and great strides have been made toward developing supportive systems to facilitate sustainability. However, additional work is

needed to complete the hinterland regions while other regions are being further strengthened by certification.

3.2.6 Workplace Programme

Workplace programmes saw increased collaboration with unions and labour organisations, corporations and the National AIDS Programme Secretariat. Sensitisation efforts included activities focused on reducing stigma and discrimination within the workplace, HIV testing, faithfulness and partner reduction.

- A National Workplace Policy on HIV and AIDS was launched in March 2009. The Ministry of Labour and the labour unions are actively involved in advocacy to increase uptake of workplace policies. A total of 26 partner enterprises were provided with technical assistance and training to develop and/or revise their workplace policies and programmes and build the capacity of enterprise focal persons to address issues of stigma and discrimination, disclosure, medical confidentiality, conflict resolution, relationship and health issues. Through the ILO Workplace Programme 31 enterprises have developed workplace policies at the end of 2009 compared to 13 in 2008.

- Programmes that addressed delivery of VCT, condom distribution and care and support services, and the reduction of stigma and discrimination were implemented in a range of workplace settings including commercial banks, mining and logging camps, garment factories, shipping companies, beverage and food manufacturers, hardware stores and accounting firms, thereby reaching a broad cross section of the population. Eighteen (18) enterprises were established as condom providers during the period under review.
- The Private Sector Partnership Programme which initially comprised a small group of companies in 2005 was transformed into a strong coalition of private sector organisations that are actively engaged in helping the GoG reach its goals of preventing and reducing HIV in Guyana. This 43-member body, Guyana Business Coalition on HIV/AIDS, was officially launched in May 2008. Seventeen (17) Coalition members have signed workplace polices on HIV and AIDS at the end of 2009. The remaining members are in the process of drafting their policies.

3.2.7 Targeted Sub-populations

MOH-NAPS developed engagements with various groups working with, and linked to, FSWs and MSM to facilitate services such as education and awareness and VCT within the groups. Surveillance and biological surveys have allowed the national programme to track changes in infection rates and behavior patterns in key groups and subpopulations and to better assess the status of the epidemic. Similar programme efforts have targeted prisoners, miners, indigenous people and adolescents and young adults.

- Activities for most-at-risk populations targeting particularly FSWs and MSM resulted in outreach to members of these groups and their partners in brothels, night spots and hangout bars. Peer education training was used as a strategy to reach members of these groups. These groups have received training in peer education and counselling to enable them to discuss safer sex strategies with their peers in Regions Four, Six and Seven. A total of 100 sex workers and MSM were targeted in Region Seven in 2009 with risk reduction information and condoms. Education and awareness activities were conducted on the impact of drug and

alcohol abuse on HIV transmission, STIs, condom use and HIV testing among a number of other related subjects. These events facilitated wider condom distribution, demonstrations of correct condom use, initiation of referrals for testing and/or treatment for STIs. Referrals were made to NGOs working with FSWs and MSM to access HIV counselling and testing services as well as screening for STIs.

- Additional training of health care workers commenced during 2009 with the objective of increasing their capacity to provide quality services to MSM, FSWs and other minority groups at a facility level. Issues addressed included gender and sexuality, gender based violence and stigma and discrimination as barriers to service uptake. Stigma and discrimination, particularly self stigma remains a challenge among these groups however the government is actively working at developing anti-stigma training programmes to engage health workers in the provision of optimal care for these groups. A manual was developed and field tested by the Adolescent Health and Wellness Unit to train health care workers to provide optimal health care to lesbians, gays, bisexuals and transgendered (LGBT) persons. Training of health care workers using this manual will commence in 2010.

- Community Health Promoters continued sensitisation activities among bars and brothel owners on the benefits of condom use and the value of being a part of the distribution network. A total of 14 brothel and bar owners in Regions Five and Six were sensitised. Of these 10 have been stocking and selling branded condoms to FSWs, clients of FSWs and MSM. Additionally, three NGOs implementing the MARPs programme will commence the sale of branded condoms and lubricants to MARPs and commercial sex establishments in the communities they service.

Health and Family Life Education (HFLE)

Emphasis is being placed on in-school youth through the revitalisation of the Health and Family Life Education (HFLE) programme. The primary avenue of delivery of education about school health, nutrition and HIV prevention in Guyana is the HFLE curriculum. HFLE was developed in response to the desire of Caribbean governments to equip the region's youth to cope better with the situations that arise from changing societal and family values and traditions, the perception of disintegrating community life and the development of new health problems. The initiative is a CARICOM multi-agency activity that seeks to empower young people with skills for healthy living and focuses on the development of the whole person (emotional, social, mental, physical and spiritual).

- Until recently, use of HFLE in Guyana has been slow to take off. During 2006 and 2007, however, there was rapid progress with the in-service training of approximately 2,000 teachers from 180 schools distributed across all regions of the country. Training in HFLE was concluded and an evaluation of the impact of the training was completed. The evaluation was conducted in 2008 to determine the extent to which the curriculum was used. The evaluation identified constraints to implementation and recommendations for overcoming them. The evaluation found that 61.6 percent (45/73) of schools surveyed reported delivering HFLE to all grades during the last academic year. It also revealed that although teachers were delivering the curriculum, they were doing so as an academic rather than a skills-based subject and that many teachers were not delivering the curriculum consistently. One of the recommendations made was that the current HFLE teacher training curriculum be revised to provide the opportunity for teachers to develop interactive teaching

methodologies, and to develop the requisite skills to infuse and deliver both HFLE content and skills.

- The HFLE programme is complemented by the National Youth Health Organisation (NYHO) - the national network of health clubs within secondary school. The NYHO was developed by the Adolescent and Young Adult Health and Wellness Unit, Ministry of Health, in collaboration with partner ministries and other stakeholders. There are now over 72 health clubs in the network that conduct peer education weekly in schools. One of the goals of this programme is to develop advocacy strategies on adolescent health and well being including reproductive health and life skills education, and to empower students to be agents of change. Peers education is the strategy being used to reach school-age adolescents.
- Non-governmental organisations implemented abstinence focused activities within school settings targeting youth aged 13 - 14 years. These efforts reached 47 schools across the country in eight of the 10 Administrative regions, which included the most heavily populated Regions Two, Three, Four, Six and Ten.
- Reviews of HIV prevention programmes in schools have shown that the current In-School Youth programme needs to be targeted to younger audiences. The Ministry of Health and NGOs working in prevention are partnering with the Ministry of Education (MOE) to examine how the current HFLE programme can be formalised within the current MOE curriculum. Engaging parents in school-based programmes to encourage abstinence among youth has proved challenging. Parental participation in sensitisation sessions specifically for them is low, particularly where there are no vibrant Parent-Teacher Associations. Alternative ways to engage parents will be examined to strengthen this component of the programme since their participation has been very valuable.

Adolescent and Young Adults Health Issues

The government has given priority to reducing transmission of HIV, especially among adolescents. An adolescent health policy and an action plan that integrate HIV and AIDS prevention were approved during the period under review. Considerable progress has been made with regard to peer education and youth's access to counselling and testing services provided by the Ministry of Health, NGOs, and FBOs. Youth peer education has been utilised to reach sub categories of youth. Youth were targeted with information regarding sexual and reproductive health, life skills and general health and wellness. Information technology was also utilised as a strategy for reaching these youth with HIV prevention information and services.

- A total of 234 peer educators were trained through the NAPS Community Mobilisation Programme in 2008 while 145 were trained in 2009 in collaboration with the Department of Youth within the Ministry of Culture Youth and Sport, the Guyana Scouts Association, Grassroots Organisations, and football clubs. The Adolescent and Young Adult Health and Wellness Unit, Ministry of Health also trained 114 peer educators in 2009. Two batches of work study students that were attached to the NAPS (13 in 2008 and 16 in 2009) complemented the work of the peer educators.
- The Ministry of Health Youth Friendly Services Unit trained 73 peer educators in Regions Four, Six and Ten to support the delivery of youth friendly services, including peer education and counselling and encourage uptake of these services.

- Peer educators supported the outreach efforts, including the mobilisation of members of the public to access VCT services during the National Week of Testing which was held in November 2009. Outreach to out-of-school youth aged 15-24 years resulted in community based organisations and youth focused bodies being targeted. Youth groups from approximately 22 faith-based organisations and other organised youth groups and sport groups were also targeted. General outreach within the community was conducted to ensure that youth not attached to organised groups were also reached with these messages. Particular attention was given to communities with high numbers of most-at-risk youth.

Military and Para-military

Guyana's uniformed services are becoming increasingly involved in the efforts to stop the spread of HIV both as "frontline soldiers' in the prevention efforts and as beneficiaries of targeted interventions. Emphasis is being placed on encouraging correct and consistent condom use and 'know your status' through increased access to VCT services offered at residential facilities for both officers of the Guyana Police Force and Guyana Defence Force.

The BBSS 2009 found that the military showed the most positive gains of any population (that is, significant changes in four indicators examined in the analysis), with significant positive changes in the proportions using a condom at last sex with a regular partner, using a condom at last sex with a non-regular partner, ever having been tested for HIV, and receiving the results of the HIV test.

Half of the NCPI respondents interviewed in relation to the uniform services reported that they are aware and are supportive of the national efforts to reach these groups, compared to all respondents who said that they were in 2007. Whilst half of these respondents acknowledged that the uniformed services are becoming increasingly involved in the efforts to halt the spread of HIV, particularly in the delivery of VCT services, all of the respondents reported that there is no strategy for targeting these groups with HIV-related activities.

Prevention for HIV Positive People

Efforts have been directed at reinforcing "prevention for HIV positive people" aimed at helping PLHIV prevent secondary infection and further transmission of HIV among sero-discordant couples. Attention will be focused on integrating targeted prevention interventions for PLHIV into care and support programmes during the 2010. Support groups will soon be established for HIV positive sex workers and MSM to fill the gap in such service for these two populations.

Prevention of Violence against Women

A Domestic Violence Act was passed in 1996 to afford protection in cases involving domestic violence by the granting of a protection order, to provide the police with powers to arrest a perpetrator of domestic violence and handle matters connected therewith or incidental thereof. The Act allows for occupation and tenancy orders for custody and maintenance. The Government worked with civil society to create awareness of the Act, launched a National Policy on Domestic Violence and created a Domestic Violence Policy Unit to enforce the Policy. Legal Aid services, equipped with lawyers, have been expanded from Georgetown, the capital city, to Regions Two, Five, Six, and Ten to ensure individuals' access to legal services at a minimal cost or no cost. There is a private shelter where abused women seek refuge.

Violence against women was widespread and crossed racial and economic lines, according to the 2009 US State Department report on Human Rights in Guyana. Regular perusal of high levels of sexual violence reported in the daily press demonstrates that girls between 12-16 years were shown to be the most vulnerable age group (Guyana Human Rights Association). Two-thirds of sexual violence crimes occurred in the home of the victim or perpetrator and fathers, step-fathers and father figures are responsible for 67.0 of family-related sexual crimes (Guyana Human Rights Association).

In response to the increase in sexual violence, a series of national consultations were conducted to inform the drafting of a Sexual Offences Bill 2009 which was tabled in Parliament in June 2009 and sent to a Select Committee of Parliament for deliberations. The Sexual Offences Bill 2009 seeks to remove archaic laws. An important innovation of the Bill is shifting the burden of proof away from the victim onto the accused by a new definition of rape. The Bill also includes measures to address grooming of young girls by male predators by providing the police with an instrument to counter the growing number of solicitations, abductions and seduction of young girls.

The 2009 BBSS revealed the need to intensify interventions among most-at-risk populations, particularly among in and out-of-school youth, MSM and FSWs and the police. Behaviour change communication strategies would have to be targeted at youth, particularly in-school youth to halt the rise in the number of youth who are reporting sexual initiation before age 15 and reduce their misconceptions regarding HIV transmission. Additionally, a concerted effort would be required to reach miners, migrant workers and indigenous populations with prevention information and intervention strategies that will result in the desired behaviour changes among these groups.

The abovementioned prevention efforts provide evidence of Guyana's commitment to halting the spread of HIV. However these efforts could be enhanced by an even better understanding of the determinants of HIV-related behaviours. Such an understanding will help both to identify vulnerable groups within the population and to devise appropriately targeted interventions to improve HIV knowledge and reduce risk behaviours.

3.3 Treatment

The Government of Guyana initiated a universal treatment and care programme in 2001 at one treatment facility in Georgetown using locally manufactured anti-retrovirals (ARVs). In 2005, the Government of Guyana provided antiretroviral (ARV) treatment to 942 persons through eight treatment facilities in Regions Two, Three, Four, Six and Seven. These services were expanded to 14 sites in 2007 and 16 in 2008, including the National Care and Treatment Centre (NCTC) established in 2008. The prison population is served through a satellite clinic operated from the National Care and Treatment Centre.

- At the end of 2009 there were 2,832 persons actively receiving antiretroviral therapy, compared to 2,473 persons in 2008 and 1,965 in 2007 (NAPS Programme Report). Of the persons receiving treatment in 2009, 178 were children, compared to 163 in 2008. Females accounted for 55.6 percent of all persons on treatment in 2009. At the end of 2006, persons on second line treatment accounted for 3.6 percent of all persons on treatment (NAPS Programme Report). This remained at the same level (3.5%) in 2007, and doubled to 6.8 percent in 2008. The average survival (persons on treatment) among 12 cohorts (994

persons) after 12 months was 72.18 percent in 2008. Some sites reported higher survival than others.

- There were 1,223 persons in care (non-ART) at the end of 2009, of which 102 were children. This compares to 103 children in 2008. Of the persons in care 441 were males and 680 were females. A total of 4,055 persons were actively enrolled in the HIV care and treatment programme at the end of 2009.

- The National Patient Monitoring System (PMS) was implemented at all care and treatment sites thereby supporting a higher quality of patient care. The PMS provides essential information for individual case management, provides key information for management of the health facility, and make available information for operating and improving the national HIV programme. Clinical forms and registers used by the National Patient Monitoring System have been revised, printed and distributed to the sites.

- An ADT-Anti-retroviral Dispensing Tool was installed at 13 of the 16 treatment sites. This tool is a Microsoft Access based computer software package used for tracking and monitoring drug consumption, identifying defaulters, collecting data for quantification and ordering drugs.

- The HEALTHQUAL-Guyana programme began in 2008. The programme is aimed at improving the quality of care at the Infectious Disease Ward at Georgetown Public Hospital, HIV care for adults and children at all treatment sites, and the well child healthcare programme, including HIV care in Guyana. This goal will be achieved by building capacity for a better quality of management. The programme is led by the NAPS, and guided by a steering committee of local and international partners. The first round of data from 20 pilot sites is being aggregated and will be reported during the first quarter of 2010. This programme will be examined in greater detail in the Best Practices section of this report.

- The National HIV Treatment Guidelines for the Management of HIV-Exposed infants, and Infected Adults and Children have undergone a second revision in 2009. An HIV Drug Resistance Protocol is in its final stages of development. A drug resistance study is anticipated to commence during the second quarter of 2010.

- The Supply Chain Management project developed and operationalised a Drug Registration Policy and conducted training on different aspects of adverse drug reporting, drug inspection and registration with the Food and Drugs Department (FDD) during the period under review. A 24-month national forecast for ARVs and Rapid Test Kits and an annual supply plan were also developed for the national programme in 2009.

- The diagnostic capacity of the treatment and care programme has been significantly enhance with the establishment of a National Public Health Reference Laboratory (NPHRL) in 2008. The NHRL has seven departments; Serology, Hematology, Molecular Biology, TB, Microbiology, Surveillance and Quality Assurance. The NPHRL provides CD4 testing for the national treatment programme and from January 2010 the country will have the capacity to provide early infant diagnosis and viral load monitoring for the national programme. CD4 testing equipment was installed at two regional hospitals (New Amsterdam, Region Six, and Linden, Region 10) and training of laboratory technicians was conducted. The capacity of

these two regional laboratories to perform CD4 testing demonstrates decentralisation of CD4 testing capability.

- Both public and private sector laboratories have been strengthened through technical support and training. The capacity of personnel within private sector hospital laboratories has been built through training and installation of high quality laboratory equipment for manual testing to increase testing accuracy for hematology, CD4 testing and parasitology. Laboratories were renovated and document control and internal quality assurance protocols and planning were strengthened. The Guyana Defence Force Laboratory now has the capability to perform Phlebotomy, Hematology, Biochemistry and Microbiology testing.

- United Nations Volunteer (UNV) physicians trained in HIV and STI management continued to support the expanded treatment programme through their placement at treatment sites across the country. Three physicians who graduated from a 9-12 month formal clinical mentoring training programme are engaged in HIV care and treatment services at treatment facilities. A total of 480 health care workers including physicians, nurses, medex, pharmacists and social workers were trained in various aspects of HIV treatment, care and support.

- Referrals between TB treatment sites and ARV treatment sites were strengthened during 2009. A total of 142 co-infected clients received treatment for TB disease in 2009 (Chest Clinic Programme Report). This period also saw tuberculin skin testing being integrated into the package of services provided at the ART sites through training of nurses, counsellor-testers and DOTS workers in the placement and reading of Mantoux tests.

- Access by HIV positive women to cervical cancer screening and treatment services was facilitated in 2009. Since services began in January 2009, 2,967 women have been screened. Of these, 302 (10.1%) were HIV positive women. Technical support to the National Cervical Cancer programme resulted in the development and approval of the Guyana National Policy on Cervical Cancer Prevention and training of health care providers to conduct screening.

- Technical capacity was strengthened to appropriately diagnose and manage persons with STIs in 2009. A total of 6,021 sexually transmitted infections (STIs) were appropriately diagnosed in 2009 (Ministry of Health Statistics Unit). Genital discharge syndrome accounted for the majority (92.5%) of cases diagnosed, while genital ulcer disease accounted for 6.2 percent, syphilis 0.28 percent and herpes simplex virus 0.18 percent.

- An STI training curriculum consisting of 12 modules was developed in 2008 and piloted in one region in 2009. This training curriculum was subsequently rolled out to several facilities in the regions. A total of 145 health care workers from Regions One, Two, Three, Four, Five, Six, Seven, Eight and Ten were trained on syndromic management of STIs. Significant strides have been made in increasing public education on STIs. A brochure on "Human Papilloma Virus (HPV) and Genital Warts" was developed, printed and distributed. Other materials have since been developed and will be printed and distributed in 2010.

3.4 Care and Support

As part of the response to HIV, the need for a Home-Based Care programme was identified and launched in June 2005. Care services are provided directly by the Ministry of Health through its national Home-Based Care (HBC) programme in collaboration with local NGOs. The support provided to PLHIV included counselling to address disclosure, relationships and diet. Referrals for social, nutritional, and economic support were also provided to PLHIV. This programme has since expanded to encompass Community, Home and Palliative Care with the support of donor and NGO partners.

- Seven hundred and ninety (790) new persons were enrolled onto the Home Based Care programme in 2008 and an additional 826 were enrolled in 2009 (NAPS Programme Report). This programme served 1,026 persons in 2006 and increased to 1,223 in 2007.

- Some 4,000 persons received services as part of the Community Home and Palliative Care (CPHC) programme. Palliative care which focused on providing family centred home based and facility based care to persons living with and affected by HIV has resulted in a range of services being provided to beneficiaries. Work at the community level through NGOs saw the provision of a package of services including skills and capacity building, psychosocial support, nutritional counselling, general healthcare and other services. Palliative Care training has extended beyond the nurses at treatment sites to all categories of nurses within the health sector. NGOs provided home-based care through their comprehensive community home and palliative care programmes headed by registered nurses.

- Partnerships with the National AIDS Programme Secretariat's Food Bank, Food for the Poor, and 25 local businesses and other organisations resulted in PLHIV receiving nutritional packs, hot meals, hampers and multivitamins. Eight hundred and three (803) persons received 1,989 hampers in 2008 and 1,129 persons received 3,983 food hampers in 2009, compared to 470 persons who received 966 hampers in 2007 (NAPS Programme Report). Economic support was provided to PLHIV (including children) at 14 ARV sites in 2008 and 2009 to enable them to access treatment and care. A cumulative total of 1,324 persons received vouchers valued at US$23.50 by the end of 2009; 884 persons in 2008 and 478 in 2009 (NAPS Programme Report).

- Support groups for adolescents and adults were established at the treatment sites and maintained to address issues of disclosure, coping with an HIV positive diagnosis, healthy living and other social and psychological matters pertinent to PLHIV.

- Hospice care which commenced in 2007 continued at the Saint Vincent de Paul Hospice Centre for PLHIV. Referrals between treatment sites, the hospice and NGOs were strengthened to ensure stronger linkages between, clinical, home based and intermediary settings.

- The existing challenge of stigma and discrimination continued to be address through training of health care workers at treatment sites and other health facilities.

- A refresher training in case navigation was conducted and case navigators were oriented to issues related to drug and alcohol abuse and the procedure for referrals to the relevant

services. Technical support and guidance was provided to NGOs to enable them to strengthen their programme through effective networking and referrals. Efforts will be directed at building self sufficiency among PLHIV during 2010.

All NCPI respondents agreed that Guyana has a policy/strategy to promote comprehensive HIV treatment and care, and support which gives sufficient attention to barriers experienced by women in accessing such services. The majority of respondents agreed that such policy/strategy also exists for MARPS, compared to 2007 when all respondents agreed.

All respondents agreed that Guyana has access to regional procurement and supply management mechanism for critical commodities, in particular, condoms, ARVS, testing kits and reagents. All respondents indicated that there are reliable estimates of current and future needs of adults and children requiring ARVS, through the use of international forecasting software.

Most respondents agreed that Guyana has made significant strides in meeting its commitment to universal access. The majority of respondents reported that PLHIV are living longer and healthier lives with less opportunistic infections and episodes of hospitalisation. All respondents also agreed that PLHIV have significantly improved work attendance due to increased quality of life as a result of earlier access to treatment and increased adherence. Respondents also reported that anyone living with HIV and who becomes eligible for treatment can access medication at both public and private treatment and care centres.

Knowledge on the extent to which HIV treatment and care, and support services were available throughout the 10 administrative regions of Guyana varied significantly among respondents. Areas of disagreement included:

(1) Palliative Care - needs to be decentralised from Region 4;
(2) HIV testing and counselling for TB patients;
(3) TB screening for infected people;
(4) TB preventative therapy;
(5) TB infection control; more work required to ensure that facilities are appropriate or relevant;
(6) Nutritional care;
(7) STI management;
(8) Lack of professionals to provide psychosocial support for PLHIV and their families;
(9) HIV care and support in the workplace.

Gaps in coverage identified by respondents included HIV treatment and care, and support services in the workplace, and psychosocial support for PLHIV and their families. All respondents however agreed that HIV-related services were more accessible in 2009, compared to 2007. Some of the specific areas of progress identified included:

- Greater involvement of NGOs in care and support;
- Greater emphasis on family level care and support, including a more structured and coordinated effort to provide Home Based Care; and
- Reduced stigma and discrimination and concomitant increased in the number of individuals and organisations embracing PLHIV and members of most-at-risk populations

3.5 Impact Alleviation

3.5.1 Orphans and Vulnerable Children (OVC)

It is the Government of Guyana's policy to provide free health care, protection, socio-economic security, education, nutritional and psychosocial to OVCs, regardless of whether or not the children are affected by HIV. OVC programme activities are therefore not HIV-specific. A primary objective of the OVC policy is to enhance the coping mechanisms of both caregivers and children in dealing with HIV within a household.

OVC Operational Definition

Orphans are defined as children under 18 years old, of whom at least one or both of their biological parents have died through causes such as AIDS, other illnesses, violence, suicide or other causes. ***Vulnerable children*** include those living without one or both parents because of long-term or permanent (national or international) migration or chronic illness and those who are living without any caregivers at all. Furthermore, OVC include those living on or who spend most of their time on the streets, and children in orphanages or other institutions of care. Moreover, children with a disability, in conflict with the law, or who are survivors of various forms of violence and/or neglect are included in the definition of OVC.

- A Child Protection Unit was established within the Ministry of Labour, Human Services and Social Security (MoLHS&SS) in 2006. To date, Parliament has approved the Child Care and Protection Agency Bill, which is the first legislation in Guyana that focuses on children and separates child care and protection from other social welfare services. The passing of this Bill paved the way for the establishment of the Child Protection Agency. Three additional Bills connected to the overall Children's Bill were passed in the National Assembly during the period under review. These are the "Protection of Children" Bill, the "Status of Children"' Bill and the "Adoption of Children" Bill.

- The work of the Child Care Protection Agency (CCPA) prevented 262 children separating from their families, ensured that 62 children who were temporarily housed in Care-Homes were reunited with their biological families while 124 children were removed from threatening environments (MoLHS&SS). Currently, three Bills: the Custody, Access, Guardianship and Maintenance Bill, the Child Care and Development Services Bill and the Sexual Offences Bill, have been referred to a Special Parliamentary Committee for review.

- In 2007, the MoLHS&SS and the MoH initiated a programme to assess the quality of care in institutions. The programme includes the establishment of Minimum Operation Standards for institutional care and the formalisation of foster care systems. All 25 children's homes across Guyana are now in compliance with minimum standards and individual care plans have been implemented for every child in institutional care. The Government of Guyana provides financial support to all 25 orphanages/children's homes. In 2008 all 25 institutions were provided with furniture and equipment and 18 were renovated in 2009 (NAPS Programme Report). Twelve (12) children from two orphanages were trained in vocational skills in 2009. The training focused on hairdressing, dress making and cake decoration and was intended to provide them with skills needed to gain employment when they attain the age of 18, and at which time they are required to leave the institutions.

- The NAPS established an Amenities Programme for OVC in 2007 as a means of increasing their access to education. Items such as text books, school bags, rain coats, and stationery, were supplied to complement the school uniform voucher programme provided by the

MoLHS&SS. During 2008 277 children received external basic support. This number increased to 929 children in 2009.

- Work at the community level through NGOs saw the provision of a package of services including educational/vocational skills training, psychosocial support, nutritional counselling, general healthcare and other services. A total of 1,418 children living with and affected by HIV received essential care and support services during 2008 and 2009. Additionally, 971 OVC received food and nutritional supplementation through OVC programmes. Three hundred (300) care providers/caretakers were trained in caring for OVC in 2009 compared to 151 in 2008. This training focused on the development of age-appropriate interventions based on the specific needs of the OVC.

- Monthly clinics maintained at NGOs facilitated the provision of general healthcare services to children living with or affected by HIV. After-school programmes were conducted to improve school performance and raise the education levels of over 1,400 OVC. Caregivers were offered essential support in caring for HIV positive children, particularly those tasked with care for children younger than five years of age.

- Support from the Guyana Legal Aid Clinic provided much needed legal aid to vulnerable children and their families. The knowledge of and importance of legal representation and advice has increased due to both print and electronic media campaigns.

The majority of the NCPI respondents reported that they were aware that Guyana has a policy and with an operational definition to address the additional HIV-AIDS-related needs of OVC. This contrasts starkly to 2007 when all respondents had reported that they were unaware of the existence of the policy.

3.5.2 Additional Support for PLHIV

In addition to the Food Bank and the voucher programmes already discussed in previous sections a new structured programme was initiated to establish support groups for PLHIV at all treatment sites. Five (5) PLHIV won house lots through a lottery initiative and were supported to build houses by Food for the Poor Incorporated. Four other PLHIV from Region Two were provided with house lots and houses through collaboration with the Regional Administration and Food for the Poor. Twenty (20) PLHIV were trained in craft making, one was employed as part of a construction project and one was contracted to provide catering services to the PLHIV support group that meets at NAPS. A total of 85 PLHIV were provided with pigeon peas plants to supplement their nutrition.

3.6 The National Multi-sector Response

Civil Society Organisations (CSOs)

Through donor support the Ministry of Health was able to provide financial resources to CSOs to significantly scale-up their contribution to the national response. As a result, the capacity of CSOs was increased and this is reflected in the increasing national coverage of services provided through these entities. The number of CSOs that are active in the HIV national response increased to over 100 in 2009, compared to 55 in 2007 and 30 in 2005. Key services were provided by CSOs in the areas of prevention (condom distribution, BCC and VCT) as well as care and support for PLHIV and OVC.

All respondents of the NCPI reported that NGOs across Guyana are the main non-clinical service providers. NGOs contributions are illustrated in Table 9 below.

Table 9: NGOs contribution to non clinical services by programme areas

Component	2007	2009
Prevention for youth	50 – 75%	>75%
Prevention for vulnerable sub-populations		
-IDU	<25%	<25%
-MSM	50 - 75 %	>75%
- Sex Workers	50 - 75 %	>75%
Counselling and Testing	25 – 50%	51-75%
Clinical Services (OI/ART)	<25%	<25%
Home Based Care	50-75%	>75%
OVC	50-75%	>75%

Half of the NCPI respondents reported that CSOs have moderately contributed to the strengthening of the political commitment of top leaders and national policy formulation, whilst a minority reported that CSOs have contributed significantly. Half of the respondents reported a high level of civil society involvement in the planning and budgeting process for the National HIV and AIDS Strategy.

The majority of CSO respondents reported that services provided by NGOs in the areas of HIV prevention, treatment, care and support are included in the National HIV and AIDS Strategy. A majority of respondents reported that these areas are also included in the national reports. More than half of the respondents were able to state which services provided by CSOs are reflected in the national budget.

The majority of the respondents reported that civil society has been included in the monitoring and evaluation of the HIV response. A majority also reported moderate to high inclusion in the development of the National M&E Plan. A minority reported moderate to high participation on the National M&E committee or working group responsible for coordinating M&E activities. A majority reported moderate to high inclusion of M&E efforts at the local level.

A majority of respondents reported that CSOs are able to easily access funding. A majority reported a moderate to high level of technical support and a majority reported that technical support was mainly provided by donor organisations.

A majority of respondents reported a moderate to high inclusion of diverse organisations in the civil society representation in the HIV efforts.

Line Ministries

As with Community Services Organisations (CSOs), the Ministry of Health was able to leverage external funds to stimulate a broader response among other Line Ministries. Focal Points were hired to facilitate the development of work plans and policies within the participating ministries. In 2005 there were seven Line Ministries with work plans and budgets to support the control of HIV.

By the end of 2007, this number had increased to 11. In addition, there were two additional state entities with work plans and budgets to implement activities to control HIV. The strategy targeted both the staff and clients of the various ministries in 2008 and 2009. The major activities implemented revolved around prevention (educational sessions for staff and their families, training peer educators) as well as care and support (training in home and palliative). The Ministry of Education conducted a situation analysis of the education sector response to HIV and AIDS and used the findings to inform the development of a School Health, Nutrition and HIV Policy to guide its response within the sector.

Private Sector Partnership

Each workplace programme is tailored to the specific needs and capacity of the company. In addition to prevention programmes the Private Sector Partnership Programme, home-based care, and community outreach support for PLHIV and OVCs are being addressed by companies. The initiative goes beyond the workforce to influencing family members, clients and the community as a whole. Specific programme areas that impact beyond the workplace include OVC and support for PLHIV. Several companies have collaborated to provide loans to PLHIV to start small enterprises. NGOs worked with companies to facilitate a more enabling environment for HIV positive and affected staff through the reduction of stigma and discrimination and improvement of existing policies and programmes on HIV.

4. BEST PRACTICES

The Guyana HIV response has resulted in several success stories and emerging best practices. Four are presented below.

National Week of Testing – A Multi-Sectoral Response within a Thematic Area

In December 2006, the United Nations General Assembly proposed the hosting of 'International Voluntary Counselling and Testing Days', as an effective way of increasing access to, and awareness of, VCT services. The main premise of this proposal was to "scale up nationally driven, sustainable, and comprehensive responses to achieving broad multi-sectoral coverage for prevention, treatment, care and support."

Guyana successfully implemented the first National Day of Testing in November 2007. Encouraged by the success of the event, the Ministry of Health took a decision to extend the activity to a Week of Testing. Guyana has since conducted two highly successful and robust National Testing Weeks in November of 2008 and 2009 under the theme, "Take Action; Take the Test".

The Ministry of Health recognises that the success of this activity depends largely on key issues common to VCT event planning, implementation, and evaluation, including: 1) obtaining support from high-profile leaders; 2) involving key stakeholders in the planning and implementation of the VCT event; and 3) addressing the challenges in supply chain management, human resource capacity, and quality assurance of the VCT process.

The event is usually highly publicised through the print and electronic media. High profile leaders including the Prime Minister, Minister of Health, and other senior Ministers of Government, members of the Diplomatic Corps and famous local artistes, took the lead and were tested publicly

to demonstrate their commitment and leadership in the HIV response. The multi-sectoral response is demonstrated within this thematic area with the involvement of both public and private sector agencies including manufacturing industry, banking, and commerce, trade unions NGOs, FBOs, military and paramilitary, youth groups, women and men's groups, and miners, in the planning and implementation of the activity.

During the 2009 National Testing Week there were 443 testing sites, 70 fixed and 373 temporary sites. Over 311 trained and certified counsellor-testers were trained and retrained to man these sites and ensure quality. A total of 28,360 persons (13,855 males and 14,505 females) were counselled and tested at sites which were opened until after midnight.

The 2009 Week of Testing saw an increased number of males who came forward for testing. Males comprised 49.0 percent of the total number of persons counselled and tested. This activity suggests a potential decrease in the level of stigma associated with testing as an increased number of men sought these services, and provides concrete evidence of Guyana's success in achieving a truly multisectoral and multidimensional response within this thematic area.

Social Marketing of Condoms – "Put It On" Campaign

Social marketing is an effective tool in the response to HIV. Using commercial marketing techniques, social marketing makes the product available and affordable while linking it to a communication campaign geared to effect sustainable behavioural change. In 2009 the 'Put It On" campaign was developed on the premise that condoms are the only affordable HIV prevention tool among sexually active persons. It aimed to promote and increase correct and consistent condom use.

The campaign utilised edutainment which was taken to communities through a series of 'road shows' conducted between July and September 2009. Community residents were treated to song, drama and condom demonstration and free condoms. Mass media messages were developed to call attention to the campaign road shows and encourage condom use. The "Put It On', message was placed onto the road show bus.

A monitoring and evaluation framework was designed to assess the short-term impact of the campaign. A three-question questionnaire was designed to gather information on condom use and accessibility methods; do people purchase condoms or obtain them free? A network of condom outlets served as the hub of "road show" outreach activities. A mapping exercise was also conducted among condom retailers in proximity to the places identified for the road shows. Preliminary data indicate that the campaign has increased short-term demand for condoms in many of these locations. Retailers reported up to 300.0 percent increased in condom sales.

Supportive Supervision – Taking care of the Care Givers

Guyana has seen massive scale-up in its HIV response, particularly in its treatment, care and support programmes. The magnitude of the scale-up requires significant human resources to address the multiplicity of needs among people living with and affected by HIV. There is great demand upon the health care system and its human resources.

Health care workers must also feel equipped to deal with the stressors involved in their work. Effective coping is likely to lead to improved worker morale, higher quality services, and greater client satisfaction. In response to the health care providers need for supervision and emotional support, the Home-Based Care (HBC) programme embarked on an initiative that seeks to ensure a

sustainable system that works with supervisors to give health workers the consistent guidance and mentoring they need to implement and maintain an effective care and support programme. This initiative began in 2008 and continued in 2009. The Home-Based Care programme is a component of the Community Home and Palliative Care programme,

Supportive supervision is a proven approach that helps transfer knowledge to practice and that ensures that learning continues beyond the traditional training setting. The HBC programme has been convening monthly meetings with 11 Nurse Supervisors from the public sector, private hospitals and NGOs in a safe and comfortable environment. Through this initiative health care providers have opportunities to discuss case studies have received mentoring and guidance from each other and the HBC Coordinator. This mechanism is also used to track and align clients who have been referred for care and treatment thereby ensuring that there is no duplication of services being provided to the same client by NGOs.

This mechanism also provided health care workers with a safe space to offload and in so doing avoid burnout. This group of health care providers have recognised that while they provide services for different agencies, they are all working towards the same goal of providing quality health care to PLHIV and those affected. Supervisors have been transferring the knowledge and experiences gained through this mechanism to staff who they supervise.

This group of health care providers has reported that they have been able to improve the management of clients and system of care and avoid burnout. With strong support, supportive supervision can become a standard practice and a way of continually updating the skills of existing and new health workers coming into the health care system. It has the potential to develop into a best practice that would ensure tremendous benefits both to the health care providers and their clients.

Quality Management –HEALTH QUAL-Guyana

HEALTHQUAL-Guyana represents the first adaptation of the HIVQUAL framework beyond HIV care during its initial phase, and has been supported by UNICEF and CDC-Guyana (HIVQUAL International). This programme commenced in 2008.

The mission of the HEALTHQUAL-Guyana programme is to improve the quality of care at the Infectious Disease Ward at Georgetown Public Hospital, HIV care for adults and children at all treatment sites and the well child healthcare programme by building capacity for quality management. Led by the National AIDS Programme Secretariat (NAPS), and guided by a steering committee composed of representatives from the Bureau of Maternal Child Health, UNICEF, CDC-Guyana and FXB-Guyana, the programme is moving rapidly through its first phase. A set of indicators has been developed for use in paediatric settings that will be used to measure the quality of well-child care. For all children, including those not infected with HIV, four well-child care indicators have been developed: clinical visits, growth monitoring, assessment of developmental milestones and vaccination coverage. Additional indicators used for children infected with HIV include CD4 monitoring, ART, adherence assessment, cotrimoxazole prophylaxis, TB screening and general medical care which includes routine measurement and documentation of vital signs.

In October 2008, a two-day training was held for representatives of the 20 participating sites to review the HIVQUAL framework, and to train participants in case list generation, sampling, and chart abstraction, as well as use of the HEALTHQUAL-Guyana software for data entry and report

generation. Data transfer procedures were also outlined for the secure and orderly submission of data from the sites to the central team. The training, led by HEALTHQUAL, in collaboration with the MOH, was a hands-on session designed to build capacity amongst facility staff. The first round of data collection commenced in February 2009 at 20 pilot sites that included a mix of HIV care and treatment clinics and well-child clinic. These data are being aggregated to provide a national report as well as other specific reports.

Emerging data describe the general performance of the institutions providing care and treatment services. For example, performance data from 15 clinics (1,013 patients) obtained during the period January to June 2008 revealed that in relation to vital signs 51.8 percent of all patients had their pulse taken at every visit and 41.8 percent of all patients had their temperature taken at every visit. Some 31.3 percent of all eligible patients received Cotrimoxazole Prophylaxis and 58.3 percent of all patients were assessed for adherence. These areas have been identified for immediate improvement given that they require minimum intervention that can yield significant improvement and benefits. Providers would require basic diagnostic equipment for documenting vital signs while adherence assessments by treating physicians need to be an essential aspect of care at each visit and should include a multi disciplinary approach. Documentation of the activities performed is crucial for the success of this programme. Guyana hopes to adapt this framework to VCT and other programmes in recognition of the importance of ensuring quality management of its programmes.

5. MAJOR CHALLENGES AND REMEDIAL ACTIONS

Whilst acknowledging the major progress made by the Government of Guyana in its response to HIV, the Guyana UNGASS Country Progress Report 2006-2007 identified the following challenges to achieving the UNGASS goals/targets. These include:

1. Attracting and retaining suitable staff remains a challenge due to both rural to urban migration and emigration;
2. Implementing standard operational procedures for TB health care workers to protect themselves and clients;
3. External quality control for all laboratories; currently, not all private sector laboratories participate in external quality programmes;
4. General discrimination against PLHIV;
5. Difficult coordination of donors to streamline the allocation of resources; and
6. Need for increasing access to services in remote areas to meet the demand generated by the BCC programme.

In response to the challenges identified, Government committed to taking remedial action to address some of the challenges mentioned above. These remedial actions and Government's actions are reflected in the matrix below.

Remedial Actions	Government's Actions
1. Given the spatial disparities in development, attracting and retaining qualified staff will continue to be a challenge for Guyana. The Government will therefore seek to	The National AIDS Programme has been able to retain qualified personnel. The Ministry of Health conducted a human resource assessment to inform the development of a human resource

collaborate with development partners to develop a strategy for sustaining human resources.	strategy for the health sector. A strategy for sustaining human resources within the sector will be built into the plan during the next two years.
2. A multi-year work plan and budget to support the implementation of the current National Strategic Plan will be developed and implemented. It is expected that this will contribute to resolving many of the challenges currently facing the national programme.	Both documents were developed during the period under review.
3. While the Presidential Commission on HIV and AIDS, the UN Theme Group on HIV and AIDS, and the CCM exist, there is need for further national coordination to avoid both duplication and gaps in resource allocation.	There has been significant improvement in coordination at the national level aided by the Country Coordinating Mechanism (CCM) and PEPFAR's Country Operational Plans. There is review of PEPFAR's implementing partners' work plans thereby avoiding both duplication and gaps in resource allocation.
4. Efforts will continue to educate health care workers in standard operational procedures to minimise incidents of discrimination and to provide quality care to patients, while protecting themselves.	A series of trainings were conducted with both pre and in-service health care providers. 'Stigma and discrimination' is infused into all training HIV-related trainings. Two pilot training were conducted among nurses and pharmacist targeting 45 persons in 2007 and 2008. I-TECH Guyana conducted a stigma and discrimination workshop targeting 14 health care providers involved in training. The CHART stigma and discrimination video trigger scenarios formed the basis of the trainings. Efforts to reduce S&D among the general population were intensified through the mass media and community interpersonal activities.
5. The recently passed Health Facilities Licensing Act 2007 which seeks to strengthen regulations of public and private hospitals, laboratories, and other services will assist in addressing the challenge of ensuring that private laboratories participate in external quality control programmes.	Significant effort was directed at implementing the Act through training, upgrading of facilities and monitoring to ensure compliance.
6. There is an ongoing media campaign against stigma and discrimination. Modules addressing this issue are also being incorporated into all training programmes. An Advocacy Desk has also been established in the NAPS office to address this issue. Finally, the draft HIV legislation once passed in Parliament will assist in addressing this	The mass media campaign continued and was intensified. The Advocacy Desk was functional during 2008 and part of 2009. With the establishment of the PANCAP Regional Stigma and Discrimination Unit (RSDU), an assessment was conducted in Guyana to determine the country's anti-stigma response. During the last quarter of 2009 the RSDU commenced peer

issue.	training and empowerment sessions that targeted PLHIV and faith based. Through the RSDU support PLHIV were also trained to collect data on stigma and discrimination affecting this population. Additional interventions will be developed and implemented in 2010 and 2011. The MOH is currently seeking to gather strategic information with which to address this issue.
7. Strategic partnership with CSOs is contributing to increasing coverage of HIV services. However, the relatively low population density of the hinterland, together with difficulties of access, mean that providing all services, including HIV to the hinterland population will always be a challenge in the foreseeable future.	Significant effort was directed at reaching distant hinterland communities. Prevention, treatment and care services were provided through three mobile units serving Regions One, Seven, Eight and Nine.

Despite the progress referred to above some challenges remain in 2009. These include:

- Attracting and retaining suitable staff remain a challenge due to both rural to urban migration and emigration. This challenge is even greater in the regions beyond Region Four.
- Technical capacity to development and implement prevention strategies that target individual behaviour.

- The TB treatment programme is challenged by limited public mobilisation around TB screening and TB-HIV co-infection care, public awareness of the availability and importance of accessing these services is minimal.

- In spite of the achievements of the treatment programme, they are still delays in persons' decision to seek treatment. This is reflected by the relatively low CD4 count of some patients when initiating treatment.

- 'Stigma and discrimination' remains a challenge among health workers, the workplace, family, FBOs, and the community and act as barriers to disclosure, adherence to medication, and access to prevention, treatment and care services. The Guyana National AIDS Committee Survey of Stigma and Discrimination Experiences of HIV Positive Guyanese (2008) conducted among 300 PLHIV in nine regions found that 61.0 percent of the respondent identified health care workers as the group that was mainly responsible for the unfair treatment they experienced when accessing anti-retrovirals (ARVs). The survey also found that 50.0 percent of the respondents reported that the family was primarily responsible for the lack of acceptance of their HIV status, workplace (16.0%), and religious community (11.0%). Judgmental attitude was reported by 56.0 percent of respondents as the most frequent form of non-acceptance experienced, avoidance (28.0%), exclusion (17.0%), belittling (31.0%), and non recognition (13.0%). Forty-seven (47.0%) percent reported that non-acceptance had remained the same since they tested positive, while 34.0 percent reported that it had decreased and 13.0 percent said it had increased. When asked about non accepting behaviours they had experienced, 22.0 percent of respondents reported judgmental

attitude belittling and gossiping (21.0%), discrimination (18.0%), avoidance (15.0%), desertion by family members (10.0%), exclusion (80%), public disclosure of their status by another (3.0%), non recognition (2.0%), and non-acceptance (1.0%).

- Limited ongoing review of the policies/laws to determine those that contradict national AIDS control policies.

- Recognition of the need for structuring of data sets which disaggregate the vulnerability of women to HIV and AIDS; such data sets could include impacts on Amerindian women, cross-border movements, widows and education levels.

6. SUPPORT REQUIRED FROM DEVELOPMENT PARTNERS

The progress reported herein is directly related to a significant increase in financial resources provided by donors and technical partners to Guyana. The Government of Guyana is appreciative of the support provided by development partners and would like to acknowledge these partners in this section.

- US President's Emergency Programme for AIDS Relief (PEPFAR): United States Government (USG) partners include United States Agency for International Development (USAID), US Centers for Disease Control (CDC), Peace Corps, GHARP i, GHARP ii, Francois Xavier Bagnaud (FXB), Catholic Relief Services (CRS), Supply Chain Management Systems (SCMS), Guyana Safer Injection Project (GSIP)

- Global Fund for HIV, Tuberculosis and Malaria

- World Bank Multicountry AIDS Programme

- UN Agencies: UNAIDS, PAHO-WHO, UNICEF, UNFPA, UNDP, , ILO, UNESCO

- Canadian International Development Agency (CIDA)

- The Clinton Foundation

- Pan Caribbean Partnership against HIV/AIDS (PANCAP)

The Government of Guyana looks forward to continued support from these partners. Such support includes:

1. Collaborating with partners to develop a plan for sustainability of the overall national AIDS programme; financial sustainability, pre service to training, and curricula development;

2. Support for Guyana to continue benefiting from competitive pricing and access to goods and services;

3. Continued funding to fill existing programme gaps, while allowing the national programme to continue developing and implementing targeted interventions;

4. Increased coordination in allocating financial resources to support implementation of the National HIV and AIDS Strategy;

5. Harmonisation of donor reporting commitments to facilitate a single national report to fulfil the information needs of multiple donors; and

6. Continued donor support for strengthening national systems so that improved strategic information can be efficiently provided to all stakeholders.

7. Continued health system strengthening including the integration of HIV into primary health care setting.

8. Support that ensures that HIV issues integrally linked to HIV such as mental health, substance abuse, and domestic violence are addressed.

7. MONITORING AND EVALUATION (M&E) ENVIRONMENT

Guyana has made significant progress on monitoring and evaluation through collaboration with its partners. Key M&E achievements during 2008-2009 include:

- Staff of the M&E Unit benefitted from capacity building through technical assistance provided by three M&E Advisers.

- The M&E Operational Plan was finalised, printed and disseminated;

- The Mid-Term Review (MTR) to assess the progress of the National HIV and AIDS Strategic Plan, 2007-11 was conducted in 2009;

- The Universal Access Report which collects individual indicators/data from various programme areas to determine achievements was completed in 2008

- The Early Warning Indicators Report that form part of the HIV Drug Resistance (HIVDR) prevention strategy, and which are collected annually for each selected site was completed in 2008;

- Consensus for national HIV estimates for 2008 was reached with key data providers;
- Data gathering for an HIV/TB Care and Treatment Client Satisfaction Survey was completed and data entry commenced during the latter part of 2009;

- Module One of an M&E Curriculum was developed to provide in-service training to the NAPS Programme Coordinators;

- The Presidential Commission on HIV and AIDS Report 2008 was completed;

- Several studies were conducted that include the Biological and Behavioural Surveillance Surveys (2009) among Sex Workers, MSM, In-school Youth, Out-of-School Youth, police and military, Demographic Health Survey (2009), These surveys provided valuable data to track the progress and were also used to guide the establishment of national targets.

- Dissemination workshop for the Biological Behaviour Surveillance Survey (BBSS) for Security Officers was conducted;

- A National Indicator Target Setting Workshop was conducted at the end of 2009;

- The Country Harmonisation and Alignment Tool (CHAT) which is a tool used to determine the inclusiveness of partners and the effectiveness of funding is being administered;

- The Coordinating AIDS Technical Support (COATS), a database used to monitor technical support is being developed.

All NCPI respondents agreed that the national monitoring and evaluation (M&E) plan was endorsed by key M&E partners and that the plan was developed in consultation with civil society, including PLHIV. A minority of respondents agreed that most partners have harmonised and aligned their M&E requirements with the national M&E plan, compared to half who reported this in 2007. The majority of respondents agreed that the national M&E plan included the following:

- A data collection and analysis strategy;
- Behavioural surveillance;
- HIV surveillance; and
- Routine Programme Monitoring.

All respondents agreed that the M&E plan had a well defined standardised set of indicators, compared to 2007 when the majority of respondents agreed. A majority agreed that the national M&E plan contained guidelines on tools for data collection, compared with half of the respondents who agreed in 2007.

The majority of respondents agreed that the national plan does not contain data dissemination and use strategy. Half agreed that there is a strategy for assessing data quality whilst all respondents agreed that there was no data analysis strategy.

The majority of respondents agreed that there is no budget for the M&E plan. However, respondents reported that several donor funded projects have M&E budgets which needed to be consolidated and linked to national M&E plan to allow Guyana to realise one national M&E Plan. A minority of respondents reported that the budget for the implementation of the M&E Plan was in progress.

All respondents agreed that M&E expenditures are being monitored, whilst half of the respondents agreed that M&E priorities are determined through a National M&E system assessment involving the use of an M&E System Strengthening Tool (MESST) developed by the Global Fund, the M&E

Operational Plan, and the revised WHO recommended tools, and the adoption of the national indicators. A majority of respondents reported that a functional M&E Unit is still evolving as reported in 2007.

Half of the respondents agreed that there are mechanisms in place to ensure that all major implementing partners submit M&E data/reports to the national M&E unit for review and consideration for inclusion in the country's national reports. In 2007 all respondents disagreed.

All respondents agreed that there is a national M&E working group. A majority reported that the group meets regularly, compared to half who agreed with the statement in 2007.

A minority of respondents reported that there is a central national database with HIV related data. The database consists of an EXCEL spreadsheet and is managed by the M&E Unit of the National TB Programme through the use of a Working Health Information System.

A minority of respondents reported that there is a functional health information system at the national level, while half reported that they were not aware. Half of the respondents agreed that Guyana publishes an M&E report on HIV, including HIV surveillance data at least once a year.
A minority of respondents reported that there is a plan for increasing human capacity at the national level. All agreed that there was none at the sub national level and a minority agreed that there was none at the service delivery levels.

A majority of informants reported that M&E activities other than trainings were conducted. These included ongoing capacity building on data analysis and an informal session on EPI Info.

The majority of respondents agreed that there was a moderately high use of M&E data in developing and revising the National HIV and AIDS Strategy, compared to all respondents who reported in 2007. Respondents provided the following examples:

- Biological Behavioural Surveillance Survey (BBSS) to determine the extent of various programmes;
- Revision of the national indicators and targets;
- HAART for co-infected patients.

A minority of respondents reported improvement in resource allocation and programme management.

The key M&E challenges identified by key respondents included:

- Need for greater collaboration between the TB and HIV programmes;
- Greater involvement of the HIV programme in TB screening and management;
- Documentation and management of information to feed into the M&E database.
- Additional staff, funding and capacity building to ensure a functional M&E Unit;

9. GUYANA 2020 HIV VISION

Outlined by the Honourable Dr. Leslie Ramsammy, Minister of Health

Guyana will lead the world in the elimination of HIV as a public health threat. This vision is grounded in the Ministry of Health's goal to serve the voiceless within Guyana. The most robust fight against HIV was experienced during the last decade and was characterised by a global solidarity and the most energise battle against any public health scourge. The Global fight was intensified because the world was in an emergency mode and leaders were convinced that the world was about to be overwhelmed. It was therefore a battle for survival. It was recognised that this battle was not one for any given nation, but one which threatened to overwhelm humanity.

This emergency solidarity has changed the trajectory and we have now entered a new phase of elimination of HIV as a public health threat. Our fear has been replaced by the confidence that we can win this battle and create a healthier world and deal with the mirage of health challenges. We can dream of a world in which every citizen is guaranteed a long and productive life. Therefore our HIV response will not be limited to public health officials. We will engage all segments of society because everyone has a role and a stake.

The Guyana 2020 HIV Vision is significant because it is a war against social injustice. Our focus for the next decade will be early attainment of genuine universal access to treatment, care and support. We envisage a Guyana where Guyanese do not suffer stigma and discrimination, criminalisation of HIV because of sero-status, sexual orientation, religion or gender. We will leverage the solidarity that has emerged from HIV. Resources for HIV will not be narrowly focused but will instead be used to address development issues within the context of empowering people for healthy lives.

We strongly believe that oppression and resistance from HIV are over and we acknowledge that the change we need will be difficult, however the results we desire make these changes imperative.

We have identified the following goals for achieving the Guyana 2020 HIV Vision:

1. Eliminate mother-to-child-transmission of HIV by 2020; ensuring that no child is left behind;

2. Ensure access of all pregnant women to prophylaxis treatment to prevent mother-to-child-transmission of HIV through an opt-out policy;

3. Ensure that HIV awareness and education are integral parts of prevention through the integration of the prevention of HIV transmission among young women within the Millennium Development Goals (MDGs) 4 and 5;

4. Ensure harmonisation between the universal access goals of 2001 and the MDGs 4 and 5.

5. Transform available HIV resources to work towards the achievement of two key MDGs; reduce child mortality and improve maternal health;

6. Develop robust HIV prevention strategies that are in keeping with the goal of reducing HIV infection to 10 in every 100,000 persons;

7. Shift more resources to long-term prevention while maintaining our work in treatment and care;

8. Reassess the global allocation of HIV spending on prevention with the aim of increasing funding for prevention to 40.0 percent of the overall AIDS spending in Guyana;

9. Produce a generation of informed young people who can protect themselves from HIV, and increase their knowledge of HIV and AIDS to 100.0 percent;

10. Place greater emphasis on delaying sexual debut by empowering young people to wait;

11. Ensure that safe sex becomes a norm among sexually active adults, and increase their access to male and female condoms;

12. Recognise that while all us are not at equal risk, we are all at risk to HIV, and address the risks we face by developing innovative programmes aimed at individuals at low and high risks;

13. Learn more about Guyana's AIDS epidemic by identifying the geographic areas where the burden of HIV is higher;

14. Address the issue of vulnerability of women and young girls within the context of the power differential in intimate relationships and sexual violence, and the cultural and social inequality of women; emphasis will be placed on empowering women to reduce their vulnerability to violence, while also addressing the needs of men;
15. Embrace universal access to treatment, from a preventative and longevity perspective, through an awareness that early treatment must not be limited to CD4 testing but rather on increasing access to potent medicines among people in developing countries;

16. Embrace and incorporate the Next Generation Treatment Plan into the national plan and explore new ways to overcome the disparity of cost;

17. Respond to tuberculosis as part of the HIV response given that TB is the number one cause of death among PLHIV;

18. Address other STIs;

19. Recognise that the HIV response created opportunity for the strengthening of the health sector thereby ensuring that people live longer and healthier lives;

20. Develop a national supply chain management, health information system (HIS), surveillance and M&E systems for the health sector, and acknowledge that HIV resources should be used for strengthening of the overall health system and the national responses.

21. Strengthen the line ministries to deal with HIV and AIDS-related issues in recognition that they have a role to play in the response.

ANNEXES

Annex 1
Consultation/preparation process for the national report on monitoring the follow-up to the Declaration of Commitment on HIV and AIDS

1) Which institutions/entities were responsible for filling out the indicator forms?	
a) NAC or equivalent	Yes
b) NAP	Yes
c) Others (key stakeholders)	Yes
2) With inputs from	
Ministries	Yes
Education	Yes
Health	Yes
Labour	Yes
Foreign Affairs	No
Others	No
Civil Society Organisations	Yes
People living with HIV	Yes
Private sector	Yes
United Nations Organisations	Yes
Bilaterals	Yes
International NGOs	Yes
Others (please specify)	No
3) Was the report discussed in a large forum?	Yes

Forum was comprised of representatives of the Government, UN agencies, bilateral agencies and NGOs, FBOs, and PLHIV.

4) Are the survey results stored centrally? Yes

5) Are data available for public consultation? Yes

6) Who is the person responsible for submission of the report and for follow-up if there are questions on the Country progress Report?

Name/title: Dr. Shanti Singh-Anthony, M.D., M.P.H.

Date: _____

Signature: _____

Annex 2

National Composite Policy Index Questionnaire (through CRIS)
National composite Policy Index – 200

Country: Republic of Guyana
Name of the National AIDS Programme Secretariat officer in charge:
Dr. Shanti Singh-Anthony, M.D., M.P.H.

Signed by: _____
Address: Hadfield Street & College Road, Wortmanville, Georgetown, Guyana
Tel: (592) 227-8683 or (592) 226-5371
Fax: (592) 225-6559
E-mail: fsjaanthony@gmail.com
Date: March 25th 2010

Report of National Composite Policy Index Questionnaire
See email attachment

ANNEX 3
National Return Forms for programme, knowledge, behaviour and impact indicators (through CRIS)

Final UNGASS National Indicators Matrix: 2008 and 2009 Values

Indicator	2008 and 2009					
National Programme	**Data Origin**	**Period**	**Value**	**Numerator**	**Denominator**	**Comments**
	-	-	-			
3. Percentage of donated blood units screened for HIV in a quality assured manner ***Note:*** *Public sector only*	NBTS Routine Data	2008 2009	100% 100%	7,360 7,700	7,360 7,700	
4. Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy	NAPS Programme Reports & ANC Survey (2006)	2008 2009	72.7% 83.5%	2,473 2,832	3,400 3,390	*The projected estimate of Adult ART need for 2009 modelled in the 2006 ANC Survey was used as the denominator for 2009 in the absence of UNAIDS 2009 estimate.*
5. Percentage of HIV-infected women who received antiretrovirals to reduce the risk of mother-to-child transmission	ANC Programme Report	2008 2009	80.45% 84.4%	210 184	(227 x 1.15) =261. (196 x 1.11 =218.	*Numerator is actual number of pregnant women uptaking ART. Denominator is the number of women giving birth multiplied by the estimated HIV prevalence rate among pregnant women (i.e., 1.15% in 2008 and 1.11% in 2009)*
6. Percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV ***Note:*** *Denominator: WHO estimated number of incidence TB cases in people living with HIV unavialble for 2009, therefore 2008 estimates reused as denominator in 2009*	Chest Clinic Programme Reports	2008 2009	94.2% (66.63%) 93% (68.18%)	73 75	79(110) 80(110)	Denominator: estimated number of incident TB cases in PLHIV. Accessed on www.who.int/tb/country/en Year of latest estimate 2008. Highlighted in red are based on estimates. All others are based on actual numbers.
All females		2008	91.1%	31	34	

All females		2009	94.7%	36	38	
All males		2008	93.3%	42	45	
All males		2009	92.8%	39	42	
Less than 15 years		2008	3.7%	3	79	
All females		2008	2.9%	1	43	
All Males		2008	4.4%	2	45	
Less than 15 years		2009	2.5%	2	80	
All females		2009	5.2%	2	38	
All Males		2009	0%	0	42	
More than 15 years		2008	96.2%	76	79	
More than 15 years		2009	97.5%	78	80	
7. Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and who know their results	DHS	2009	24.8%			
All females	DHS	2009	27.0%			
All males	DHS	2009	21.6%			
8. Percentage of most-at-risk populations that have received an HIV test in the last 12 months and who know their results	-	-	-			*This indicator is not defined in the same way in the 2008/ BBSS. The indicators actually used in the BBSS are presented here as a proxy.*
Percent tested within last 12 months (**FSW**)	BBSS	2009	87.9%	138	157	
<25 years	BBSS	2009	91.3%	53	58	
>25 years	BBSS	2009	85.9%	85	99	
Percent ever had an HIV test (**FSW**)	BBSS	2009	78.5%	157	200	
<25 years	BBSS	2009	68.2%	58	85	
>25 years	BBSS	2009	86.8%	99	114	
Percent returned to receive results – from any test ever taken (not necessarily within past 12 months) (**FSW**)	BBSS	2009	93.0%	147	158	
<25 years	BBSS	2009	94.8%	55	58	
>25 years	BBSS	2009	92.0%	92	100	
Percent tested within last 12 months (**MSM**)	BBSS	2009	87.1%	88	101	
<25 years	BBSS	2009	97.1%	34	35	
>25 years	BBSS	2009	81.8%	54	66	
Percent ever had an HIV test (**MSM**)	BBSS	2009	77.7%	101	130	
<25 years	BBSS	2009	71.4%	35	49	
>25 years	BBSS	2009	81.5%	66	81	

Percent returned to receive results – from any test ever taken (not necessarily within past 12 months) (**MSM**)	BBSS	2009	100.0%	102	102	
<25 years	BBSS	2009	100%	35	35	
>25 years	BBSS	2009	100%	67	67	
9. Percentage of most-at-risk populations reached with HIV prevention programmes .	-	-	-			*This indicator is not defined in the same way in the 2008BBSS. The indicators actually used in the BBSS are presented here as a proxy*
9.a Percent who know of place in community to access HIV test (**FSW**)	BBSS	2009	61.4%	108	176	
<25 years	BBSS	2009	63.0	46	73	
>25 years	BBSS	2009	60.2%	62	103	
9.b Percent who know of place in community to access HIV test (**MSM**)	BBSS	2005	16.0%			Indicator not included in 2008 BBSS for MSM, hence 2005 value reported
10. Percentage of orphaned and vulnerable children aged 0-17 whose households received free basic external support in caring for the child	-	-	-			Not required to report since national prevalence is below 5%
11. Percentage of schools that provided life skills-based HIV education in the last academic year	Ministry of Education HFLE Survey	2008	61.6%	45	73	
Nursery School	-	2008	100.0%	6	6	
Primary School	-	2008	73.9%	34	46	
Secondary School	-	2008	23.8%	5	21	
Knowledge and Behaviour						
12. Current school attendance among orphans and among non-orphans aged 10-14	-	-	Not available			MICS 2006 sample too small
13. Percentageof young women and men aged 15-24 who both correctly identified ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	BBSS	2009	45.50%		1575	
Males 15-19 years	BBSS	2009	43.5%	589	1353	

Females 15-19 years	BBSS	2009	48.7%	424	870	
Males 20-24 years	BBSS	2009	44.0%	345	784	
Females 20-24 years	BBSS	2009	59.60%	362	636	
13.1 Percentage of persons who identified that having one uninfected faithful partner can reduce the risk of HIV transmission	BBSS	2009	86.0%		1568	
Males 15-19 years	BBSS	2009	75.9%	388	511	
Females 15-19 years	BBSS	2009	84.8%	786	927	
Males 20-24 years	BBSS	2009	86.7%	731	843	
Females 20-24 years	BBSS	2009	89.3%	617	691	
13.2 Percentage of persons who correctly identified that condom use reduces HIV transmission	BBSS	2009	90.5%		1568	
Males 15-19 years	BBSS	2009	88.9%	465	523	
Females 15-19 years	BBSS	2009	89.6%	843	941	
Males 20-24 years	BBSS	2009	91.6%	772	843	
Females 20-24 years	BBSS	2009	92.3%	626	678	
13.3 Percentage with knowledge that a healthy looking person can transmit HIV	BBSS	2009	95.7%		1567	
Males 15-19 years	BBSS	2009	94.2%	503	534	
Females 15-19 years	BBSS	2009	97.8%	959	981	
Males 20-24 years	BBSS	2009	97.0%	821	846	
Females 20-24 years	BBSS	2009	96.6%	678	700	
13.4 Percentage with knowledge that mosquito cannot transmit HIV	BBSS	2009	73.0%		1566	
Males 15-19 years	BBSS	2009	84.3%	430	510	
Females 15-19 years	BBSS	2009	89.6%	828	924	
Males 20-24 years	BBSS	2009	74.7%	591	791	
Females 20-24 years	BBSS	2009	84.4%	552	654	
13.5 Percentage with knowledge that sharing a meal cannot transmit HIV	BBSS	2009	78.6%		1568	
Males 15-19 years	BBSS	2009	86.7%	456	526	
Females 15-19 years	BBSS	2009	92.8%	887	956	
Males 20-24 years	BBSS	2009	79.9%	653	817	
Females 20-24 years	BBSS	2009	85.4%	580	679	
FSW **14.** Percentage of most-at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject misconceptions about HIV transmission	BBSS	2009	35.0%	55	157	

<25 years	BBSS	2009	29.9%	20	67	
>25 years	BBSS	2009	38.9	35	90	
FSW **14.1** Percent who has knowledge of HIV prevention methods (defined as: correctly identified abstinence, faithfulness, and consistent condom use as ways that HIV can be transmitted)	BBSS	2009	74.9%	125	167	*Note: the specific indicators for a faithful partner and use of condoms are reported separately immediately below*
<25 years	BBSS	2009	68.5%	50	73	
>25 years	BBSS	2009	79.8%	75	94	
14.1.1 Percent who identify that having one faithful uninfected partner can reduce the risk of HIV transmission (**FSW**)	BBSS	2009	82.0%	141	172	
<25 years	BBSS	2009	78.7%	59	75	
>25 years	BBSS	2009	84.5%	82	97	
14.1.2 Percent who identify that consistently using a condom correctly can reduce the risk of HIV transmission (**FSW**)	BBSS	2009	95.4%	185	194	
<25 years	BBSS	2009	94.0%	78	83	
>25 years	BBSS	2009	96.4%	107	111	
14.1.3 Percent who identify that abstinence can reduce the risk of HIV transmission (**FSW**)	BBSS	2009	92.9%	156	168	
<25 years	BBSS	2009	93.2%	69	74	
>25 years	BBSS	2009	92.6%	87	84	
FSWs **14.2** Percent with no incorrect beliefs about HIV (correctly rejected three most common local misconceptions: mosquito bites, sharing a meal with infected persons and healthy looking persons)	BBSS	2009	50.6%	78	154	*Note: the specific indicators for the above misconceptions are reported separately immediately below*
<25 years	BBSS	2009	50.0%	33	66	
>25 years	BBSS	2009	51.1%	45	88	

14.2.1 Percent with knowledge that mosquitoes cannot transmit HIV (**FSW**)	BBSS	2009	71.3%	107	150	
<25 years	BBSS	2009	71.0%	49	69	
>25 years	BBSS	2009	71.6%	58	81	
14.2.2 Percent with knowledge that sharing a meal cannot transmit HIV(**FSW**)	BBSS	2009	74.7%	127	170	
<25 years	BBSS	2009	78.7%	59	75	
>25 years	BBSS	2009	71.6%	68	95	
14.2.3 Percent with knowledge that a healthy looking person can transmit HIV (**FSW**)	BBSS	2009	93.8%	166	177	
<25 years	BBSS	2009	94.9%	74	78	
>25 years	BBSS	2009	92.9%	92	99	
MSM 14- Percentage of men who have sex with men who both correctly identify ways of preventing sexual transmission and who reject major misconceptions about HIV transmission	BBSS	2008-2009	46.8%	58	124	
<25 years	BBSS	2009	42.6%	20	47	
>25 years	BBSS	2009	49.4%	38	77	
14.1 Percent who has knowledge of HIV prevention methods (defined as: correctly identified abstinence, faithfulness, and consistent condom use as ways that HIV can be transmitted)	BBSS	2009	68.2%	88	129	*Note: the specific indicators for a faithful partner and use of condoms are reported separately immediately below*
<25 years	BBSS	2009	63.3%	31	49	
>25 years	BBSS	2009	71.3%	57	80	
14.1.1 Percent who identify that having one faithful uninfected partner can reduce the risk of HIV transmission (**MSM**)	BBSS	2009	82.9%	107	129	
<25 years	BBSS	2009	83.7%	41	49	
>25 years	BBSS	2009	82.5%	66	80	
14.1.2 Percent who identify that consistently using a condom correctly can reduce the risk of HIV transmission (**MSM**)	BBSS	2009	94.5%	120	127	
<25 years	BBSS	2009	89.6%	43	48	

>25 years	BBSS	2009	97.5%	77	79	
14.1.3 Percent who correctly identify that abstinence reduces the Risk of HIV transmission	BBSS	2009	86.2%	112	130	
<25 years	BBSS	2009	83.3%	40	48	
>25 years	BBSS	2009	87.8%	72	82	
MSM **14.2** Percent with no incorrect beliefs about HIV (correctly rejected three most common local misconceptions: mosquito bites, sharing a meal with infected persons and healthy looking persons)	BBSS	2009	64.5%	80	124	
<25 years	BBSS	2009	59.6%	28	47	
>25 years	BBSS	2009	67.5%	52	77	
14.2.1 Percent with knowledge that mosquitoes cannot transmit HIV (**MSM**)	BBSS	2009	81.8%	99	121	
<25 years	BBSS	2009	72.95	35	48	
>25 years	BBSS	2009	87.7%	64	73	
14.2.2 Percent with knowledge that sharing a meal cannot transmit HIV(**MSM**)	BBSS	2009	80.6%	104	129	
<25 years	BBSS	2009	80.9%	38	47	
>25 years	BBSS	2009	80.5%	66	82	
14.2.3 Percent with knowledge that a healthy looking person can transmit HIV (**MSM**)	BBSS	2009	94.6%	123	130	
<25 years	BBSS	2009	95.8%	46	48	
>25 years	BBSS	2009	93.9%	77	82	
15. Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15	DHS	2009	13.6%			In addition to the DHS, the BSS of 2009 reports that for 15-19 agegroups male reported 59.2% (157/265) an dfemales 30.7% (67/218). Further for agegroups 20-24 Males reported 27.7%

						(165/595) and females 12.5% (53/425)
Females	DHS	2009	10.1%			
Males	DHS	2009	18.9%			
16. Percentage of women and men aged 15-49 who have had sexual intercourse with more than one partner in the last 12 months.	DHS	2009	4.9%	417	8,518	
All Females	DHS	2009	1.3%	63	4,996	
All Males	DHS	2009	9.9%	348	3,522	
Females 15 – 19	DHS	2009	1.1%	11	1,016	
Females 20 – 24	DHS	2009	1.5%	12	767	
Females 25-29	DHS	2009	2.2%	14	658	
Females 30-39	DHS	2009	1.6%	21	1,342	
Females 40-49	DHS	2009	0.4%	5	1,213	
Males 15 - 19	DHS	2009	8.0%	55	689	
Males 20 - 24	DHS	2009	18.4%	94	511	
Males 25-29	DHS	2009	9.5%	44	462	
Mles 30-39	DHS	2009	10.1%	100	990	
Males 40-49	DHS	2009	6.4%	56	870	
17. Percentage of women and men aged 15-49 who had more than one sexual partner in the past 12 months reporting the use of a condom during their last sexual intercourse	DHS	2009	62.7%	258	411	
All Females	DHS	2009	47.9%	30	63	
All Males	DHS	2009	65.4%	228	348	
Females 15 -19	DHS	2009	-			fewer than 25 unweighted cases and has been suppressed
Females 20 - 24	DHS	2009	-			ditto
Females 25 - 49	DHS	2009	47.90		63	
Males 15-19	DHS	2009	85.8%	47	55	
Males 20-24	DHS	2009	70.4%	66	94	
Males 25-49	DHS	2009	57.7%		199	
18. Percentage of female and male sex workers reporting the use of a condom with their most recent client	BBSS	2009	61.4%	27	44	Data only available for female sex workers
<25 years	BBSS	2009	57.1%	12	21	
>25 years	BBSS	2009	65.2%	15	23	
19. Percentage of men reporting the use of a condom the last time they had anal sex with a male partner						***T****he BBSS indicator is the same, except that it distinguishes*

						between 3 classes of partners as specified below
Regular partner	BBSS	2009	79.7%	51	64	
<25 years	BBSS	2009	80.0%	16	20	
>25 years	BBSS	2009	79.5%	35	44	
Non-regular partner	BBSS	2009	75.0%	30	40	
<25 years	BBSS	2009	82.4%	14	17	
>25 years	BBSS	2009	69.9%	16	23	
Commercial partner	BBSS	2009	84.2%	16	19	
<25 years	BBSS	2009	100%	8	8	
>25 years	BBSS	2009	72.7%	8	11	
20. Percentage of injecting drug users reporting the use of a condom the last time they had sexual intercourse			Not Applicable			2008 BBSS survey findings suggest that this is not a major population
21. Percentage of injecting drug users reporting the use of sterile injecting equipment the last time they injected			Not Applicable			2008 BBSS survey findings suggest that this is not a major population
Impact						
22. Percentage of young women and men aged 15 – 24 who are HIV infected	Routine ANC Data	2008 2009	1.12% 1.11%	141 130	12587 11776	
23. Percentage of most-at-risk populations who are HIV infected						
23a.FSW	BBSS	2009	16.6%	30	181	
<25 years	BBSS	2009	6.6%	5	76	
>25 years	BBSS	2009	23.8%	25	105	
23 b. MSM	BBSS	2009	19.4%	21	108	
24. Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	Patient Monitoring System (NAPS)	2008	72.17%	358	496	*This is the average survival values of twelve cohorts after 12 months on treatment. The cohorts cover the period January to December 2008 .*
All Females	PMS	2008	74.6%	188	252	
All Males	PMS	2008	69.67%	170	244	

<15 years	PMS	2008	65.22%	15	23	
>15 years	PMS	2008	72.51	343	473	
25. Percentage of infants born to HIV-infected mothers who are infected	-	-	Will be modelled at UNAIDS from data reported at indicator 5			