Republic of Guyana

Country Report

STATUS OF THE NATIONAL RESPONSE TO THE UNGASS DECLARATION OF COMMITMENT TO HIV/AIDS

For the reporting period of January 2003 to December 2005

Guyana Presidential Commission on HIV/AIDS

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Message from the Minister of Health

I am convinced that Guyana has developed a comprehensive, multi-sector response to the HIV/AIDS crisis. The encouraging news is that implementation of the plan was far more effective in 2005 than in previous years. This has been due, in large part to the expansion of partnerships both locally and internationally revolving around the:

- exemplary Political leadership in the fight against HIV/AIDS
- evolution of a multi-sectoral approach
- involvement of employers
- involvement of PLWHA
- involvement of NGO's, FBO's and CBO's
- greater involvement by UNAIDS, PAHO/WHO, UNICEF, UNFPA, ILO and UNDP has ensured steady flow of technical assistance
- Global Fund Grant has ensured increased funding
- PEPFAR has ensured increased increase in funding
- CIDA ensured initial funding and technical assistance
- World Bank has ensured adequate funding and support for technical assistance

I believe Guyana have the potential to achieve the goal of universal access to prevention, care, treatment and support by 2010. I believe we will win the fight against HIV/AIDS.

This is Guyana's first UNGASS Report since the establishment of the PCHA in 2005 and we hope this and other reports will become written memoirs of the evolving unity in this fight against HIV/AIDS. But Guyana by itself will not win this battle. Globally we may have been late in our efforts, but we have now on board the relevant partners to support our National response to HIV/AIDS, under our own leadership. In an address to Members of Parliament of Guyana, I stated however "our response must be measured in small steps, in acts of kindness, in dedication, in commitment and great leaps in science and legislative innovations to protect people and their rights."

Remember, that failure to respond is a fatal response. Globally, we have already dug a reservoir of permanent share in the way we have handled the epidemic in the world and no matter what happens now, we can only redeem ourselves and win the war against AIDS.

FORWARD

"*While the enormity of the problem cannot escape us, there is a glimmer of hope," Dr. Leslie Ramsammy, Minister of Health, Guyana, 20 December 2002*

This report highlights the considerable and long-standing efforts of the Government of Guyana (GoG) to combat the devastating effects of HIV/AIDS. Since the successful implementation of the first National Strategic Plan (NSP) for HIV/AIDS (1999-2001), the GoG has fully recognized that HIV/AIDS not merely a public health crisis, but also a development and security challenge. HIV/AIDS was central to the Guyana National Development Strategy, the Poverty Reduction Strategy Paper, and the National Health Plan (2003-07). Strong political will to combat the HIV/AIDS epidemic resulted in the national policy on HIV/AIDS, which was passed by parliament in 1999; and in 2005, the GoG established the Presidential Commission on HIV/AIDS (PCHA) to provide the leadership and multi-sectoral coordination of the national response. These efforts successfully link the challenges of HIV/AIDS to the broader national health sector strategy and development goals.

To fully realize the strategic leadership and coordination role of the PCHA, a new NSP for HIV/AIDS (2006-10) has been developed with a monitoring and evaluation plan that will harmonise monitoring and evaluation efforts between partners and the GoG, and ensure that the impact of the HIV/AIDS epidemic and the effectiveness of the national response are adequately monitored.

The new NSP (2006-10) contains the following objectives:

- Empower citizens by providing universal HIV/AIDS care, support, education and awareness program;
- Promote behaviour changes that reduce risks among all people;
- Enable each citizen to know his or her HIV status by providing easy accessible counselling and testing;
- Provide easily accessible PMTCT services to all pregnant women and their families;
- Ensure safe blood supply through 100% screening;
- Provide treatment, care and support for OVC;
- Provide free treatment, care and support for all PLWHA;
- Create space for the involvement of all citizens and group in the multi-sector fight against HIV/AIDS, including space for the involvement of PLWHA;
- Reduce stigma and discrimination;
- Build capacity to the overall response;
- Improve the information system and strengthen the surveillance program;
- Strengthen the overall coordination of the HIV/AIDS program.

The report includes an overview of the HIV/AIDS Crisis in Guyana and the initiatives implemented to prevent and reduce HIV and AIDS. Through the submission of these core indicators to the United Nations (UN) General Assembly, the GoG is fulfilling its reporting requirements on its national HIV/AIDS programme.

ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
AIS	AIDS Indicator Survey
ANC	Antenatal Clinic
ART	Anti-retroviral Therapy
ARV	Anti-retroviral
BCC	Behavior Change Communication
BSS	Behavioral Surveillance Study
BBSS	Bio-Behavioral Surveillance Study
CAREC	Caribbean Epidemiology Center
CARICOM	Caribbean Community
CBO	Community-based Organization
CDC	US Centers for Disease Control and Prevention
CHRC	Caribbean Health Research Council
CIDA	Canadian International Development Agency
CRIS	Country Response Information System
CSO	Civil Society Organization
CSW	Commercial Sex Worker
DHS	Demographic and Health Survey
EU	European Union
FBO	Faith-based Organization
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GHARP	Guyana HIV/AIDS Reduction Project
GoG	Government of Guyana
GPC	Guyana Pharmaceutical Corporation
GUM	Genito-Urinary Medicine Clinic
GUYSUCO	Guyana Sugar Company
HBS	Household Budget Survey
HDI	Human Development Index
HMIS	Health Management Information System
HPC	Home and Palliative Care
HIV	Human Immunodeficiency Virus
HSDU	Health Sector Development Unit
IDB	Inter-American Development Bank
IEC	Information, Education, Communication
ILO	International Labor Organization
JICA	Japanese International Cooperation Agency
MARP	Most At-Risk Population
M&E	Monitoring and Evaluation
MDG	Millennium Development Goals
MICS	Multiple Indicator Cluster Survey
MoLHSSS	Ministry of Labour, Human Services and Social Security
MoH	Ministry of Health
MSM	Men Who Have Sex With Men
NAC	National AIDS Committee

ACRONYMS (*con't*)

NAP	National AIDS Program
NAPS	National AIDS Program Secretariat
NBTS	National Blood Transfusion Service
NGO	Non-Governmental Organization
NSP	National Strategic Plan
OPEC	Organization of Petroleum Exporting Countries
OVC	Orphans and Vulnerable Children
PAC	Secretariat of the Presidential AIDS Commission
PAHO	Pan-American Health Organization
PANCAP	Pan Caribbean Partnership Against HIV/AIDS
PCHA	Presidential Commission on HIV/AIDS
PEPFAR	US President's Emergency Plan for AIDS Relief
PLWHA	Person Living With HIV / AIDS
PMTCT	Prevention of Mother-to-Child Transmission (of HIV)
PRSP	Poverty Reduction Strategy Paper
RAC	Regional AIDS Committee
RHA	Regional Health Authority
SPA	Service Provision Assessment
TB	Tuberculosis
UNDP	United Nations Development Program
UNGASS	United Nations General Assembly Special Session
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNAIDS	United Nations Program on HIV/AIDS
UNTG	United Nation Theme Group
USAID	United States Agency for International Development
VCT	Voluntary Counseling and Testing
WB	World Bank
WHO	World Health Organization

I. **Status at a glance**

NATIONAL COMMITMENT			
UNGASS or UNGASS-related Indicator (*)	**Data Origin**	**Period**	**Value**
1. Amount of national funds spent on HIV/AIDS † Solely denotes amount of funds obligated to NAPS; however, this excludes significant financial resources obligated to the national HIV/AIDS care and treatment programme, PMTCT, blood safety, TB/HIV, HIV/AIDS policy strengthening, etc.	Guyana	2005	US$538,188†
2. National composite policy index	-	-	See annex 2
NATIONAL PROGRAMS			
3. Percentage of schools with teachers who have been trained in life-skills based HIV/AIDS education and who taught it during the last academic year	-	-	Insufficient data to report indicator in full; see 3.1 below
3.1 Number of teachers who have been trained in life skills based education in the past year *	Desk review	2005	715
4. Percentage of large enterprises/companies which have workplace policies and programs	-	-	Insufficient data to report indicator in full; see 4.1 below
4.1 Number of companies with HIV/AIDS workplace policies *	Survey	2005	16
5. Percentage of women and men with sexually transmitted infections at health care facilities who are appropriately diagnosed, treated, and counseled	-	-	Not reported
6. Percentage of HIV infected women receiving a complete course of ARV prophylaxis to reduce the risk of MTCT	Routine PMTCT program data	2005	31.66%
7. Percentage of people with advanced HIV infection receiving ARV	Special survey	2005	32.95%
8. Percentage of orphans and vulnerable children (OVC) whose household receive free basic external support in caring for the child	-	-	Insufficient data to report indicator in full; see 8.1 below
8.1 Number of units of service provided to OVCs *	Routine program data	2005	5209
9. Percentage of transfused blood units screened for HIV	-	-	Insufficient data to report indicator in full; see 9.1 below
9.1 Percentage of transfused blood units in the public sector screened for HIV *	Special survey	2005	100.0%
KNOWLEDGE AND BEHAVIOR			
10. Percentage of young women and men aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	BSS	2005	39.48%
All Females	-	-	44.46%
All Males	-	-	34.49%
All Rural	-	-	37.08%

Rural Females	-	-	41.70%
Rural Males	-	-	31.94%
All Urban	-	-	46.23%
Urban Females	-	-	51.41%
Urban Males	-	-	40.94%
11. Percentage of young women and men who have had sex before the age of 15	BSS	2005	21.12%
All Females	-	-	11.76%
All Males	-	-	30.48%
All Rural	-	-	20.21%
Rural Females	-	-	11.37%
Rural Males	-	-	27.86%
All Urban	-	-	25.18%
Urban Females	-	-	12.75%
Urban Males	-	-	37.07%
12. Percentage of young women and men who have had sex with a non-marital, non-cohabitating sexual partner in the last 12 months	AIS	2005	59.72%
All Females	-	-	39.46%
All Males	-	-	79.99%
All Rural	-	-	50.39%
Rural Females	-	-	31.54%
Rural Males	-	-	77.40%
All Urban	-	-	71.07%
Urban Females	-	-	59.42%
Urban Males	-	-	86.53%
13. Percentage of young people aged 15-24 reporting the use of a condom during sexual intercourse with a non-regular sexual partner	AIS	2005	66.36%
All Females	-	-	64.60%
All Males	-	-	67.60%
All Rural	-	-	Not available
Rural Females	-	-	Not available
Rural Males	-	-	Not available
All Urban	-	-	Not available
Urban Females	-	-	Not available
Urban Males	-	-	Not available
14. Ratio of current school attendance among orphans to that among non-orphans, aged 10-14	-	-	Not reported
IMPACT			
15. Percentage of young men and women aged 15-24 who are HIV infected	ANC Survey Data	2004	2.01%
16. Percentage of adults and children with HIV still alive 12 months after initiation of ARV therapy	Desk review	2005	77.69%
All Females	-	-	79.36%
All Males	-	-	76.22%

All 15+	-	-	78.21%
All <15	-	-	66.66%
Females 15+	-	-	66.66%
Females <15	-	-	80.00%
Males 15+	-	-	66.66%
Males <15	-	-	76.64%
17. Percentage of infants born to HIV infected mothers who are infected	Routine PMTCT program data	2005	28.0%

*UNGASS related indicator

II. Overview of the HIV/AIDS epidemic

Guyana has a population of 751,223 with a landmass of 216,000 km^2 extending along the northeastern shore of South America. It is the only English-speaking country in South America and along with Suriname are the only South American members of the Caribbean Community (CARICOM). Most of the population (86 percent) is concentrated in the coastal areas and 71.6 percent of the population lives in rural communities. Per capita GDP is estimated to be about US$597 (2000), among the lowest in the Americas, and its 107 rank in the Human Development Index (HDI) Report is the lowest of the English-speaking Caribbean. Administratively, Guyana is divided into 10 regions, with three coastal regions (3, 4, and 6) collectively accounting for 72 percent of the household population.

At the end of 2004, UNAIDS estimated that the prevalence of HIV infection among adults in Guyana was 2.5 percent (range 0.8 – 7.7 percent). The HIV/AIDS epidemic in Guyana is generalized as a HIV prevalence of greater than one percent has been consistently found among pregnant women attending antenatal care clinics. The cumulative incidence of AIDS in Guyana was 558.0 per 100,000 and a cumulative total of 4192 AIDS cases have been officially reported to the Ministry of Health (MoH) by the end of 2004. The first case of AIDS in Guyana was reported in 1987 and there has been a progressive increase in the reported number of cases. The major exposure category for HIV infection in Guyana is heterosexual contact, accounting for more than 80 percent of all cases. The current male to female ratio for HIV cases is 1.1, down from 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 groups (15-24), where there are more female than male cases. The most current data show an annual increase in HIV/AIDS-related deaths, and HIV-related illness is currently among the leading cause of death among persons 25-34 years old. Although AIDS cases have been reported from all regions in the country, region 4, which contains the capital city of Georgetown, has the highest cumulative incidence of AIDS (Table 1).

Although the HIV/AIDS epidemic is generalized, select high-risk subpopulations in Guyana are disproportionately affected. For instance, the overall prevalence of HIV infection among female sex workers was found to be 26.6 percent with a higher prevalence among those who work in downtown Georgetown. The prevalence of HIV infection among men-who-have-sex-with-men (MSM) in region 4 was 21.2 percent. For STI patients, the prevalence of HIV infection among males was 13.2 percent in 1992 and 17.3 percent in 2005, while for females it was 6.5 percent in 1993 and 16.9 percent in 2005. Since the first reported case, there has been a progressive increase in the incidence of HIV/AIDS in Guyana; however, the true rate of infection and absolute number of infected individuals is largely unknown because under-reporting is estimated to be as high as 60 percent and AIDS data are incomplete. UNAIDS estimates (2004) for Guyana suggest that at the end of 2003, there are about 11,000 people currently living with HIV/AIDS and about 1100 AIDS-attributable deaths annually.

HIV/AIDS continues to affect all segments of the population and all regions of Guyana. Data from the 2005 Behavioural Surveillance Surveys (BSS) that were conducted among youths, employees of the sugar industry, members of the uniformed services, female sex workers, and men-who-have-sex-with-men (MSM) suggested that the overall knowledge of HIV transmission is very high but a number of misconceptions regarding HIV transmission still prevail. For instance, among out-of-school youths, approximately 30 percent of all respondents believed that HIV can be transmitted via mosquitoes and close to one-quarter thought it could be transmitted through the sharing of a meal with an infected person. The report also suggested that there are attitudes and beliefs that may lead to significant levels of stigmatization and discrimination of HIV-infected persons. For example, approximately one-quarter

of the respondents reported they would not purchase food from an HIV-infected shopkeeper and approximately one-third believed that if they have a family member who is infected, their status should remain a secret. The BSS data also found that in all of the populations, the level of condom use was higher with non-regular than with regular partners and that the probability that a condom will be used during a sexual encounter decreases as familiarity increases. In addition, only a small proportion of all respondents reported knowing their HIV status.

Table 1. Cumulative incidence of AIDS by Region and Gender – 1989 to 2004

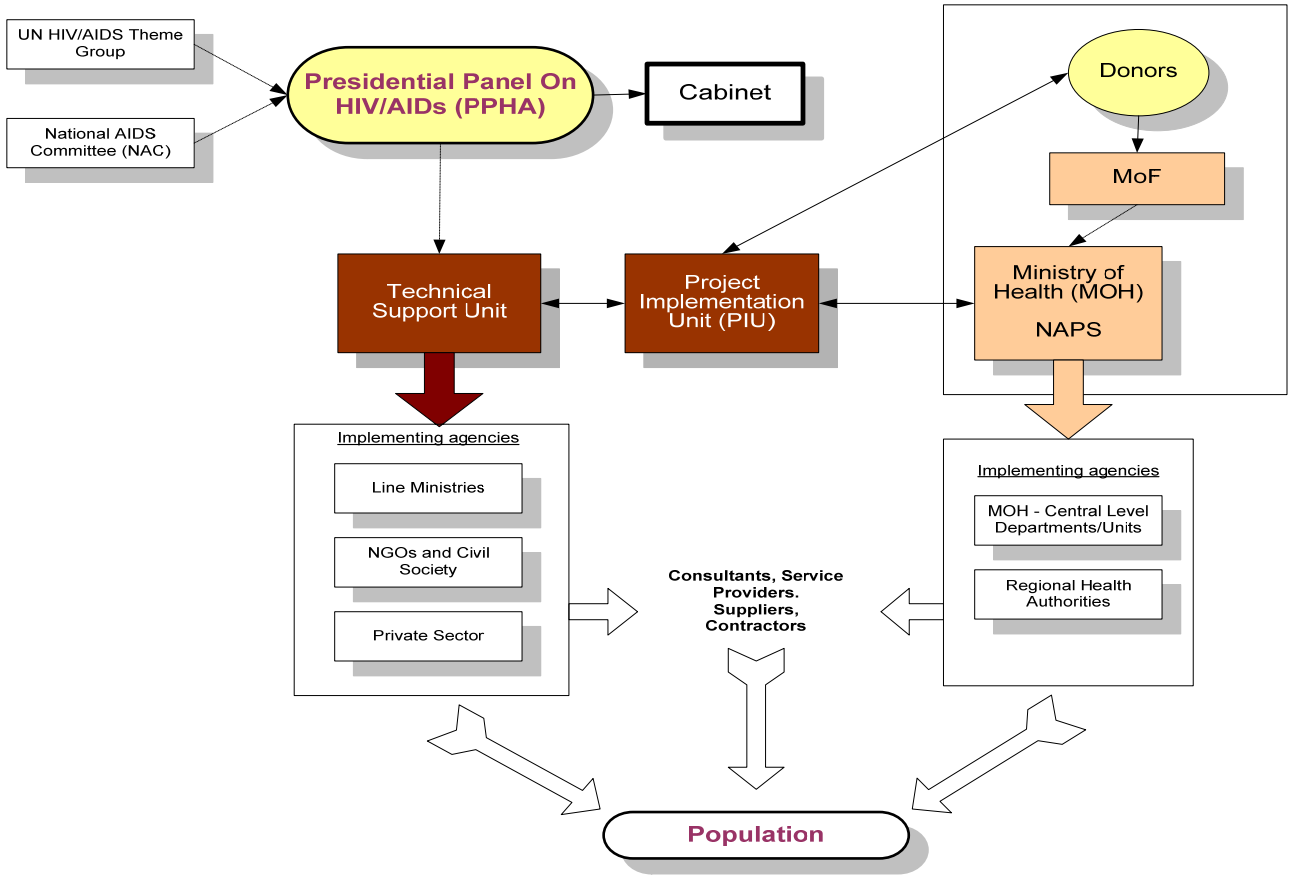
Region	Number of AIDS Cases				
	Male	Female	Unknown	Total	IR/100,000
I	10	9	0	19	78.3
II	23	18	1	42	85.3
III	164	132	7	303	294.0
IV	1785	1096	63	2944	948.7
V	55	47	1	103	196.5
VI	173	112	5	290	234.4
VII	23	17	1	41	233.0
VIII	3	2	0	5	49.5
IX	7	3	0	10	51.6
X	161	141	6	308	749.2
Unknown	84	35	8	127	-
Total	**2488**	**1612**	**91**	**4192**	**558.0**

III. National response to the HIV/AIDS epidemic

National Commitment

Since the first reported case of AIDS in 1987, the GoG has been cognizant of the devastating effects of HIV/AIDS on national development and poverty reduction efforts. To-date, the GoG has demonstrated strong political will in combating the HIV/AIDS epidemic. In 1989, the GoG 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 Program Secretariat (NAPS) was established and charged with the role of coordinating the national response to the HIV/AIDS epidemic. Regional AIDS Committees (RAC) were also established to coordinate and implement HIV/AIDS activities at the sub-national level. Figure 1 provides the current national multi-sectoral mechanism for responding to the HIV/AIDS epidemic in Guyana.

Figure 1. Guyana multi-sectoral response mechanism for HIV/AIDS



The 2001 Guyana Poverty Reduction Strategy Paper (PRSP) identified HIV/AIDS as an important focal area in the health sector and proposed a number of multi-sectoral actions to combat HIV/AIDS. A five-year National Strategic Plan (NSP) for HIV/AIDS was developed and implemented in 2002, and

in 2003 a national HIV/AIDS policy paper (originally passed by parliament in 1999) was revised to reflect changes in the coordinating mechanisms within the NAP and to provide a policy framework for providing access to free care and treatment for all persons living with HIV/AIDS (PLWHA). Since the implementation of the 2002 NSP for HIV/AIDS, resource requirements to expand HIV-related services throughout the country have become clearer and external financing for HIV/AIDS has greatly increased (Table 2). It is estimated that external financing for HIV/AIDS has surpassed domestic sources of funding by at least 50 percent since 2000. In this context, significant progress has been made by the GoG under the 2002-06 NSP. A pilot of prevention of mother-to-child-transmission (PMTCT) services was conducted at eight sites in November 2001 and the GoG has committed to an expansion to 62 PMTCT services sites by December 2006. Since 2002, antiretroviral (ARV) drugs have been locally produced by New Guyana Pharmaceutical Corporation (GPC) and a treatment program with free ARVs has been available at the Genito-Urinary Medicine (GUM) Clinic since April 2002. The MoH has committed to a plan to scale up antiretroviral treatment (ART), with a targeted enrollment of about 6400 people by the end of 2008. The GoG response to HIV/AIDS is augmented by the independent activities of numerous non-governmental organizations (NGOs), community-based organizations (CBOs), faith-based organizations (FBOs), the private sector, and civic organizations.

Guyana is at a critical point in its HIV/AIDS response where its National Programme is faced with a number of significant new challenges. Following the success of the 2002-06 NSP for HIV/AIDS and mindful of the greater funding levels for HIV/AIDS, a new five-year NSP (2006-10) for HIV/AIDS was written in late 2005. In addition, in order to strengthen the implementation and coordination of the various components of the NSP across all sectors, the GoG established the Presidential Commission on HIV/AIDS (PCHA) in 2005 under the aegis of the Office of the President. The Commission is chaired by the President of Guyana and operates in a coordination role for all HIV/AIDS-related activities nationally. Over the last two years, through a combination of strong political leadership and the use of National Strategic Plan, the GoG has been able to mobilize significant resources to support the HIV/AIDS programs. In order to maximize the impact of the available resources and minimized duplication, the GoG has committed to strengthening the "Three Ones" approach and applying the recommendations of the Global Task Force Team on improving AIDS coordination among multilateral and bilateral institutions.

Table 2. Donors/Partners in the fight against HIV/AIDS (2005)

Donor/Partner	Major Area of Assistance	Funding
UNAIDS	Co-ordinate HIV/AIDS activities of the UN Theme Group; strengthen capacity for UNGASS reporting	Ongoing
UNDP	Policy development; mainstreaming HIV/AIDS in instrument development	Ongoing
UNICEF	Strengthen coordination and M&E of PMTCT services; support knowledge of women, children, and health care workers; support care and treatment and support for HIV positive children; youth-friendly health services; support for orphans and vulnerable children	$1.5 mil (est) (2006-10)
PAHO/WHO	Technical assistance for HIV/AIDS prevention, TB, and malaria control; small grants scheme	Ongoing

	management; surveillance and laboratory support	
CAREC	Technical support in surveillance, monitoring and evaluation, and laboratory	Ongoing
PANCAP	Technical support through regional institutions	Ongoing
CIDA	HIV/AIDS prevention; communicable disease control; public health management system; stigma and discrimination; TB prevention and malaria	CN$5mil (2003-07)
EU	Strengthen national capacity to respond to HIV/AIDS	Limited
World Bank	Grant for HIV/AIDS program; support institutional capacity strengthening; monitoring, evaluation, and research; strengthening civil society	US$10 mil (2004-08)
UNFPA-OPEC Fund	Caribbean-Central America project for HIV prevention among youth as part of adolescent health program	US$450,000 (2004-08)
GFATM	Multifaceted support for HIV/AIDS prevention, treatment, care and support; training; HMIS; upgrade laboratory capacity; strengthen surveillance system; quality care for persons living with HIV/AIDS; expand care and treatment; reduce stigma and discrimination; condom social marketing	US$27.2 mil (2004-08) Phase 1 and Phase 2
IDB	Caribbean Regional support for HIV/AIDS	US$6.7mil (2004-08)
JICA	Small grant for HIV/AIDS	Limited
GATC	HIV/AIDS project targeting commercial sex workers	Limited
US Emergency Plan	Coordinated, comprehensive HIV/AIDS support for care and treatment, prevention, and laboratory support. Main partners are CDC and USAID	US$34mil (est) (2004-08)

Prevention, Knowledge and Behaviour Change

In response to a critical need to create behavioral interventions to prevent HIV infections, the MoH has created a National Behaviour Change Communication (BCC) Strategy, which serves as a roadmap to guide the GoG, donors, and other stakeholders in a process of planning appropriate and timely behavioural interventions in a coordinated and transparent manner. The activities of the MoH within the BCC Strategy are supported by a number of international organizations, such as PAHO, CDC, CSIH, FXB, UNDP, UNAIDS, UNICEF, ILO, CIDA, and CAREC. NGOs and FBOs also have a central role at the community and regional level in educating, informing and building awareness among the Guyanese population about HIV/AIDS.

A one-year BCC campaign was launched in November 2005 by the MoH with funding from The Global Fund. The BCC campaign aims to promote safer sexual practices, reduce stigma and discrimination, encourage early HIV testing, and increase community involvement in HIV/AIDS treatment and care. At the end of 2006, 200,000 brochures on HIV/AIDS highlighting condom use and early HIV testing will be distributed. Posters, television and radio advertisements, with a series of half-hour television documentaries on HIV/AIDS have been produced. There has also been an AIDS-in-our-community magazine produced, which is targeting youth and the general community. At the regional level, Guyana HIV/AIDS Reduction Project (GHARP) sales promoters in Regions 3,4,5,6,7, and 10 promote condom use through interpersonal communication. A significant highlight of these prevention efforts was the high level of prevention knowledge (ability to cite at least three prevention interventions – Abstinence, Be faithful, or use a Condom) documented in the 2005 BSS. Seventy-one percent of Out-of-School Youths, 62 percent of In-School Youths, 75.3 percent of GUYSUCO workers, 67.1 percent of MSM, and 63.1 percent of Female Commercial Sex Workers were able to identify at least three prevention interventions.

The 2005 BSS documented a relatively early mean age at first sex of 16 years; however, there was a high level of condom use among non-regular partners at last sex, particularly in urban areas. About 1.7 million male condoms were distributed in 2004 through a focused effort on increasing access to condoms by high-risk groups with the strategic placement of condom vending machines at high traffic locations, e.g., bars and clubs. It is believed that mass media communication and inter-personal communication have played a significant role in the rapid increase of condom use over the past two years. The target for 2006-07 is to distribute 7 million male condoms.

Treatment, Care and Support

Guyana's response at the beginning of the HIV/AIDS epidemic was a medical one, with a primary focus on the treatment of opportunistic infections (OIs). In April 2002, the national treatment programme was launched at one treatment facility in Georgetown using locally manufactured antiretrovirals (ARVs). At that time, the GoG and the MoH declared universal access to free care and treatment for HIV/AIDS. Guyana is still firmly committed to universal access to prevention, treatment, and care and support by 2010. By the end of 2005, the national treatment network has expanded to include nine treatment sites across the country, including a unique collaboration with two private sector facilities. A total of 1202 patients are actively being treated with ARV therapy in 2005. First and second line medications are available for all adults and children. National treatment guidelines for the management of adult and pediatric HIV infections were developed in 2004, and updates were completed in September 2005. Treatment guidelines were also available for the prophylaxis and management of OIs in adults and children.

Laboratory support for the treatment programme have been strengthen over the years resulting in all patients currently having access to CD4 testing and other required laboratory tests for monitoring and analyses. There is also limited access to viral load testing with plans to increase capacity by the expansion of laboratory infrastructure and investments in targeted training of laboratory personnel. Diagnosis of OIs has expanded with a wider range of available testing including TB culture, India Ink Stain, and modified Zeil Nelson.

Care and support services are provided directly by the MoH through its national Home Based Care (HBC) Programme. This is provided in collaboration with local NGOs, who receive funding from different sources, including the US Emergency Plan for HIV/AIDS and the MoH through the World

Bank HIV/AIDS Prevention and Control Project. Various forms of support are provided to patients, including different counseling sessions (disclosure, couples, nutritional, etc.), and referral for social and economic support. Social and economic support systems are provided by the Ministry of Social Services and the NGOs. In addition to routine psychosocial support, the treatment sites have support groups for PLWHA. These support groups benefit from HIV/AIDS/STI and other health issues, educational sessions, as well as skill building such as fabric designing, floral arrangement, among other skills.

Collaboration with the National Tuberculosis Control Programmes have been made stronger over time resulting in a national TB/HIV coordinating mechanism, which oversees TB/HIV activities.

Orphans and Vulnerable Children

The HIV/AIDS epidemic continues to result in increasing numbers of children being orphaned and made vulnerable by HIV/AIDS. Currently, there are an estimated 4000 orphans and vulnerable children (OVCs) in Guyana. The GoG has adopted a definition in which HIV/AIDS and related illnesses are but one contributor to vulnerability. *Orphans* are defined as children, under 18 years, of whom at least one or both of their biological parents have died through causes such as HIV/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 chronicle illness and those who are living without any caregivers at all. Furthermore, OVCs 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.

Policy and planning efforts on OVC are reflected through the initiation of a national OVC policy document as well as a National Plan of Action (NPA) for OVC by the Ministry of Labour, Human Services and Social Security (MoLHSSS) in 2005. The national policy provides a broad framework for national strategies on OVC. The NPA ensures the operational framework on OVC in line with the 2006-10 NSP on HIV/AIDS. A PMTCT operational plan, which would contribute to prevention of orphaning, is also being developed. All three documents are projected to be finalised in 2006.

During 2005 efforts to support children outside of family care were accelerated, with the aim to allow them stay at home and thus to prevent the number of children in institutions from rising. The MoLHSSS and the MoH, with support from UNICEF and the Global Fund, initiated a programme looking at quality of care in institutions. It includes the establishment of minimum standards for institutional care and the formalization of foster care systems, which are expected to be completed in 2006.

A growing number of OVC and their households are being reached with basic external support from the MoLHSSS and civil society organizations, including medical, school, psychosocial, nutritional and financial support. The MoLHSSS provides 25,000 children with school uniforms, and 3,000 families receive direct financial aid. In 2005, around 5,000 families received psychosocial counseling. From the end of 2004 to the end of 2005, GHARP provided 5,209 units of the above-mentioned services to OVC in Guyana. Between April and September of 2005, they also reached out to an additional 345 OVC.

IV. Major challenges faced and actions needed to achieve the UNGASS goals/targets

There are several major challenges faced by the GoG and the National AIDS Programme to achieve the UNGASS goals. These include limited human resource capacity at the national and regional levels, timely procurement of drugs and commodities, limited storage and nascent distribution networks, adequate coordination of implementing partners, quantifying and mobilizing national resources in a timely manner, limited service provision in remote areas, and the availability of adequate financial resources.

Attrition rates are affected by several push and pull factors. One such factor is wages in the Guyana public sector, which is usually lower that what is offered in the private sector. Human resource capacity is also affected as a result of a relatively high attrition of skilled and experience professionals from Guyana into the Caribbean Common Market, or more developed economies, such as the United States and Great Britain. The Common Market allows skilled, licensed professionals from one Caribbean country to practice in other Caribbean countries. As a result, there are limited barriers to emigration of health care professionals from Guyana. Additionally, wages in Guyana are much lower than that what is offered in most neighboring Caribbean countries. The internal migration from rural areas in the interior to urban areas on the coast makes it difficult for facilities in remote areas to adequately staff. In areas where there is adequate staff, there are limited resources to provide continuous medical education to ensure good quality service

Timely procurement of various health commodities is essential to ensuring adequate supplies for existing facilities and for future expansion. Despite an increase in commodities required for the expansion of HIV/AIDS care and treatment programs, adequate storage for pharmaceutical products at the MoH bond is limited.

Coordination of implementing partners is performed through various mechanisms such as the thematic groups, programmatic subcommittees, CCM and Presidential commission. This should continue to be a work in progress, as current mechanism are continuously reviewed and strengthen in light of current needs and future requirements.

Increasing service provision to remote areas is necessary to ensure equity and access to service for some vulnerable groups. However, limited human resources and other constraints have slowed the expansion of services to many of these areas and vulnerable groups. Strengthening collaboration between the public sector and NGOs and other agencies to fill some of these niches is central to increasing quality service provision for PLWHA.

Lastly, continuous support for program expansion is important. With the completion of the costing 2006 -10 NSP for HIV/AIDS it will be necessary to collaborate with many donors to secure the resources necessary to properly implement the Plan.

V. Support required from country's development partners

Developmental partners have played an important role in the expansion of the program. The GoG looks forward to this continued support, particularly in the mobilization of resources for Guyana. The aim is to develop a secure mechanism for adequate funding of the national HIV/AIDS programme in the short- and medium-term.

Support will also be needed to counteract or mitigate the effects of the high attrition rates of skill and experience health care professionals. Assistance will be needed not only as technical assistance, but to develop creative mechanisms and approaches for addressing this major constraint in a pragmatic way.

Improved coordination would lead to improved implementation. This is often facilitated by better information flow among partners and between partners and the GoG. Partners have to be more accommodating to requests for information, particularly as it relates to HIV-related programming and strategic information.

VI. Monitoring and evaluation environment

The response by the GoG and other key stakeholders to contain the HIV/AIDS epidemic in Guyana is targeted and a number of programs within the various program areas are being implemented. This has led to the generation of a number of different monitoring reports by various agencies in an uncoordinated manner. The need for the establishment of a functional national Monitoring and Evaluation Unit has been recognized by the national authorities and efforts are being made for the establishment of this unit. Definitive steps that has been taken in this regard includes the development of a national Monitoring and Evaluation Plan with a set of standardized indicators and the establishment of a Monitoring and Evaluation Reference Group, which meets on a regular basis. Efforts are also being made to share M&E results by the various agencies involved in implementation.

ANNEXES

ANNEX 1

Consultation/preparation process for the national report on monitoring the follow-up to the *Declaration of Commitment on HIV/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	Yes
Civil society organizations	Yes
People living with HIV/AIDS	Yes
Private sector	Yes
United Nations organizations	Yes
Bilaterals	Yes
International NGOs	Yes
Others (please specify)	No
(please specify)	

3) Was the report discussed in a large forum? Yes

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

4) Are the survey results stored centrally? Yes

5) Are data available for public consultation? Yes

Name / title: Dr. Frank Anthony, M.D., M.P.H.

Date: _____

Signature: _____

ANNEX 2

National Composite Policy Index Questionnaire (through CRIS)

National composite policy index – 2006

Country: Republic of Guyana

Name of the National AIDS Committee officer in charge: Dr. Frank Anthony, M.D., M.P.H.

Signed by: _____

Address:

Tel:

Fax:

E-mail:

Date:

Report of National Composite Policy Index Questionnaire

Indicator	Data Origin	Period	Value
Part A			
A.1. Strategic Plan			
A.1.1. Country has developed a national multi-sectoral strategy/action framework to combat HIV/AIDS	Guyana	2005	Yes
A.1.2. Country has integrated HIV/AIDS into its general development plans		2005	Yes
A.1.3. Country has evaluated the impact of HIV and AIDS on its economic development for planning purposes		2005	Yes
A.1.4. Country has a strategy/action framework for addressing HIV and AIDS issues among its national uniform services, military, peacekeepers and police		-	Not assessed
A.1.R. Strategy planning efforts in the HIV and AIDS programmes overall rating		2003	7
		2005	10
A.2. Political Support			
A.2.1. The head of the government and/or other high officials speak publicly and favourably about AIDS efforts at least twice a year		2005	Yes
A.2.2. Country has a national multisectoral HIV and AIDS management/coordination body recognized in law? (National AIDS Council or Commission)		2005	Yes
A.2.3. Country has a national HIV and AIDS body that promotes interaction between government, people living		2005	Yes

with HIV and AIDS, the private sector and civil society for implementing HIV and AIDS strategies/programmes			
A.2.4. Country has a national HIV and AIDS body that is supporting coordination of HIV-related service delivery by civil-society organizations		2005	Yes
A.2.R. Political support for the HIV/AIDS programme overall rating		2003	9
		2005	10
A.3 Prevention			
A.3.1. Country has a policy or strategy that promotes information, education and communication (IEC) on HIV and AIDS to the general population		2005	Yes
A.3.2. Country has a policy or strategy promoting HIV and AIDS related reproductive health education for young people		2005	Yes
A.3.3. Country has a policy or strategy to promote information, education and communication and other preventive health interventions for most-at-risk populations		2005	Yes
A.3.4. Country has a policy or strategy to expand access, including among most-at-risk populations to essential preventive commodities. (These commodities include, but are not limited to, access to confidential voluntary counseling and testing, condoms, sterile needles and drugs to treat sexually transmitted infections.)		2005	Yes
A.3.4.R. Policy efforts in support of prevention overall rating		2003	8
		2005	9
A.3.5. Prevention activities have been implemented in 2003 and 2005 in support of the HIV-prevention policy/strategy		2003	Yes
		2005	Yes
A.3.6. Efforts in the implementation of HIV prevention programmes overall rating		2003	7
		2005	8
A.4. Care and support			
A.4.1. Country has a policy or strategy that promotes information, education and communication (IEC) on HIV and AIDS to the general population		2005	Yes
A.4.2. Activities have been implemented under the care and treatment of HIV and AIDS programmes		2003	Yes
		2005	Yes
A.4.3. Country has a policy or strategy to address the additional HIV and AIDS-related needs of orphans and vulnerable children (OVC)		2005	Yes

A.4.R2. Efforts to meet the needs of orphans and other vulnerable children overall rating		2003	0
		2005	7
A.5. Monitoring and Evaluation			
A.5.1. Country has one national Monitoring and Evaluation (M&E) plan		2005	In Progress
A.5.2. The Monitoring and Evaluation plan includes something		2005	Yes
A.5.3. There is a budget for the Monitoring and Evaluation plan		2005	Yes
A.5.4. There is a Monitoring and Evaluation unit or department		2005	Yes
A.5.6. Individual agency programmes have been reviewed to harmonize Monitoring and Evaluation indicators with those of your country		2005	Yes
A.5.7. Degree (low or high) with which UN, bi-laterals, other institutions are sharing Monitoring and Evaluation results			7
A.5.8. The Monitoring and Evaluation unit manages a central national database		2005	Yes
A.5.9. There is a functional Health Information System		2005	Yes
A.5.10. There is a functional Education Information System		2005	In Progress
A.5.11. Country publishes at least once a year an evaluation report on HIV and AIDS, including surveillance reports		2005	Yes
A.5.12. Extent to which strategic information is used in planning and implementation		2005	8
A.5.13. In the last year, training in Monitoring and Evaluation was conducted		2005	Yes
A.5.R. Monitoring and Evaluation efforts of the HIV and AIDS programme overall rating		2003	5
		2005	7
Part B			
B.1. Human Rights			
B.1.1. Country has laws and regulations that protect people living with HIV and AIDS against discrimination		2005	Yes
B.1.2. Country has non-discrimination laws or regulations which specify protections for certain groups of people identified as being especially vulnerable to HIV and AIDS discrimination		2005	Yes
B.1.3. Country has laws and regulations that present obstacles to effective HIV prevention and care for most-at-risk populations		2005	Yes
B.1.4. The promotion and protection of human rights is explicitly mentioned in an HIV and AIDS policy/strategy		2005	Yes

B.1.5. The Government has, through political and financial support, involved vulnerable populations in the governmental HIV-policy design and programme implementation		2005	Yes
B.1.6. Country has a policy to ensure equal access, between men and women, to prevention and care		2005	Yes
B.1.7. Country has a policy to ensure equal access to prevention and care for most-at-risk populations		2005	Yes
B.1.8. Country has a policy to prohibiting HIV screening for general employment purposes (appointment, promotion, training, benefits)		2005	Yes
B.1.9. Country has a policy in ensure that HIV research protocols involving human subjects are reviewed and approved by a national/local ethical review committee		2005	Yes
B.1.10. Country has a monitoring and enforcement mechanism		2005	N/A
B.1.11. Members of the judiciary have been trained/sensitized to HIV and AIDS and human rights issues that may come up in the context of their work		2005	Yes
B.1.12. Legal support services are available in the country		2005	Yes
B.1.13. There are programmes designed to change societal attitudes of discrimination and stigmatization associated with HIV and AIDS to understanding and acceptance		2005	Yes
B.1.R. Policies, laws and regulations in place to promote and protect human rights in relation to HIV and AIDS overall rating		2005	6
B.1.R2. Effort to enforce the existing policies, laws and regulations overall rating		2005	6
B.2. Civil society participation			
B.2.1. Extent to which civil society has made a significant contribution to strengthening the political commitment of top leaders and national policy formation		2005	4
B.2.2. Extent to which civil society representatives have been involved in the planning and budgeting process for the National Strategic Plan on HIV and AIDS or for the current activity plan (attending planning meetings and reviewing drafts)		2005	5
B.2.3. Extent to which the complimentary services provided by civil society to areas of prevention and care are included in both the National Strategic plans and reports		2005	7
B.2.4. Country has conducted a National Periodic review of the Strategic Plan with the participation of civil society		2005	Yes
B.2.5. Extent to which country has a policy to ensure that HIV and AIDS research protocols involving human subjects are reviewed and approved by an independent		2005	Yes

national/local ethical review committee in which people living with HIV and caregivers participate			
B.2.R. Efforts to increase civil-society participation overall rating		2003	2
		2005	6
B.3. Prevention			
B.3.1. Prevention activities have been implemented in 2003 and 2005 in support of the HIV-prevention policy/strategy		2003	Yes
		2005	Yes
B.3.R. Efforts in the implementation of HIV prevention programmes overall rating		2003	4
		2005	8
B.4. Care and support			
B.4.1. Activities have been implemented under the care and treatment of HIV and AIDS programmes		2003	Yes
		2005	Yes
B.4.R. Efforts in care and treatment of the HIV/AIDS programme overall rating		2003	6
		2005	8
B.4.2. Country has a policy or strategy to address the additional HIV and AIDS-related needs of orphans and other vulnerable children (OVC)		2005	Yes
B.4.R2. Efforts to meet the needs of orphans and other vulnerable children overall rating		2003	3

ANNEX 3

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