2014

GLOBAL AIDS RESPONSE PROGRESS REPORT

Republic of Guyana

Reporting Period: January 2012- December 2013

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Presidential Commission on HIV and AIDS

FOREWORD

This Country Progress Report 2012-2013 provides us with an opportunity to assess the progress made towards achieving the bold targets set in June 2011 Political Declaration on HIV and AIDS and its MDG goal 6 of halting the spread and beginning the reversal of HIV and AIDS. In addition, the recently concluded mid-term assessment conducted in 2013 provided a snapshot of the status of the 8 applicable targets and allowed us to understand the degree of achievements and the challenges encountered in achieving these targets. Indeed, I am proud that Guyana's HIV response is well positioned to report on many of these, foremost being the elimination of mother to child transmission (eMTCT).

Guyana embarked on bold and progressive initiatives over the last 20 years in its HIV response. PMTCT has been a trailblazer from the inception with the integration of these services within the primary health care and antenatal services. The rapid expansion of the programme to achieve high national coverage with testing and ART treatment resulted in reduced perinatal transmission rates. More recently the revision of the HIV treatment guidelines to formally ensure Option B Plus is provided to all HIV positive pregnant women is another indication of the national commitment to the eMTCT.

The body of this report provides a preponderance of evidence that points to the further stabilizing of the HIV epidemic. There has been an annual reduction in the number of HIV cases reported since 2009 and the number of AIDS-related deaths.

HIV prevention programmes continue with National Coverage and much cognizance of the importance of reaching the key populations at higher risk with the prevention package of services. To this end, there has been greater involvement of these communities in the programming and decision-making, more Civil Society Organisations are engaged, and HIV testing and other prevention initiatives have been refocused to reach these populations. Similarly the national programme continues to benefit from the contributions of people living with HIV. I am pleased that this reporting period notes the significant enhancement of the involvement of Gplus, the network of Guyanese living with and affected by HIV.

HIV testing also continued among other populations and we continue to report high coverage among the TB and antenatal populations

The HIV treatment programme reported Universal Access for ART in the previous reporting period. We have expanded the number of fixed care and treatment sites from 19 in 2012 to 22 in 2013. We continue to identify and place more persons on treatment. There were 4,054 persons actively receiving antiretroviral therapy (ART) at the end of 2013, compared to 3,717 in 2012, representing a 2.7 percent increase. Evidently we have maintained Universal access for ART in this reporting period with stable 12-months ART survivability and retention rates.

Guyana's progressive approach to HIV treatment with full endorsement of the principle of treatment as prevention will ensure that people living with HIV receive ART earlier, significantly improving their quality of life.

Guyana is fortunate to have a truly multi-sectoral and inclusive response. We have partnered with the business community, non-governmental organizations, faith-based organizations, line ministries, disciplined services, youth, sex workers, men who have sex with men and donor agencies to bring together human, financial and material resources to mount this truly multi-sectoral response. Our progress highlighted in this report is a result of these partnerships developed, nurtured and strengthened over the years.

Despite our achievements, we must remain vigilant and must harness the collective energy of our people to aggressively tackle barriers to universal access, such as stigma and discrimination, archaic laws, geography, and attrition of highly qualified staff. It is imperative that we continue to deliver evidence-informed strategies and activities to achieve prevention, particularly among the most vulnerable – youth, sex workers, men who have sex with men, drug users and persons with disabilities. We will work assiduously in reducing the vulnerabilities for HIV as we comprehensively address the social determinants of health and tackle the difficult and challenging issues of gender based violence. We must work in understanding the factors affecting adherence and develop strategies to improve this. We must continually work towards improving the quality of life of people living with HIV.

In the face of the dwindling resources for the HIV response globally we will focus our efforts at ensuring full integration of our programmes since offering services in isolation expends much more resources. We will continue to mobilize resources to increase services to the populations at greater risk for HIV, to ensure that every Guyanese knows his or her HIV status, that no baby is born HIV positive and that persons living with HIV receive care of the highest standard. Our collective efforts and continued strong political commitment and leadership are imperatives.

Guyana National HIV Strategic Plan (HIVision 2020) presents a clear and visionary road map for guiding the response over the next 8 years. I am confident that this guidance with our combined efforts will ensure that Guyana sees the end of AIDS.

I wish to thank all of partners, donors, technical, civil society organizations, the community of people living with HIV and all others for working with us in turning the tide of this epidemic. I look forward to your continued support as we aim for an AIDS free generation in our country.

Honorable Dr. Bheri Ramsaran
Minister of Health

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ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
AIS	AIDS Indicator Survey
ANC	Antenatal Clinic
ART	Antiretroviral Therapy
ARV	Antiretroviral
BCC	Behavior Change Communication
BMS	Breast Milk Substitute
BSS	Behavioral Surveillance Survey
BBSS	Biological and Behavioral Surveillance Survey
CAGI	Consultative Association of Guyanese Industry
CARICOM	Caribbean Community
CBOs	Community-based Organizations
CCM	Country Coordinating Mechanism
CCPA	Child Care Protection Agency
CDC	US Center for Disease Control and Prevention
CEDAW	Convention to Eliminate all forms of Discrimination Against Women
CFNI	Caribbean Food and Nutrition Institute
CIDA	Canadian International Development Agency
CHAT	Country Harmonization and Alignment Tool
CRIS	Country Response Information System
CSIH	Canadian Society for International Health
CSW	Commercial Sex Worker
CSO	Civil Society Organization
DHS	Demographic Health Survey
DOTS	Direct Observed Therapy
DNA	Deoxyribonucleic Acid
FAO	Food and Agriculture Organization
FBO	Faith-based Organization
FCSW	Female Commercial Sex Worker
FITUG	Federation of Independent Trade Unions of Guyana
FSWs	Female Sex Workers
GBCHA	Guyana Business Coalition on HIV/AIDS
GBV	Gender Based Violence
GCF	Guyana Cycling Federation
GDF	Guyana Defence Force
GDP	Gross Domestic Product
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GHARP	Guyana HIV/AIDS Reduction Project
GIZ	Deutsche Gesellschaft fur Internationale Zusammenarbeit
GoG	Government of Guyana
GUD	Genital Ulcer Disease
GDF	Guyana Defence Force
GDP	Gross Domestic Product
GDS	Genital Discharge Syndrome
GFCHA	Guyana National Faith Coalition on HIV and AIDS
GoG	Government of Guyana
GSWC	Guyana Sex Worker Coalition
GTUC	Guyana Trades Union Congress
GUM	Genito-Urinary Medicine
GUYBOW	Guyana Rainbow Association
GUYSUCO	Guyana Sugar Corporation
HAART	Highly Active Antiretroviral Therapy
HAPSAT	HIV/AIDS Programme Sustainability Analysis Tool
HBC	Home-Based Care
HBsAg	Hepatitis B Surface Antigen
HFLE	Health and Family Life Education
HDI	Human Development Index
HIV	Human Immuno-deficiency Virus
HIV DR	HIV Drug Resistance
HPV	Human Papilloma Virus
HSDU	Health Sector Development Unit
HTLV	Human T-Lymphotropic Virus
IDU	Injecting Drug Users
IEC	Information, Education, Communication
ILO	International Labor Organization
IMAI	Integrated Management of Adult and Adolescent Illness
ISY	In School Youth
JFA	Justice for All
LEEP	Electrosurgical Excision Procedure
LGBT	Lesbian, Gay, Bisexual and Transgender
LOSH	Labor, Occupational Safety and Health
MARPs	Most At-Risk Populations
MERG	Monitoring and Evaluation Reference Group
M&E	Monitoring and Evaluation

MIS	Management Information Systems
MMU	Materials Management Unit
MoLHS&SS	Ministry of Labor, Human Services and Social Security
MoH	Ministry of Health
MOU	Memorandum of Understanding
MSM	Men Who Have Sex with Men
MSW	Male Sex Worker
MTCT	Mother-to-Child-Transmission
MYCS	Ministry of Youth Culture and Sports
NAC	National AIDS Committee
NAP	National AIDS Programme
NAPS	National AIDS Programme Secretariat
NBTS	National Blood Transfusion Service
NCTC	National Care and Treatment Centre
NCPI	National Commitments and Policy Instrument
NGOs	Non Governmental Organizations
NLID	National Laboratory for Infectious Disease
NPHRL	National Public Health Reference Laboratory
NTP	National Tuberculosis Programme
NSP	National Strategic Plan
OIs	Opportunistic Infections
OSY	Out of School Youth
OVC	Orphans and Vulnerable Children
PAHO-WHO	Pan American Health Organization-World Health Organization
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
PMS	Patient Monitoring System
PMTCT	Prevention of Mother-to-Child-Transmission
PRSP	Poverty Reduction Strategy Paper
RACs	Regional AIDS Committees
SASOD	Society against Sexual Orientation Discrimination
SCMS	Supply Chain Management Systems
SHARE	Strategic HIV/AIDS Responses in Enterprises
SPSS	Statistical Package for Social Sciences
SRH	Sexual and Reproductive Health
STIs	Sexually Transmitted Infections
SVA	Single Visit Approach
SW	Sex Workers
TB	Tuberculosis
TUC	Trades Union Congress
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNDAF	UN Development Assistance Framework
UNDP	United Nations Development Programme
UNESCO	United Nations Education Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Sitting
UNICEF	United Nations Children Fund
UNV	United Nations Volunteers
USAID	United States Agency for International Development
VCT	Voluntary Counseling and Testing
VIA	Visual Inspection with Acetic Acid
WBMAP	World Bank Multi-country AIDS Programme
WAD	World AIDS Day
YES	Youth Educators Safe Guarding over Workforce

I. STATUS AT A GLANCE

Inclusiveness of Stakeholders in the Report Preparation

The preparation of the Guyana AIDS Response Progress Report (GARPR) for the 2012-2013 reporting period was led by a broad-based country team comprising key stakeholders involved in the national response to HIV (see Annex 6). Oversight for the preparation was provided by the Monitoring and Evaluation Reference Group (MERG) which comprised monitoring and evaluation representatives from key partner agencies involved in the national response to HIV. The country team held ongoing meetings to discuss the report preparation process, including the determination of the list of interviewees for the National Commitments and Policy Instrument (NCPI) and also the list of indicators that Guyana would report on.

The inputs of key stakeholders including bilateral and donor partners, technical agencies, Civil Society Organisations, and non health Line Ministries, were also solicited during the desk review process in the GARPR preparation by way of request and subsequent submission of their individual progress reports for incorporation in the overall GARPR. During this period, there was ongoing verification of data provided and continuous communication with partners. The NCPI interviews also provided a unique opportunity for key stakeholders to contribute towards the writing of 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. Prior to the finalization of the GARPR, a broad-based consensus meeting was held with key stakeholders (see Annexes 4 and 6) to obtain feedback on the draft GARPR that was circulated prior to the meeting. This feedback along with further feedback received after the meeting, were taken into consideration in finalizing the GARPR for submission to UNAIDS.

Status of the Epidemic

Based on the UNAIDS 2012 estimation exercise, Guyana's adult HIV prevalence is 1.3%. There has been a steady reduction in the prevalence of HIV among the general population from 2004, when it was 2.4 percent.

The MoH surveillance data continues to show a decline in the number of reported HIV cases. At the end of 2012, a total of 820 cases of HIV were diagnosed while in 2013, 758 cases were diagnosed. This represents a continuous reduction from 1,176 HIV cases in 2009.

While the trend since 2010 has shown more reported HIV cases among females compared to males, the male female ratio once again increased in 2013 to 1.01 showing a slightly higher proportion of males compared to females (MoH Surveillance data). In terms of notified AIDS cases, the male female ratio continues to show a higher proportion among males with a ratio of 1.5 in 2012 and 1.4 in 2013.

The highest number of reported cases of HIV in 2012 and 2013 occurred in the 20-49 age-group accounting for 79.1% (649/820) and 78.6% (596/758) of all cases respectively. It is important to note that the number of HIV cases under 1 year old has remained below 5 since 2008. Children aged 0-4 accounted for 1.7% of the reported HIV cases in 2012 while in 2013, this decreased to 0.7%. Persons 50 years and above accounted for 9.9% of all cases of HIV in 2012 while in 2013 this increased to 14.1% (MoH Surveillance Unit).

The proportion of all deaths attributable to AIDS has been declining steadily. In 2002, the proportion was 9.5%, declining to 8% in 2003, 7.1% in 2004, 6.9% in 2005, 4.2% in 2009 further decreasing to 3.6% in 2010 (MoH Statistics Unit).

HIV prevalence among pregnant women was 1.7% in 2012 and 1.9 % in 2013 (PMTCT programme reports). In 2012, 1.7% (3/180) of babies born to HIV-positive mothers were infected with HIV and 2.1% (4/191) were infected in 2013 (PMTCT programme reports). HIV prevalence among blood donors remained constant at 0.3 % in 2012 and 2013 (Blood Bank Programme data).

The Biological and Behavioral Surveillance Survey (BBSS) 2009 showed a sharp decrease in the HIV prevalence among female sex workers (FSWs), from 26.6 percent (BBSS, 2005) to 16.6 percent (BBSS, 2009). In contrast only a slight decrease was observed among MSM, from 21.2 percent (BBSS, 2005) to 19.4 percent (BBSS, 2009). Notwithstanding these encouraging signs, female sex workers and men who have sex with men are disproportionately affected by the epidemic. A new BBSS has commenced in 2014 and the results of this survey will be reported in the next GARPR.

Data for the period 2005 – 2013 indicate that the rate of TB/HIV co-infection fluctuated between 36 % in 2005 to 31% in 2012 with a reduction to 25 % in 2013.

While declining over the last three years, Region 4 continues to be disproportionately affected by the epidemic with 63.1% (586/925) of all HIV cases in 2012 and 75.4% of all cases in 2013 (MoH Surveillance Unit). The notification of these cases in Region 4 can be attributed to the concentration of HIV prevention services including counseling and testing, and information and education programmes in that Region.

Policy Response

During the reporting period of January 2012 – 31 December 2013, work was ongoing in drafting regulations that sought to enforce the National Workplace HIV and AIDS Policy that was launched in 2009. The drafting of the regulations to enforce this policy was done through collaborative efforts between the Ministry of Labour, MoH, the Attorney General's Chambers, ILO and other key stakeholders. The Draft Regulations were finalized in November 2013, gazetted in December 2013, and tabled in Parliament in January 2014.

Guyana and Suriname signed a Declaration in 2013 to cooperate on health matters, particularly in relation to migrant and mobile populations in both countries. The Migrant Project is a PANCAP project that focuses on prevention of HIV transmission and the provision of migrant friendly and culturally appropriate health services, with specific

emphasis on migrant and mobile populations. The declaration served to elevate the status of cooperation from border collaboration to a bi-national commission and also to explore a border Guiana shield intervention with French Guiana and Brazil. Priority areas for follow-up include the establishment of an integrated HIV programme and strengthening of joint surveillance for communicable diseases.

Under the migrant initiative two assessments were conducted on the legal and policy framework influencing access to HIV services by migrants and on improving access to HIV services for migrant populations. The recommendations of these assessments are under consideration.

During the reporting period a National Youth Policy was drafted and is currently under review for finalization. This policy seeks to protect the rights of adolescents and youth, including those living with HIV.

During 2013, a Sexual and Reproductive Health (SRH) policy and strategy were drafted with inputs from a broad-based technical committee chaired by the Chief Medical Officer and supported by legal personnel. This policy and strategy and will be finalized in the 2014

The MoH's Sexual and Domestic Violence Protocol for health care workers was finalized during the reporting period. This protocol focuses on elements of immediate response to victims of sexual abuse that are the responsibility of health care providers: medical care for sexual assault patients; validating and addressing patients' health concerns; minimizing the trauma patients may experience; promoting healing and; maximizing the collection and preservation of evidence from patients for potential use in the legal system.

An Orphans and Vulnerable Children (OVC) Policy was prepared and approved by the Ministry of Labor, Human Services and Social Security (MOLHS&SS) during the previous reporting period.

The stigma and discrimination policy targeting the health care setting developed in the last reporting period, was implemented during this reporting period. This was done through ongoing training of health care workers to provide services in a non discriminatory, non judgmental and friendly manner. Stigma-free status was assigned to these facilities with ongoing refresher training and monitoring.

Programmatic Response

"HIVision 2020 is underpinned by the principles of Human Rights, Gender Equality, Inclusiveness, Accountability, Value for Money and Sustainability. I wish to call on all Guyanese and all our friends and partners to jointly make the vision of Zero New HIV Infections, Zero Discrimination and Zero AIDS-Related Deaths, come true." These were the words of the Honourable Minister of Health, Dr. Bheri Ramsaran on 9 August 2013 during the launch of HIVision 2020, Guyana's National HIV Strategic Plan (2013 – 2020). The programmatic response of the Government of Guyana has therefore been grounded in these fundamental principles throughout the HIV response.

HIVision 2020 replaced the previous strategic plan for 2007–2011. The vision of HIVision 2020 is "To eliminate HIV in Guyana." Its goal is "To reduce the social and economic impact of HIV and AIDS on individuals and communities and ultimately the development of the country." HIVision 2020 focuses on five priority areas: Coordination; Prevention; Treatment, Care and Support; Integration and: Strategic Information. The development of HIVision 2020 was led by a steering committee that involved a wide cross section of stakeholders and supported by technical working groups for each priority area.

The period under review was characterized by increased coverage of HIV-related services in the areas of prevention, treatment, care and support. The period also saw emphasis being placed on strengthening monitoring, evaluation and surveillance systems in addition to increased use of strategic information to inform programming and quality improvements.

Prevention

The Prevention of Mother to Child Transmission (PMTCT) programme is now poised to report on the elimination of mother to child transmission of HIV in alignment with the MDG goals. A proactive case management system ensures that HIV infected pregnant women and HIV exposed children are followed through pregnancy and 18 months postpartum, for each HIV positive pregnant woman and exposed infant, and appropriate care, treatment and support are provided. The PMTCT programme was expanded to increase coverage through 183 PMTCT sites in 2012 and 187 sites in 2013. The uptake of voluntary counseling and testing (VCT) by pregnant women attending these sites was 93.3% in 2012 with an increase to 97.2 in 2013. The national HIV treatment guidelines were revised during the period to include the introduction of Option B Plus for pregnant HIV positive women.

VCT services expanded from 38 fixed sites and 2 mobile units in 2006 to 62 fixed sites in 2013, spread across all ten administrative regions and 1 mobile unit serving the hinterland communities. Heightened VCT efforts have seen a steady increase in the number of persons seeking testing with a total of 113,139 tests done during the reporting period. Special emphasis was placed on reaching key populations at higher risk through outreaches. Initiatives directed at increasing male testing such as Valentine's Day couples testing, have seen significant increases in the number of persons being tested during the period. This one-day initiative in 2012 achieved 3% of the overall total number of persons tested for the entire year while in 2013, the proportion tested was 6.1% of the annual total.

Information, education and communication along with behaviour change communication, continued to be a prominent part of the national strategy to reach the masses with HIV/AIDS prevention messages. The national response included a number of mass media advertisements on television and radio during major events that had large audiences countrywide. Prevention efforts sought to maximize the use of annual commemorative days such as World AIDS Day, Valentine's Day, International Women's Day and also national events such as GUYEXPO (Guyana's premier exhibition) and Mashramani (local carnival) which provided unique opportunities to increase HIV awareness among the general public and promote healthy lifestyles. Special attention was paid to key populations at higher risk, particularly men who have sex with men (MSM) and female sex workers (FSWs). Youth were also specifically targeted.

A total of 12,703,274 condoms, including male and female condoms, were distributed through the national programme free of cost. This was approximately double the amount distributed through this source during the previous reporting period. The private sector sold 1,024,918 condoms at a reduced price representing a small increase from the previous reporting period.

There was special focus on key populations at higher risk during the reporting period. A total of 1,631 individuals from this group, specifically including MSM and sex workers (SWs), were reached with an appropriate package of HIV prevention services in 2012 and 1,929 reached in 2013. Miners and loggers in the hinterland regions also benefitted from HIV testing and sensitization sessions. Outreach programmes were also held in the prisons and work commenced for the third Biological and Behavioural Surveillance Survey among key populations at higher risk.

A priority of the workplace programme during 2012 and 2013 was the integration of gender based-violence and male norms and behaviors into the training curricula, in view of their relationship with HIV. An estimated 1,599 employees were sensitized on gender issues in relation to HIV and AIDS during the reporting period.

The proportion of units collected by the blood bank from voluntary blood donors increased from 90% (6,941/7,712) of all units collected in 2012 to 96% (10,697/11,148) of all units collected in 2013 (Blood Bank Reports). All units were screened for infectious markers and the proportion of units that tested positive for HIV remained at a constant of 0.3%.

The VIA (Vaginal Inspection with Acetic Acid) screening programme continued at 17 health care facilities including all HIV treatment sites. VIA was done through onsite administration using a Single Visit Approach (SVA). During the period, 12,905 persons received VIA of which 1,105 required follow up and 1,049 accepted treatment.

The delivery of the Health and Family Life Education (HFLE) programme as a timetabled subject was expanded to 110 secondary schools compared to 70 during the last reporting period, with approximately 8,000 students reached with life skills education and 78 teachers trained to deliver the programme. This pilot programme underwent an in-depth evaluation during the reporting period to assess its effectiveness.

The national programme reintroduced the Youth Friendly Health Services Initiative in Primary Health Care facilities for the purpose of providing sexual reproductive health services to adolescents. This service also included the establishment of special antenatal clinics for pregnant teenagers.

STI treatment and prevention efforts continued with the launching of an STI campaign to target the 15-29 age group that was found to have the highest prevalence of STIs. The objectives of the campaign were to build awareness of STI screening and prevention and to increase health seeking behaviour. The campaign also included a specific focus on gender. A total of 858 persons were trained in STI syndromic management during the reporting period. A cross-sectional study to assess STI seroprevalence and risk behaviours was also conducted within the military population.

There was timely provision of post-exposure prophylaxis (PEP) to 40 reported cases in 2012 and 69 cases reported in 2013.

During the period 24,696 health care workers and other individuals received training in a wide range of subject areas (see Annex 1) including: stigma and discrimination; clinical management of HIV; STI syndromic management; peer education; DNA-PCR training; PMTCT; VCT; PEP; laboratory techniques; adolescent health; health and family life education; gender based violence; HIV basics; parenting skills; Integrated Management of Adolescent Illness; Tuberculin Skin Testing; TB/HIV co-infection management; home based care; care and support for orphans and vulnerable children; nutrition and HIV; life skills and; monitoring and evaluation.

Treatment

A total of 4,635 persons were listed on the register in the care and treatment programme at the end of 2012 with 3,717 receiving antiretroviral therapy (ART) (NAPS programme reports). By the end of 2013, 4,896 persons were listed with 4,054 on ART. These services were delivered through 19 fixed sites in 2012 with the number of sites increasing to 22 in 2013.

The diagnostic capacity of the treatment and care programme continued to be supported by the National Public Health Reference Laboratory (NPHRL) which provides CD4, viral load and DNA PCR testing. CD4 testing was also provided by two regional laboratories (New Amsterdam, Region Six, and Linden, Region Ten) and three additional sites with CD4 testing capacity were introduced during the reporting period – Bartica, Suddie, and West Demerara Hospitals.

The construction of the Materials Management Unit warehouse was completed in November, 2012. This was followed by successful migration of the operations from the old facility to the new warehouse and stabilization of operations there. The new warehouse was officially opened in 2013 and through effective forecasting and compliance with supply planning, there were no stock outs of ARVs.

Care and support

The provision of care and support to persons living with and affected by HIV was intensified. A total of 1,236 new persons were enrolled into the Home Based Care (HBC) programme in 2012 and 1104 new persons were enrolled in 2013 (NAPS programme reports). The psychological, social and nutritional needs of persons living with HIV (PLHIV) were addressed through monthly support group activities and the distribution of 8,524 nutritional food hampers through the food bank to eligible PLHIV. Public Assistance for eligible PLHIV was also provided through the Ministry of Human Services & Social Security.

A national PLHIV conference was held to explore ways and means of ensuring the sustainability of PLHIV support groups through personal empowerment and income generation in light of decreasing donor funding. The theme of the conference was "Motivation Towards Positive Living, Supporting Sustainability".

The Home Based Care (HBC) and the OVC programmes contributed to improving the well being of 1,345 children who were provided with a minimum of one care service during the period. A total of 1,378 children in children's homes and those at treatment sites benefitted from school amenities, recreational activities and furnishings. The capacity of children's homes to provide care services to children was strengthened country-wide during the period.

Monitoring and Evaluation

Throughout the reporting period Monitoring and Evaluation (M & E) of the national response continued with oversight provided by the MERG. Achievements included target setting for HIVision 2020, the MDG Mid Term Review, rollout of a revised HIV case surveillance system, and revision of the M & E system for HIV testing to facilitate reporting on key populations. HIV prevalence estimates were also developed, work commenced on the third BBSS among key populations, a client satisfaction survey was conducted, and the antenatal care survey protocol was finalized. Throughout the period, M & E personnel received ongoing training to adequately equip them to perform their respective functions.

Table 1*: Overview of Indicator Data*

Targets	Indicator	Data origin	Period	Value	Remarks
Target 1: Reduce sexual transmission of HIV by 50 percent by 2015 General Population	**1.1** Percentage of young women and men aged 15-24 who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconception about HIV transmission	DHS	2009	51.10%	No new survey
	1.2 Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15	DHS	2009	13.60%	No new survey
	1.3 Percentage of adults aged 15-49 who have had sexual intercourse with more than one partner in the last 12 months	DHS	2009	4.90%	No new survey
	1.4 Percentage of adults aged 15-49 who have had more than one sexual partner in the past 12 months who report the use of a condom during their last intercourse ***Note**: There were fewer than 25 unweighted cases for females 15-19 and 20-24, 25-29, 30-39, 40-49, and have been suppressed in DHS report.*	DHS	2009	-	No new survey
	All Females	DHS	2009	-	

Targets	Indicator	Data	Period	Value	Remarks
	All Males	DHS	2009	65.50%	
	1.5 Percentage of women and men aged 15-49 who received an HIV test in the past 12 months and know their results	DHS	2009	24.80%	No new survey
	1.6 Percentage of young people aged 15-24 who are living with HIV *Note: Data not disaggregated by sex*	ANC Programme data	2013	1.9%	Data reported is from the total pregnant woman population and is not only reflective of women 15-24. Additionally, the reported data reflects women who were newly tested HIV positive during the reporting period as well as women with known HIV positive status who accessed ANC services.
Sex Workers	**1.7** Percentage of sex workers reached with HIV prevention programmes	BBSS	2009	21.4%	
	1.8 Percentage of sex workers reporting the use of a condom with their most recent client	BBSS	2009	94.20%	No new survey
	1.9 Percentage of sex workers who have received an HIV test in the past 12 months and know their results	BBSS	2009	83.90%	No new survey
	1.10 Percentage of sex workers who are living with HIV	BBSS	2009	16.60%	No new survey
Men who have sex with men	**1.11** Percentage of men who have sex with men reached with HIV prevention programmes	BBSS	2009	-	**No new survey**. This indicator is measured by two questions. Unable to calculate composite since one if the questions was not asked in the BBSS 2009.
	Percentage who know of place in community to access HIV test	BBSS	2005	17.20%	This question was not asked in the 2009 BBSS
	Percentage who have been reached by a Peer Educator within the last 12 months	BBSS	2009	68.70%	The Peer Educator Programme entails distribution of condoms, IEC materials and referral to HIV testing sites.
	1.12 Percentage of men reporting the use of a condom the last time they had anal sex with a male partner				No New survey
	Regular partner	BBSS	2009	79.70%	

Targets	Indicator	Data	Period	Value	Remarks
	Non-regular partner	BBSS	2009	75.00%	
	Commercial partner	BBSS	2009	84.20%	
	1.13 Percentage of men who have sex with men that have received an HIV test in the past 12 months and know their results	BBSS	2009	72.30%	No new survey
	1.14 Percentage of men who have sex with men who are living with HIV *Note: Data not disaggregated by age group*	BBSS	2009	19.40%	No new survey
Target 2: Reduced transmission of HIV among people who inject drugs by 50 percent by 2015	**2.1** Number of syringes distributed per person who injects drugs per year by needle and syringes programmes	-	-		Target 2 is Not applicable to Guyana
	2.2 Percentage of people who inject drugs who reported the use of a condom at last sexual intercourse	-	-		
	2.3 Percentage of people who inject drugs who reported using sterile injecting equipment the last time they injected	-	-		
	2.4 Percentage of people who inject drugs that received an HIV test in the past 12 months and know their results	-	-		
	2.5 Percentage of people who inject drugs who are living with HIV	-	-		
Target 3: Eliminate mother-to-child transmission of HIV by 2015 and substantially reduce AIDS-related maternal deaths	**3.1** Percentage of HIV-positive pregnant women who received antiretrovirals to reduce the risk of mother-to-child transmission	ANC Programme Report	2013	109%%	Numerator is derived from care and treatment programme. Data includes women receiving Single dose nevirapine from PMTCT. Denominator derived from Spectrum file. Using programme data, coverage is 73.5%
	3.2 Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth	NPHRL & PMTCT data	2013	32.5%	62 samples were processed within 2 months; 170 between 2 to 12 months and 19 samples beyond 12 months.
	3.3 Mother-to-child transmission of HIV modeled	Modeled using Spectrum	2013	1.59%	

Targets	Indicator	Data	Period	Value	Remarks
Target 4: Have 15 million people living with HIV on antiretroviral treatment by 2015	**4.1** Percentage of eligible adults and children currently receiving antiretroviral therapy	NAPS Programme Reports Modeled using Spectrum	2013	79.1%	4054 persons received treatment in 2013. Denominator reflects HIV Estimates for adults and children needing ART in 2013
	4.2 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 16 cohorts after 12 months on treatment. The cohorts cover the period January to December 2010.*	Patient Monitoring System (NAPS	2013	79.70%	
Target 5. Reduce tuberculosis deaths in people living with HIV by 50 percent by 2015	**5.1** Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV	Chest Clinic Programme Reports	2013	49.00%	Numerator reflects number of co-infected patients at TB sites who commenced ART. Programme coverage reflects 70% Denominator is WHO published data for 2012
Target 6: Reach a significant level of annual global expenditure (US22-24 billion) in low and middle-income countries	**6.1** Domestic and international AIDS spending by categories and financing sources	-			NASA report is appended to the online submission of the GARPR. The Global disbursement figures are available, the details for the various technical areas are currently being finalized. Final report available by May 2014
Target 7: Critical Enablers and Synergies with Development Sectors	**7.1** National Commitments and Policy Instruments (prevention, treatment, care and support, human rights, civil society involvement, gender, workplace programmes, stigma and discrimination and monitoring and evaluation)	Key informant interviews			Responses have been inputted in the online reporting tool
	7.2 Proportion of ever-married or partnered women aged 15-49 who experienced physical violence from a male intimate partner in the past 12 months				 Data not available. The DHS 2009 asked about women's attitude towards wife beating: 16.3% of women 15-49 agree with at least one specified reason.

Targets	Indicator	Data	Period	Value	Remarks
	7.3 Current school attendance among orphans and non-orphans aged 10-14	-			Indicator relevant but data not available
	7.4 Proportion of the poorest households who received external economic support in the last 3 months	-			Indicator relevant but data not available
Target 8: Eliminating Stigma & Discrimination	**8.1** Percentage of women and men aged 15–49 who report discriminatory attitudes towards people living with HIV	DHS 2009	women men	20.10% 23.90%	

II. OVERVIEW OF THE AIDS 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 lives in rural communities (a new population census was launched in 2012 and a preliminary report is to be released within the first half of 2014).

The 2002 census also showed almost equal numbers of males and females. The 5-9 age group comprised the highest proportion (12.9%) of the population followed by the 0-4 age group (11.8%). The 20-49 age range combined (the productive sector) comprised 42.2% of the population.

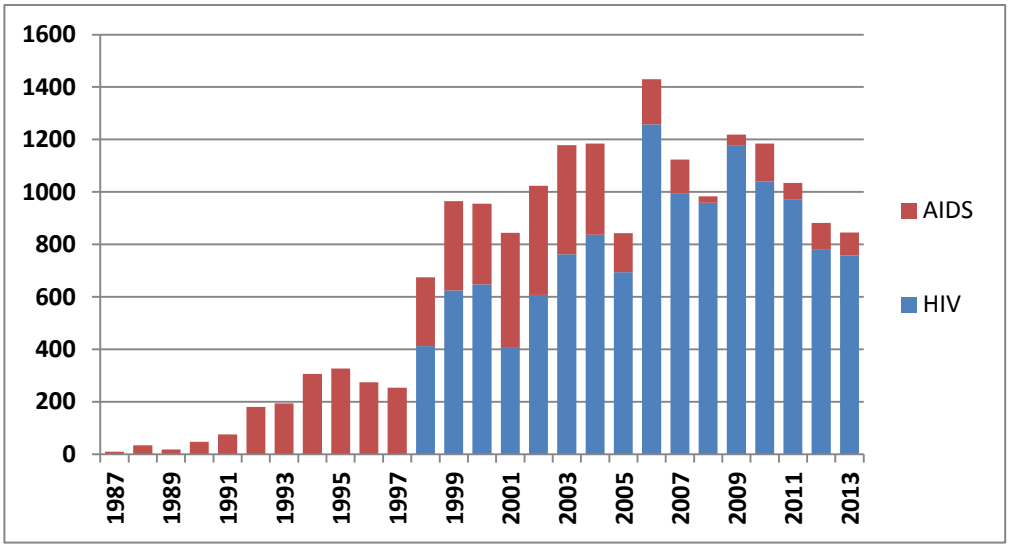
Guyana is divided into 10 administrative regions, with four coastal regions (3, 4, 5, and 6) collectively accounting for 72.0 percent of the total household population. Per capita GDP is US$2,869.00 (GBoS, 2011 rebased series) and the country is ranked as a medium development country moving up one point on the Human Development Index (HDI) scale to 118 of 187 countries in 2013 (HDI Report).

The first case of AIDS was reported in 1987 followed by a progressive increase in the number of reported cases. The epidemic in Guyana is considered generalized, as an HIV

prevalence of greater than 1.0% has been consistently found among the general population. Since the introduction of VCT in 1998 up until 2008, there has been a fluctuating trend in the number of HIV cases diagnosed with a peak of more than 1,200 infections being diagnosed in 2006. From 2009 through 2013, there has been a continuing reduction in new cases both for HIV as well as AIDS.

In 2012 there were 820 reported cases of HIV and 105 reported cases of AIDS. In 2013, there was a reduction with 758 cases of HIV and 88 cases of AIDS. Figure 1 shows the number of annual cases of HIV and AIDS during the period 1987 – 2013.

Figure 1: ***Annual Cases of HIV and AIDS, 1987-2012 (to be updated to include 2013)***



TRENDS IN THE EPIDEMIC

Distribution of HIV and AIDS Cases According to Sex

The male to female ratio for HIV cases has fluctuated over the past four years. While HIV was initially more prevalent among males, by 2003 the annual number of reported cases of HIV was higher among females and remained so until 2009 when the male female ratio was 1.1. The situation was again reversed from 2010 to 2012 when more females were diagnosed with HIV, with a male to female ratio of 0.9 in 2012. In 2013, the male to female ratio once again showed a higher number of males infected with a ratio of 1.01 (MoH Surveillance Unit). This trend is illustrated in Table 2.

Table 2*: Trends in Reported Cases of HIV and AIDS by Sex 2002 – 2013*

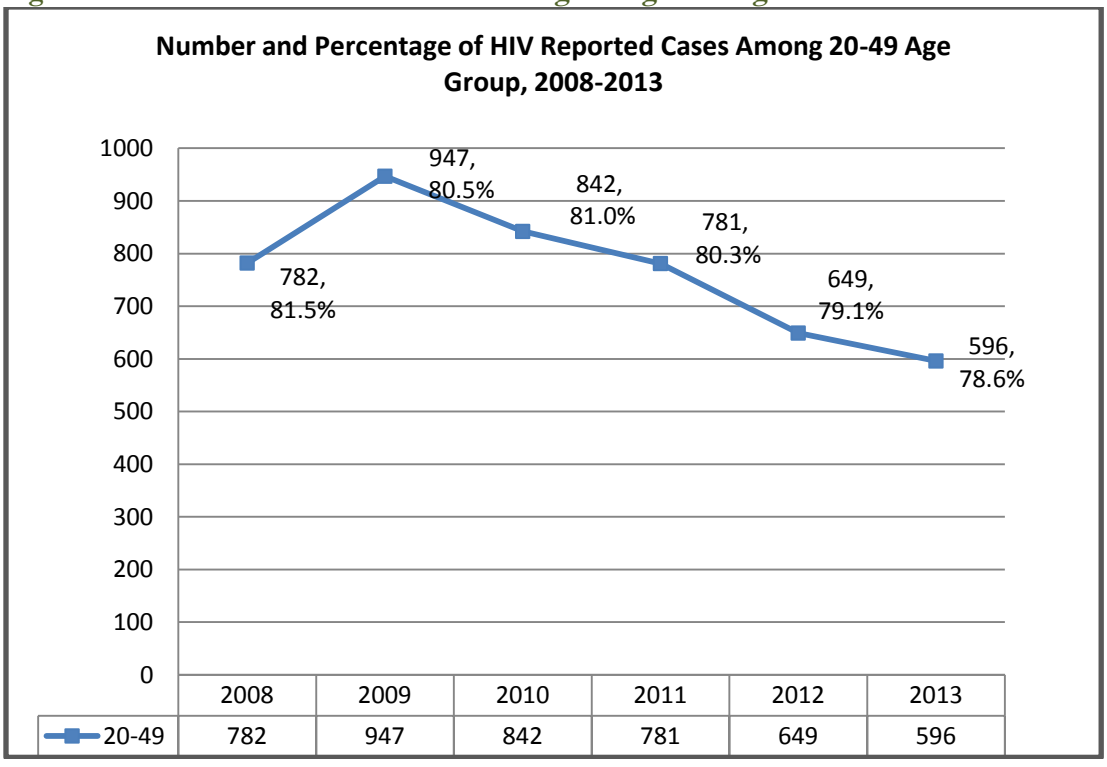
CLASSIFICATION		2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
HIV	Male	301	339	368	325	591	422	446	600	449	432	393	378
	Female	268	368	408	421	626	531	490	567	547	517	424	374
	Unknown	39	55	61	36	41	40	23	9	43	23	3	6
	Total	**608**	**762**	**837**	**809**	**1,258**	**993**	**959**	**1176**	**1039**	**972**	**820**	**758**
	Sex Ratio	1.1	0.9	0.9	0.8	0.9	0.8	0.9	1.1	0.8	0.8	0.9	1.01
AIDS	Male	243	232	117	58	99	80	14	21	86	41	61	51
	Female	146	163	204	77	68	49	8	21	58	21	42	37
	Unknown	26	22	27	7	5	1	2	1	2	0	2	0
	Total	**415**	**417**	**348**	**142**	**172**	**130**	**24**	**43**	**146**	**62**	**105**	**88**
	Sex Ratio	1.7	1.4	0.6	0.8	1.5	1.6	1.8	1.0	1.5	2.0	1.5	1.4
TOTAL HIV & AIDS		**1,023**	**1,179**	**1,185**	**951**	**1,430**	**1,123**	**983**	**1,219**	**1,185**	**1,034**	**925**	**846**

Source: Ministry of Health Surveillance Unit and NAPS

Distribution of HIV Cases According to Age Groups

The HIV epidemic continues to affect the productive sector of Guyanese society. At the end of 2012, a total of 649 cases were reported within the combined age group of 20-49 which accounted for 79.1% of all HIV cases reported during the year. In 2013, there was a slight decrease with a total of 596 cases reported within this age group accounting for 78.6% of all cases. Figure 2 and table 8 below show the trend within this age range during the period 2008-2013.

Figure 2: *HIV Prevalence Within the 20-49 Age Range During 2008-2013*



Source: MoH Surveillance Unit

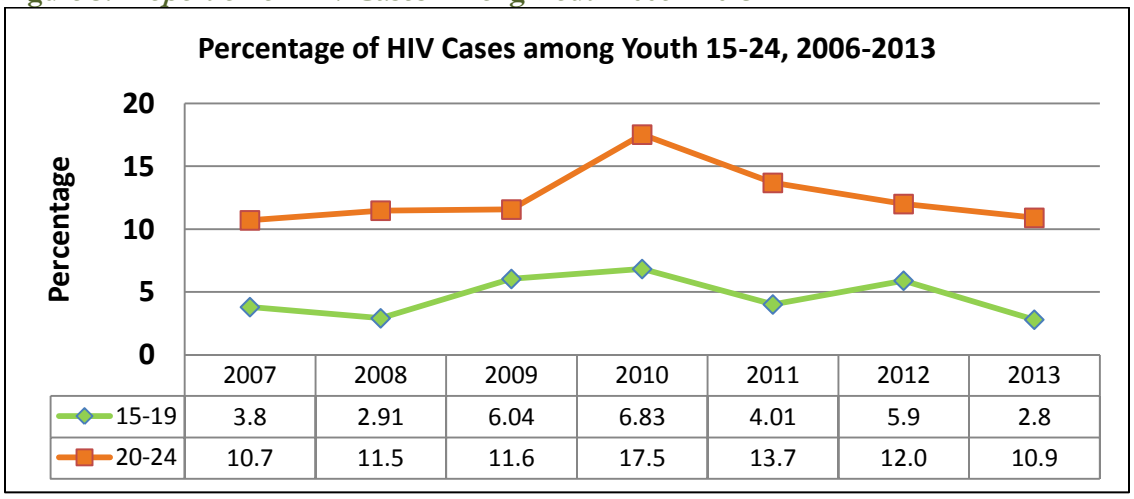
Table 3 shows the distribution of HIV cases among the various age groups during the period 2008 - 2013

Table 3: ***Distribution of HIV Cases by Age Groups 2008 – 2013***

Age Group	2008	2009	2010	2011	2012	2013
Under 1	0	1	1	4	3	1
1-4	5	9	5	5	10	4
5-14	15	14	9	9	11	6
15-19	28	71	71	39	48	21
20-24	110	136	182	133	98	83
25-29	166	161	133	129	125	103
30-34	173	204	193	176	139	110
35-39	157	198	142	148	141	127
40-44	106	143	124	112	91	104
45-49	70	105	68	83	55	69
50-54	48	48	42	55	41	45
55-59	21	30	27	40	22	31
60+	33	25	21	21	21	31
Unknown	27	31	21	18	15	23
Total	**959**	**1,176**	**1,039**	**972**	**820**	**758**

Figure 3 below shows the HIV prevalence among the 15-19 and 20-24 age groups during the period 2006-2013. As indicated, this prevalence fluctuated between 3.6% and 2.8% in the former age group and 12% and 10.9% in the latter age group.

Figure 3: ***Proportion of HIV Cases Among Youth 2006 – 2013***



Source: Ministry of Health Surveillance Unit

Geographic Distribution of HIV and AIDS

Region 4, with 41.3% of the general population, continues to account for the largest proportion of reported HIV cases with a proportion of 63.3% in 2012 and 75.4% in 2013. The geographic distribution of HIV cases is illustrated in Table 4.

Table 4*: Proportion of HIV Cases by Region 2006 – 2013*

Region	Total Population	% of population	2006	2007	2008	2009	2010	2011	2012	2013
1	24,275	3.2	0.2	0.1	0.5	0.9	0.6	0.8	1.5	0.83
2	49,253	6.6	4.6	3.8	3.9	2.6	1.3	4.1	2.2	2.25
3	103,061	13.7	6.8	7.4	8.2	10.6	10.7	2.7	15.9	9.57
4	**310,320**	**41.3**	**65.2**	**66.2**	**59.1**	**56.3**	**71.5**	**70.8**	**63.3**	**75.41**
5	52,428	7.0	2.3	3.7	1.7	2.7	2.6	9.0	2.7	1.42
6	123,695	16.6	10.5	7.6	9.7	9.9	7.4	2.8	6.0	6.74
7	17,597	2.3	2.5	1.8	1.6	2.4	1.6	4.9	1.2	0.71
8	10,095	1.3	0.1	0.4	0.1	0.5	0.3	1.1	0.4	0.47
9	19,387	2.6	0.3	0.4	0.3	0.0	0.3	0.4	0.4	0.35
10	41,112	5.5	4.0	4.3	3.7	3.1	2.5	0.1	2.1	1.65
Unknown	0	0	3.7	4.2	11.1	10.8	1.3	3.3	4.5	0.59
Total	751,223	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Source: Ministry of Health Surveillance Unit

AIDS-Related Mortality

The proportion of all deaths attributable to AIDS has declined steadily from 9.5 percent in 2002 to 3.6 percent in 2010 (Ministry of Health Statistics Unit). The actual number of AIDS-related deaths has also generally declined as illustrated in Table 5.

Table 5: *Annual Number and Proportion of AIDS-Related Deaths*

Year	% of AIDS Related Deaths	No. of AIDS Related Deaths	Rate per 1,000 population
2002	9.5	475	0.6
2003	8.0	399	0.5
2004	7.1	356	0.5
2005	6.86	360	0.5
2006	5.9	298	0.4
2007	5.7	289	0.4
2008	4.7	237	0.3
2009	4.2	192	0.2
2010	3.6	194	0.2

Source: Ministry of Health Statistics Unit

Table 6 illustrates the pattern of decreasing prevalence among key populations.

Table 6: ***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	0.7 (3.1)	PMTCT Programme Reports show prevalence of just over 1% since 2005. As seen in brackets, the percentage of new cases that are HIV positive have consistently been around 1%
		2004	0.9 (2.5)	
		2005	1.6 (2.2)	
		2006	1.5 (1.6)	
		2007	1.3 (1.4)	
		2008	1.1 (1.2)	
		2009	1.3 (1.1)	
		2010	1.2 (1.0)	
		2011	1.6 (0.9)	
		2012	1.7 (0.7)	
		2013	1.9 (0.8)	
Blood Donors	All	2004	0.7	Blood Bank Programme Reports
		2005	0.9	
		2006	0.42	
		2007	0.29	
		2008	0.46	
		2009	0.16	
		2010	0.20	
		2011	0.1	
		2012	0.3	
		2013	0.34	
Sex Workers	Female	1997	45.0	Special Survey
		2005	26.6	BBSS
		2008/2009	16.6	BBSS
MSM	Male	2005	21.25	BBSS
		2008/2009	19.4	BBSS
TB Patients	All	1997	14.5	Chest Clinic Records
		2003	30.2	
		2004	11.2 (52% tested)	
		2005	30.24 (82% tested)	
		2006	33.2(67% tested)	
		2007	35.32	
		2008	22.0	
		2009	28.0	
		2010	26.0	
		2011	23.4	

POPULATION	SEX	YEAR	PREVALENCE	REMARKS
		2012	31	
		2013	25	
Miners	Male	2000	6.5	Special Survey One mine study
		2003	3.9	Special Survey 22 mines study
Security Guards	All	2008/2009	2.7	BBSS
Prisoners	All	2008/2009	5.24	BBSS

Source: National AIDS Programme Secretariat, 2013

III. NATIONAL RESPONSE TO THE AIDS EPIDEMIC

POLITICAL COMMITMENT

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

In 1989, the Government of Guyana established the National AIDS Programme (NAP) under 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 NGOs involved in the HIV response. The government's response is complemented by the activities of various civil society organizations, whose approach focused primarily on prevention (disseminating information, education and communication initiatives).

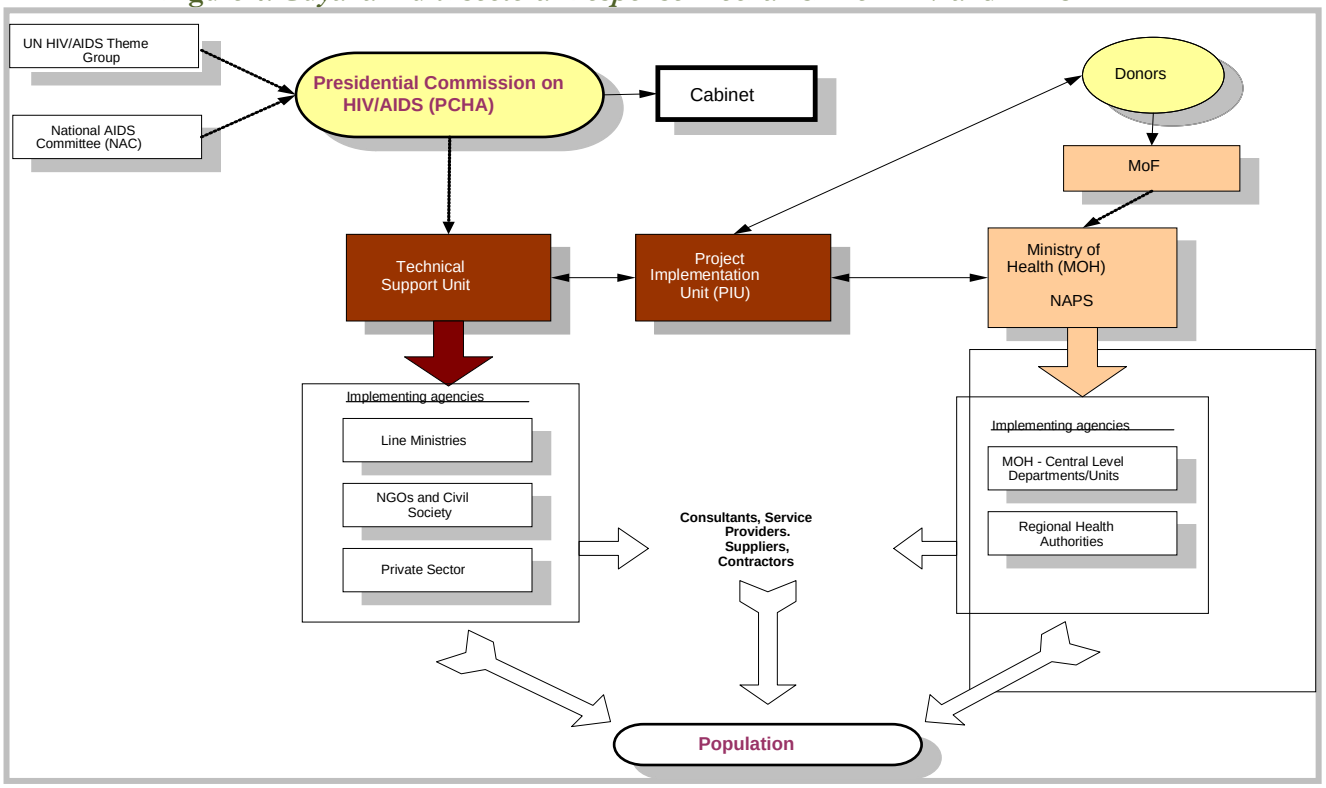
The government also developed a number of strategic plans for the health sector over the years and in 2013, HIVision 2020 and Health Vision 2020 were launched for the period 2013-2020. Health Vision 2020 was designed to be in concert with the various strategic plans for the different components of the health care programme, including HIV and sexually transmitted infections. For the latter, a National Sexually Transmitted Infections Strategy and Monitoring and Evaluation Plan 2011-2020 was developed during the last reporting period.

Institutional Roles and Responsibilities

Political commitment was further demonstrated over the years 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 across all sectors. The Commission is chaired by the President of Guyana and coordinates all HIV activities nationally. This institutional structure permits the wide participation of all public and private sector actors, civil society, and the international donor community (Country Harmonization and Alignment Tool Report, 2010). Figure 4 illustrates the Guyana multi-sectoral response mechanism for HIV and AIDS.

Figure 4: ***Guyana Multi-sectoral Response Mechanism for HIV and AIDS***



The Presidential Commission on HIV/AIDS (PCHA) is the Government of Guyana body that has been established to support, coordinate, and provide oversight for the national HIV/AIDS response under the aegis of the Office of the President.

NAPS, operating from within the MoH, is the technical agency responsible for coordination, implementation and the monitoring and evaluation of the national response. NAPS provides support to the PCHA on technical issues and works closely in providing technical directional guidance to donors and to Line Ministries and Civil Society organizations implementing HIV programmes.

The Health Sector Development Unit (HSDU) has responsibility for coordinating donor funded projects for the Ministry of Health which includes HIV funded projects.

The Country Coordinating Mechanism (CCM) is a multi-sectoral body charged with the responsibility for providing oversight to the Government of Guyana Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) grants. The CCM has representation from

government, civil society including NGOs, faith-based organizations, private sector, donor agencies, academia, key populations at higher risk, and PLHIV.

The NAC is an independent advocacy body for civil society and the private sector. In principle the body is responsible for providing the Minister of Health with recommendations and advising on HIV and AIDS policies, educational, training and public information activities in addition to measures for improving programmes and the effectiveness of the national response.

Multi-Sectoral Coordination

Guyana successfully implemented its previous National Strategic Plan, 2007-2011. A multi-stakeholder process resulted in the development of a new National HIV Strategic Plan 2013 - 2020, HIVision 2020. This plan identified priorities areas with key strategic objectives necessary for the achievement of the Millennium Development Goals (MDGs) 2015, as well as the long term goal of the plan. To support effective implementation of HIVision 2020, the monitoring and evaluation framework will be expanded to a national M&E plan in 2014. A detailed costed 3-year operational plan will be developed as well as an estimated cost for the overall plan.

In coordination with UNAIDS, Guyana took stock of the situation with regard to achieving the ten targets for the MDGS, through a Mid Term Review. Of the ten targets, two were determined not to be applicable to Guyana. These were the reduction of transmission of HIV among people who inject drugs by 50% by 2015, and the elimination of HIV restrictions on entry, stay and residence. The stock-taking exercise highlighted Guyana's readiness to favourably report on six of the eight high level targets. The two targets that presented some uncertainties were "Closing the AIDS Resource Gap by 2015" and "Eliminating Gender Inequalities and Gender-based Abuse and Violence and Increase the Capacity of Women and Girls to Protect Themselves from HIV." Measures were defined to increase impact in these two areas.

A National AIDS Spending Assessment (NASA) for the years 2011 and 2012 was conducted in 2013 and the report is being finalized.

The National Programme coordinated with the Country Coordinating Mechanism and partners in the successful submission of a phase 2 Global Fund application for HIV. The proposal considered the Epi profile of the disease and thus was approved with a 50% focus on key populations at higher risk. Further, the implementation of this grant will see in 2014, significantly greater involvement of civil society organizations as Sub Recipients, Sub Sub Recipients and implementers in reaching the key populations.

Donor Coordination

The Paris Declaration 2005 which is further reinforced by the Accra Agenda for Action, lays out a practical, action-oriented roadmap to improve the quality of aid and its impact on development (*www.oecd.org/dac*). The Paris Declaration outlines the following five fundamental principles for making aid more effective:

- Ownership: Developing countries set their own strategies for poverty reduction, improve their institutions and tackle corruption.
- Alignment: Donor countries align behind these objectives and use local systems.
- Harmonisation: Donor countries coordinate, simplify procedures and share information to avoid duplication.
- Results: Developing countries and donors shift focus to development results and results get measured.
- Mutual accountability: Donors and partners are accountable for development results.

In keeping with these principles, as part of the national response to HIV, the Guyana government maintains ongoing communication and collaboration with its donor partners to ensure that the aid provided achieves its full impact.

Throughout the reporting period, UN agencies and US government partners/PEPFAR agencies were represented on various Steering Committees for the development of HIVision 2020, they were represented on the Country Coordinating Mechanism for Global Fund, and they were also members of several high level sub committees and ad hoc committees. These include the Monitoring and Evaluation Reference Group (MERG) which aims at streamlining monitoring and evaluation efforts among the various partners with regard to HIV and also the Prevention Technical Working Group, Care and Treatment Technical Working Group, Guidelines Committee, and VCT Steering Committee among others. In addition, there were a number of joint development partners' forums aimed at coordinating donor funding. Through this mechanism, high level decisions on the procurement of ARVs by agencies were made and collaborative support was also provided to the Ministry of Health for the construction of the MMU warehouse

Additional coordination with US government partners included:

- Annual GOG/PEPFAR portfolio review to discuss successes, identify gaps and develop activities for the coming fiscal year's country operational plan
- High-level PEPFAR/GOG quarterly meetings to discuss program implementation, challenges and transitioning
- Quarterly USAID/Ministry of Finance Progress Update meetings to update Ministry of Finance officials on program progress/challenges
- Bi-monthly GOG/PEPFAR Sustainability Transition Planning Meetings to provide updates on progress in transitioning the PEPFAR-supported products and services

Coordination with the UN included participation in the monthly UN Joint Meetings which addressed issues related to the UN Joint Plan for HIV. At this meeting, each UN agency is represented by a focal point. The UN was actively involved in technical working groups and steering committees at NAPS on PMTCT, ART, STI and especially the HIV/DR committee that spearheaded the HIV Drug Resistance survey. The UN also actively participated in the quarterly Donor Coordinating Team that has the participation of the various donors who report on progress with respect to their HIV-related programs in Guyana.

The Country Coordinating Mechanism (CCM) established to oversee global fund grants also serve as an important mechanism for coordination. The CCM convened on a quarterly

basis, brings together a wide range of stakeholders including representatives from the UN System and from the PEPFAR programme.

Coordination with People Living with HIV

Aligned to the guiding principle of HIVision2020, "HIV programming will adhere to the principle of the Greater Involvement of People Living with HIV (GIPA)", the reporting period saw continued leadership and involvement of this population in the response. The PLHIV community was represented on the Steering Committee for the development of the HIVision 2020 and a targeted focus group session was conducted among this group to solicit feedback on the performance of the previous strategic plan and to receive inputs into the HIVision 2020.

The PLHIV community is represented on the country CCM for Global Fund and they also serve on several special sub-committees and ad hoc committees, including the oversight and proposal writing committees.

PLHIVs are represented at several national level technical and coordinating committees. The National Steering Committee for support to PLHIV comprises leaders of support groups and the members of this Committee meet quarterly to discuss with the National Programme, issues affecting PLHIV. The PLHIV population is also represented on the technical working group for the client satisfaction survey.

The Network of Guyanese living with and affected by HIV (G+) was revitalized during the reporting period and continued to provide services to its target population. During the period, G+ benefitted from funding to support its implementation.

The PLHIV community provided inputs into HIV programme implementation through several mechanisms. Support groups whilst primarily seeking to address social issues through counseling and education, also serve as a forum for information gathering from the beneficiaries regarding the quality of services and other service delivery issues. The two-day annual PLHIV conference held in 2013 developed a roadmap for support groups in achieving sustainability. Through direct involvement in implementation within the National Programme, PLHIVs employed within the programme, continue to work to bridge the gap between testing and treatment and to impact treatment outcomes through reduced defaulter rates.

Coordination with Line Ministries

Line Ministries continued to be engaged in the national response through their active participation in the steering committee for the development of the National Strategic Plan, HIVision2020. Line Ministries also serve on the CCM for Global Fund and also on several high level sub committees and ad hoc committees, including the governance and oversight sub committees.

Line Ministries and their technical arms also serve on steering committee to define and roll out implementation strategies. For example, the Guyana Forestry Commission and the Guyana Geology and Mines Commission linked to the Ministry of Natural Resources serve on the technical working group for miners and loggers.

Key Line Ministries are required to mainstream the implementation of HIV-related activities as part of their ministry's work programme. In this regard, some Line Ministries have specific focal points for example, the Ministry of Local Government and the Ministry of Education.

Workplace programme activities focused on achieving prevention of HIV and STIs through training, education and behavior change communication, condom distribution, and dissemination of information. Linkages were also provided to treatment and care for PLHIV and their families. There was special emphasis during the reporting period on creating awareness within public and private sector entities with regard to gender based violence and its impact on HIV. Promotion of the ministries' workplace policy on HIV was ongoing throughout the period (see section on workplace programme).

During the period, key line ministries utilized their core functions for achieving complementarity in the HIV response. Such involvement included the Ministry of Education's continued implementation of the HFLE programme, the Ministry of Home Affairs' collaboration in the testing of prison inmates and their referral to care and treatment services, and the Ministry of Public Service's delivery of an HIV module as part of its training for all employees within the Public Service. Of special note is the Ministry of Culture, Youth and Sports continued use of sports as a vehicle for healthy living and in particular, its collaboration with the Ministry of Health, the private sector and CSOs in hosting the "Ride for Life" focused on HIV prevention. This initiative which started out with full funding from the Ministry of Health, has been fully transitioned to the MCYS in 2013. The MCYS also integrated within its summer camps, modules on HIV prevention.

The Ministry of Human Services continues to provide public assistance to PLHIV and it is also very proactive in providing support for victims of gender based violence, in addition to providing public education on gender based violence. The Ministry of Housing and Water continues to collaborate with the Ministry of Health in facilitating the allocation of house lots to PLHIV and it has also integrated HIV education and VCT into its one-stop shop initiative in its house lot allocation process. The Central Employment and Recruitment Agency facilitates the employment of PLHIV through collaboration with the National Programme and the Ministry of Labour Occupational Health and Safety remains vigilant in the implementation of the HIV workplace programme. During the annual World AIDS Day commemoration, all Line Ministries are involved in the national HIV testing initiative.

In addition to their staff, key line ministries also identified their external clients for the provision of HIV sensitization and HIV-related services. External clients comprised youth (in-school and out-of-school including street children), orphans, cultural groups, professional groups, associations (including parents-teachers associations), trade union groups, farmers, women's and other groups (see details in relevant sections of the report).

Coordination with the Private Sector

The Private Sector provides leadership at the level of the CCM through its representation on the Guyana Business Coalition on HIV and AIDS.

Throughout the reporting period there has been support from the private sector in various forms. There was a steady increase in private sector sponsorship for the food bank during

the period 2009 – 2013. Through the food bank, hampers were provided to PLHIV and HIV/TB co-infected patients. In addition, the private sector contributed towards the provision of hot meals and nutritious drinks for the latter patients. As part of the national level prevention efforts, a number of mass media advertisements in the form of public service announcements were aired on the private television and radio through concessionary arrangements granted by the private media. The media was also engaged in the annual World AIDS Day sensitization.

During the reporting period, the private sector continued to support the national Valentine's Day Couples Testing by sponsoring incentives such as romantic dinners, food hampers, gift certificates, recreational trips, and even Blackberry phones. The Supermarket Initiative which aims at promoting awareness of HIV and AIDS and general health and wellness, continued through collaboration with the 10 participating supermarkets whose focal points were proactive in following up on the provision of training for their staff on HIV and general health-related matters.

The workplace programme continued with the active engagement of the private sector in implementing comprehensive health and wellness programmes which addressed issues beyond HIV, to include the promotion of human rights and social security. A major focus of the programme during the reporting period was the integration of gender based-violence and male norms and behaviors into the training curricula, given their relationship to HIV. The Guyana Business Coalition on HIV and AIDS (GBCHA) continued to be a key agency in supporting the HIV workplace programme in keeping with Guyana's National HIV Policy. Through this programme, employees participated in the workplace policy implementation and other workplace educational sessions, including peer education and gender based violence. The GBCHA also extended its work in this latter subject area to schools. Through the GBCHA's efforts, both staff and clients of the member companies were offered VCT on an ongoing basis.

Coordination with Civil Society Organizations (CSOs)

Civil Society Organizations (CSOs) continued to provide leadership at the highest level in the national response to HIV, serving as key members of the National Steering Committee for the development of Guyana National HIV Strategic Plan, HIVision2020 and also on the Steering Committee for Key Populations at Higher Risk. The CSO constituent is represented and serves as the Vice Chair on the CCM. Additionally, the CSO representative also serves on several high level select ad hoc and sub committees of the CCM including the Governance and Oversight Sub Committees.

At the coordination level, CSOs contribute through established technical working groups (TWGs) such as the TWG on migrants and mobile populations, the steering committee for the key population's response and the steering committee on home based care. Ad hoc committees also received CSOs' leadership e.g. the Technical Working Group for the Biological and Behavioural Surveillance Surveys.

During the reporting period, through donor support, CSOs continued to contribute to the national HIV response in providing HIV prevention and support services. CSOs operated in collaboration with government, other local partners and the international community in providing services to PLHIV. With decreasing donor funding within recent years (including

the conclusion of GHARP II that supported a number of CSOs), CSOs have been placing more emphasis on sustainability through partnerships with the business community and creative resource mobilization ventures. Since the conclusion of GHARP II, a new project – Advancing Partners and Communities, has approved the applications of 10 NGOs involved in HIV, to receive grants to improve their capacity to deliver effective HIV services for key populations in Guyana.

During 2012 and 2013, CSOs played a key role in delivering the HIV package of services primarily to the key populations in both the urban areas and the outlying regions. Outreaches were conducted to sensitise target groups about stigma and discrimination, HIV prevention and to provide VCT services. Condom distribution and lubricants formed an essential part of the CSO service delivery. This included the promotion and demonstration of use of condoms and also condom negotiating skills. Behaviour Change Communication (BCC) efforts also included the distribution of educational materials. Family planning services and linkages to PMTCT services formed part of the CSOs' program of activities

Several CSOs were instrumental in providing support to PLHIV. These included psychosocial support through support group mechanisms, counseling sessions and others. Home Based Care Services were delivered through a network of trained volunteers in collaboration with the Home Based Care nurses at the NGOs and at the HIV treatment site. The Network of Guyanese Living with and affected by HIV (G+) was revitalized and received funding to continue services to the population. Work through G+ commenced on Positive Health, Dignity and Prevention (PHDP) among PLHIV to support this work already initiated by several CSOs. With donor support, CSOs provided job readiness and skills training to more than 153 FSWs, 98 PLHIV and 37 OVC and also linked 54 of these FSWs and 56 PLHIV to either job placement or small business ventures through loans issued by these CSOs.

The Guyana Faith Coalition on HIV and AIDS continued to coordinate the response among the faith community, with a focus on the strength of the family as the core unit of society.

National Commitments and Policy Instrument (NCPI)

The main objective of the National Commitments Policy Instrument (NCPI) survey 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. Fifty two (52) key informants representing government (25), civil society organizations (17), and UN organizations and bilateral partners (10), drawn from Regions Three, Four, Six and Ten were interviewed for the NCPI survey, compared to 35 key informants interviewed for the 2012 GARPR. The NCPI questionnaire comprised two parts. Part A was administered to government officials and it covers:

I. Strategic plan
II. Political support and leadership
III. Human Rights
IV. Prevention
V. Treatment, care and support

VI. Monitoring and evaluation

Part B was administered to civil society organizations, bilateral agencies and UN organizations and it covers:

I. Civil Society involvement
II. Political support and leadership
III. Human Rights
IV. Prevention
V. Treatment, care and support

I. Strategic Plan

Key Developments/Modifications

Results from the NCPI show that all respondents (20/20) agreed that Guyana has developed a national multisectoral strategy to respond to HIV from 2013-2020. A majority of respondents, agreed that the strategy has key developments/modifications from the last strategy which include a focus on the most at risk/key populations such as men who have sex with Men (MSM), sex workers (SWs), transgenders, clients of SWs, orphans & vulnerable children (OVC), miners and loggers. The strategy redefines the entire population as people who live in Guyana to include migrants who have access to services. Respondents indicated that the new strategy advocates for the advancement of universal access to treatment, emphasizes treatment for TB-HIV co-infection, increases efforts to eliminate sources of HIV infection among children and also through blood transfusion. They also stated that the strategy supports integration of HIV services into primary health care services and it addresses the need for use of epidemiological data to strengthen evidence-based national response. Other respondents stated that a human rights based approach, sustainability and country ownership are also key modifications compared to the last strategy.

Sectors Included in the Strategy

The majority of the respondents (18/19) reported that the health sector, women, and young people populations are included in the strategy and that they have an earmarked budget. More than seventy percent of the respondents (14/19) reported that labour and the military/police sectors were included in the strategy, whilst twenty one percent of the respondents (4\19) felt that the transportation sector is included in the strategy and a minority (2/19) reported an earmarked budget for activities. Majority of the respondents (19\21) reported that home affairs (police and prisons) were not included in the strategy, but less than half (9\19) reported a budget for its activities.

Identified Key Populations

Respondents reported that the multisectoral strategy addresses the key or target populations as being in the greatest need for HIV interventions. A majority of respondents (20/21) identified MSM, migrant/mobile populations, and OVC as the key populations that the strategy addresses whilst more than half of the respondents (15\21) agreed that persons with disabilities and the transgender population were addressed in the strategy. A majority of the respondents (12/21) agreed that injecting drug users were not addressed in the strategy. Respondents believed that Guyana does not identify injecting drug use as an issue hence there was not a strong emphasis on this area in the strategy.

Identified Settings and Cross Cutting Issues
A majority of respondents (19\21) agreed that cross cutting issues such as schools, workplaces, stigma & discrimination, gender empowerment/gender equality, HIV and poverty, human rights protection and the involvement of people living with HIV were settings and cross cutting issues addressed in the strategy.

HIV and AIDS Issues Among National Uniformed Services
Guyana's uniformed services are becoming increasingly involved in the efforts to stop the spread of HIV. A majority of respondents (17\21) reported that there is a strategy for addressing the HIV issues of this group as beneficiaries of targeted interventions.

Operational Plan
A majority of the respondents (17/21) reported that the strategy has an operational plan. They agreed that the operational plan includes formal programme goals, clear targets or milestones, indication of funding sources, and a monitoring & evaluation framework. Half of the respondents (11/21) reported that detailed costs for each programmatic area were part of the operational plan.

Civil Society Involvement in the National Strategy
The majority of respondents (16/21) agreed that Guyana has ensured full and active involvement of civil society in the development of the national strategy. As part of its strategy, Guyana has developed plans to strengthen its health systems, including the infrastructure, human resources capacity, logistical systems to deliver & procure drugs, and its health information system. All respondents reported that most development partners, i.e. bi-laterals and UN organizations have endorsed the national strategy. However, more than seventy five percent of the respondents reported that only some of partners have aligned or harmonised their HIV-related programmes to the national strategy.

HIV and AIDS and the General Development Plans
A small margin of respondents (9\21) reported negative socio-economic impact of HIV on national development. A comparison with the NCPI results for the 2010-2011 period indicates that the response was similar.

More than half of the respondents (14\21) indicated their support for HIV integration in the UN development assistance framework whilst a large margin (20/21) indicated their support for HIV integration in the national development plan. However, all respondents indicated their support for HIV integration in the poverty reduction strategy and more than half (15/21) combined supported HIV integration in the national social protection and sector-wide approach plans.

All of the respondents, (20\21) indicated that reduction of gender inequalities, treatment and support (including social security and other schemes) were included in the general development plans. HIV impact alleviation, reduction of stigma & discrimination, women's economic empowerment recorded a margin of support in the country's general development plan. More than half of the respondents(13/21) supported the elimination of punitive laws and reduction of income inequalities in one or more development plans.

Key Achievements and Challenges

Guyana has recorded key achievements since 2011 in the strategic planning process. Areas of improvement include the reduction of AIDS-related deaths and a decrease in mother to child transmission of HIV through the PMTCT program which has achieved 92% coverage. The involvement of civil society is an achievement in the coordination efforts and in the development of the HIVision 2020 strategy. However, many challenges remain including sustainability of human and financial resources within an environment of diminishing resources. The inability to reach all of the key populations due to Guyana's geographical make up is a significant challenge.

II. Political Support

Ninety percent of respondents (18\20) agreed that the Minister of Health as well as other Government Ministers have demonstrated public leadership in rolling out the national response to HIV and AIDS. Government has played an active role in its participation in domestic, international forums and activities for HIV/AIDS. The development of the country coordinating mechanism (CCM) for HIV/AIDS set up by the Global Fund for TB, HIV and Malaria, is an important step to encourage government and civil society participation and involvement in the national HIV/AIDS response.

National AIDS Programme Secretariat

In keeping with the NCPI results for the previous GARPR almost all the respondents (19/20) indicated that NAPS is the national coordination mechanism that promotes interaction among government, people living with HIV/AIDS, civil society, and the private sector and that it implements HIV and AIDS strategies in Guyana.

Among the main achievements of NAPS noted by respondents since 2009 are:

- Improved data and information sharing systems
- Partnerships with interfaith and business organizations in civil society
- CSOs make up at least 40% of representation in the country coordinating mechanisms for Global Fund's country coordinating mechanism
- Social and economic support for PLHIV in areas such as the food bank and public assistance
- Promotional campaigns to end stigma & discrimination
- Work place programmes for HIV

Remaining challenges include but are not limited to:

- Financial and human resource sustainability
- Competing national priorities with the HIV/AIDS programme
- Inability to reach key/vulnerable populations due to Guyana's geographical anatomy.

All of the respondents (6/6) noted that the NAPS supports civil society by providing technical guidance and coordination with other implementing partners. A majority (19\20) reported that capacity building and information on priority needs were provided and over a

half (13/21) of the respondents reported that NAPS procures and distributes medications and other supplies.

More than half the respondents (16/29) from civil society, bilateral agencies and UN organisations reported that the government through political and financial support, involved key populations and or other vulnerable sub-populations in Governmental HIV policy design and programme implementation. This was demonstrated through the development of the HIV policy and the Ministry of Health policy statement against stigma and discrimination as well as subventions granted to the national AIDS committee (NAC).

III. Human Rights

A majority of the respondents (20\25) noted that Guyana has non-discrimination laws or regulations which specify protection for specific key populations and other vulnerable subpopulations including: people living with HIV/AIDS, orphans and other vulnerable children, migrant & mobile populations, people with disabilities, women and girls.

(18/23) and (19\28) respondents representing the government and civil society/bilateral agencies/UN organisations respectively, reported that there was specific protection for persons living with HIV. A majority of respondents from government (21/23) and civil society, bilateral agencies and UN organisations (22/28) reported the presence of specific protection for women, young women and young men.

A majority of respondents from government, civil society, bilateral and UN Organizations (43\51) reported no specific protections for the MSM population, whilst more than half (15\23) representing government reported that migrants/mobile populations, sex workers and transgender populations were not specifically protected. A similar view was shared by a majority of respondents (19\28) from civil society, bilateral agencies and UN organisations. More than half the respondents from both groups of interviewees (15\28) held the view that there were no specific protections for prison inmates.

More than eighty percent (23\28) from civil society, bilateral agencies and UN organisations agreed that Guyana has a general, not specific HIV-related discrimination law. The respondents cited the constitution of Guyana, which contains a section that states "citizens cannot/should not be discriminated against on the grounds of age, sex, gender, ethnicity, religion."

Respondents from civil society, bilateral agencies and UN organisations reported the enforcement of non-discriminatory laws through the judiciary system, commissions (such as the ethnic relations committee, women & gender and rights of the child commissions) and the Ministry Of Health workplace policies. A minority of respondents (5/22) from the government held the same view while less than half (10/22) reported uncertainty about whether mechanisms are in place or laws are implemented.

Most of the respondents, (18\23) from the government and from civil society, bilateral and UN Organizations (21/23) reported the presence of laws that present obstacles to effective HIV prevention, treatment, care and support for MSM, sex workers, prison inmates, transgender and migrants/mobile populations. During the previous NCPI survey, more than

half the respondents held a similar view. The following are examples of laws, policies and regulations:

- The buggery laws and the Gross Indecency Act which affect MSM
- There are specific laws against prostitution and solicitation of sex which affect sex workers.
- There are specific laws against cross-dressing which affect transgendered people
- The policy that disallows distribution of condoms in prisons

Additionally, there are laws that criminalise and discriminate against vulnerable populations and contribute to increased high-risk behaviours underground and also result in ineffective prevention efforts.

Respondents from civil society, bilateral agencies and UN organisations reported that Guyana has a policy, law or regulation to reduce violence against women, which is covered under the domestic violence act. Most of the respondents (18\26) reported that the promotion of human rights is explicitly mentioned in the national HIV/AIDS policy document as well as the Guyana national HIV prevention, principles, standards and guidelines as a cross cutting issue. This same view was expressed in the previous NCPI survey.

More than half of the respondents (14/27) from civil society, bilateral agencies and UN organisations society reported that there is a mechanism to record, document and address cases of discrimination experienced by persons living with HIV, key populations and other vulnerable sub populations which was in contrast to the previous NCPI survey in which most respondents agreed that there was no mechanism to record, document and address cases of discrimination experienced by PLHIV as well as key populations and other vulnerable sub populations.

Most of the respondents (23/27) from civil society, bilateral agencies and UN organisations noted that Guyana has a policy of free services for HIV prevention services, antiretroviral treatment and HIV-related care and support interventions compared which was the same view held by the majority in the previous NCPI survey. In addition, most respondents (18/22) reported that Guyana has a policy to ensure equal access for women and men to HIV prevention, treatment and support services, with coverage for women outside of the context of childbirth which is the same view held by most respondents in the previous NCPI survey.

Most respondents (18/22) from civil society, bilateral agencies and UN organisations agreed that Guyana has a policy to ensure equal access for key populations and/or vulnerable sub-populations to HIV prevention, treatment, care and support services. This is one of the milestones included in the national HIV strategy and implemented at most healthcare facilities throughout the country. This view is the same as that held in the previous NCPI survey.

More than half (15/27) the respondents from civil society, bilateral agencies and UN organisations reported that Guyana has a policy prohibiting HIV screening for general employment. Most of the respondents were in agreement with a national HIV workplace

policy that ensures protections of employees and disallows employment based on HIV status.

More than half (16\27) the respondents from governmental and non-governmental entities reported the presence of an independent national institution for the promotion and protection of human rights which considers HIV-related issues within their work.

Less than half the respondents (10\22) from civil society, bilateral agencies and UN organisations reported that there were no performance indicators or benchmarks for compliance with human rights standards within the context of HIV efforts, compared to a majority who held this view in the previous NCPI survey.

A majority of the respondents (15/21) from civil society, bilateral agencies and UN organisations noted that the members of the judiciary and law enforcement officials have not been trained on HIV and human rights issues that may come up within the context of their work which is the same view held by the respondents in the previous NCPI survey. Most of the non-government respondents (19\21) reported that there were programmes to educate and raise awareness among persons living with HIV and key populations concerning their rights within the context of HIV which is the same view held by the respondents in the previous NCPI survey.

More than half the respondents (12/22) from civil society, bilateral agencies and UN organisations reported the presence of a legal aid system for HIV case work but the majority (16/22) noted no support from private sector law firms or university-based centres to provide free or low cost legal services to PLHIV. In the previous NCPI survey, the majority of respondents from civil society, bilateral agencies and UN organisations reported no legal aid system for HIV case work or private sector law firms or university-based centres to provide free or low cost legal services to PLHIV.

Most respondents (26\27) from civil society, bilateral agencies and UN organisations reported the presence of programmes in place to reduce HIV related stigma and discrimination for the media, within the work place and for health care workers. A similar view was held in the previous NCPI survey.

In keeping with the previous two NCPI surveys, respondents noted many key achievements, in policy, laws and regulations to promote and protect human rights in relation to HIV. Respondents from civil society, bilateral agencies and UN organisations noted the following key achievements:

- Ministry of Health policy on stigma and discrimination
- A code of ethics for healthcare workers
- Anti-discrimination policy in the workplace
- Steps at a national level to draft policies for HIV.
- Implementation of the suggestion box at healthcare facilities
- Human rights training and capacity building activities

- Civil society groups such as friends across differences (group of transgendered people), Guyana sex workers coalition (GSWC); SASOD and GUYBOW have become more vocal.

Challenges identified included but are not limited to: lack of support from faith based organizations to support HIV legislation; absence of a redress system; reformation of the punitive laws that criminalise the LGBT community and other vulnerable groups and; stigmatization and ridicule of the marginalised populations perpetuated by some religious groups.

NCPI Results for CSOs

IV. Civil Society Participation

Most respondents (16\26) noted that civil society organizations (CSOs) have contributed significantly to strengthening of the political commitment of top leaders and national policy formulation. In comparison less than half the respondents (4\15) in 2009 and 2011 shared this view. Since 2011, less than half of the respondents (5\26) indicated that CSOs have contributed moderately to strengthening the political commitment of top leaders and national policy formulation compared to more than half of respondents in 2009 and 2007 that shared this view. Respondents cited active involvement/representation of civil society organizations in the national HIV response in planning and decision-making.

A majority of the respondents indicated that there has been significant involvement of civil society in the planning and budgeting process for the national strategic plan on HIV. Less than half of the respondents (8\26) reported that there has been little or no involvement of civil society in the planning and budgeting process of the national strategic plan for HIV. In 2011 and 2009 less than a half of the respondents (7\15) and more than half of the respondents in 2007 acknowledged moderate to high levels of civil society involvement.

A majority of respondents (22\26) noted significant or high involvement of CSOs in the provision of services in the areas of HIV prevention, treatment, care and support services that were included in the national HIV strategy. More than half the respondents in 2011 (8\15) and a majority of the respondents in 2009 reported high levels of involvement of CSOs in the provision of services in the areas of HIV prevention, treatment, care and support services that were included in the national HIV strategy.

A majority of respondents, (17\26) noted little or no involvement for the services provided by civil society in the areas of HIV prevention, treatment, care and support in the national HIV budget compared to more than half of respondents (8\15) in 2011 who shared this similar view. In contrast, in 2009 most of the respondents reported that there was inclusion of civil society in the areas of HIV prevention, treatment, care and support that were included in the national HIV budget.

A majority of the respondents (22\26) noted significant involvement for services provided by civil society in the areas of HIV prevention, treatment, care and support were included in the national HIV reports. This is in comparison to (8\15) of the respondents in 2012, that

reported little or no involvement and in contrast to 2009, where most of the respondents reported that there was inclusion in the national HIV reports.

More than half of the respondents (16\26) reported a moderate to high inclusion of Civil Society in the development of the national M&E plan, compared to more than half (10\15) of the respondents in 2011 and a majority in 2009, who reported moderate to high inclusion in the development of the national M&E plan. Since 2011, less than half of the respondents (10\26) reported little or no participation in the national M&E committee or working group for the coordination of M&E activities and participation in the use of the data for decision-making. In contrast to 2009, where respondents reported moderate to high participation on the National M&E committee or working group responsible for coordinating M&E activities.

An overwhelming majority (23\26) of respondents indicated moderate to high level of civil society representation in HIV efforts inclusive of diverse organisations such as networks of people living with HIV, sex workers and faith-based organisations compared to less than half (7\15) of the respondents in 2011 who indicated that there was moderately high civil sector representation in the HIV efforts inclusive of diverse organisation such as networks of people living with HIV, sex workers and faith-based organisations. Respondents cited organisations such as the: Guyana Sex Work Coalition, Faith Coalition on HIV and AIDS, Society Against Sexual Orientation Discrimination (SASOD), Linden Care Foundation, Artistes in Direct Support (AIDS) and Network of Guyanese living with HIV and AIDS (G+). In 2009, a majority reported a moderate to high inclusion of diverse organisations in the civil society representation in HIV efforts.

A majority of respondents (20\26) reported that it was fairly easy to access adequate financial support to implement HIV activities compared to more than half (11/15) in 2007, 2009 and 2011 who shared this similar view.

A majority of respondents (24\26) reported a moderate to high level of access to adequate technical support to implements their HIV activities. A majority (12\15) of respondents also reported moderate to high level of access to adequate technical support to implements their HIV activities in 2011& 2009 and 2007.

Respondents from Civil Society, Bilateral Agencies and UN Organisation were unanimous that NGOs across Guyana are the main non-clinical service providers as reflected in Table 7

Table 7: ***Estimates of Proportion of HIV Services Provided by CSOs with Support from Bilateral and UN Organisations***

Prevention Component	2007	2009	2011	2013
Prevention for youth	50 – 75%	>75%	25-50	N/A
Prevention for vulnerable sub-populations				
-IDU	<25%	<25%	NA	NA
-MSM	50 - 75 %	>75%	>75%	>75%
- Sex Workers	50 - 75 %	>75%	>75%	>75%
Transgendered people	----------	----------	>75	>75
People living with HIV	----------	----------	25-50	>75
Counselling and Testing	25 – 50%	51-75%	25-50	51-75
Clinical Services (OI/ART)	<25%	<25%	<25	<25
Home Based Care	50-75%	>75%	>75	25-50
OVC	50-75%	>75%	>75	>75

Progress made in Civil Society Participation since 2009 include:

- Civil Society advocated against the call for the criminalisation of HIV;
- Civil Society participation on the CCM has been retained and maintained;
- Civil Society was offered an opportunity to submit funding proposals to the GFATM;
- Men who have sex with men have been trained as counselors-testers and an increased focus on target/ key and vulnerable populations;
- UNAIDS has offered support through community life competence by working for and with communities;
- Establishment of technical working groups, consultations on the development of the National Strategic Plan (HIVision 2020).
- Partnerships with private sector organization; and
- HIV programmes that target Sex Workers and Men who have Sex with Men.

Challenges remaining include:

- Sustainability of programmes and services;
- Financial support from the national system;
- Inclusion in the planning, budgeting and monitoring and evaluation of the response;
- Human resources;
- Private sector collaboration;
- The way to engage civil society is not the same as engaging other Government officials or multilaterals; and
- Civil Society is very docile in Guyana.

3.2 PREVENTION

The Guyana National Reference Group for HIV Prevention is led and coordinated by NAPS to support national level prevention efforts and to ensure adherence to the National HIV Prevention Policy. Meetings held during the reporting period focused on the status of national prevention efforts and on refining the content of the draft HIV prevention section of the new national strategic plan, HIVision 2020.

Behavior Change Communication (BCC)

During the period, the national programme continued to work on the development and production of Behaviour Change Communication campaigns, and existing campaigns were disseminated. Campaigns developed and disseminated addressed a variety of issues including stigma and discrimination, HIV testing, couples and partner testing, condom use, talking to your son and talking to your daughter on sex and HIV, etc. These campaigns were disseminated through the mass media (TV advertisements, documentaries, radio announcements), print media (posters, brochures, stickers and others), billboards and other forms of communication. Table 8 provides a list of the mass media campaigns that were launched during the period 2005 – 2013.

Table 8: ***Mass Media Campaigns Held During the Period 2005-2013***

Period	Campaign
2005-2006	1. Reduce Stigma and Discrimination 2. Increase Community Involvement in HIV/AIDS Prevention, Treatment and Care 3. Encourage Early HIV Testing 4. Increase Condom Social Marketing
2007-2009	5. Reduce Stigma and Discrimination 6. Increase Community Involvement in HIV/AIDS Prevention, Treatment and Care 7. Reduce HIV Transmission among High Risk Groups 8. Encourage Early HIV Testing 9. Increase Condom Social Marketing 10. Promote Early Diagnosis and Treatment of Opportunistic Infections 11. Promote Women Empowerment and Increase skills in Condom Negotiation 12. Promote Adherence Among HIV Positive Persons on Anti-retroviral Therapy
2010-2013	13. Prevention of TB/HIV Co-infection Among Persons Living with HIV 14. Prevent Sexually Transmitted Infections 15. Prevention of Mother to Child Transmission of HIV

In 2012, MoH collaborated with the Ministry of Education (MoE) to launch a project titled 'Youth Educators Safe Guarding our Workforce'. The objectives of the programme were to reduce the vulnerability of in-school youth to HIV infection and to build the capacity of out-of-school youth to avoid risky sexual behaviour. An STI campaign was also launched to target the 15-29 age group that was found to have the highest prevalence of STIs. The campaign also included a specific focus on gender. The objectives of the campaign were to build awareness of STI screening and prevention and to increase health seeking behaviour.

One of the high points of 2013 was the holding of a two-day consultation on health that targeted in and out of school youth. The main objectives of the consultation were: to raise awareness of health and social issues; define strategies for action; establish a national youth network on health and; strengthen current inter-sectoral partnerships while generating new ones. Recommendations to chart the way forward were made by the some 150 youth who attended from various parts of the country. These recommendations were later shared at a dissemination meeting held with key stakeholders who were requested to use these as the basis for the proposed formation of a National Coordinating Council on Adolescent Health.

Ride For Life (see section on Best Practices also)
The highly publicized Annual Five Stage Cycle race saw the participation of 65 participants riding from host country Guyana with others coming from Suriname, Trinidad, Anguilla, Curacao, the US and England in 2012. In 2013, 60 participants representing Guyana, the US and Barbados took part. This event is staged to: increase awareness and knowledge about HIV and AIDS among participants and the general public; encourage HIV and AIDS activism and volunteerism among the participants and inspire participants to become ambassadors in the response to HIV. A major achievement during 2013 was the seamless transition of the Ride for Life activity to the Ministry of Culture, Youth and Sport (see Best Practice story).

Information, Education and Communication (IEC)

During the reporting period IEC materials were produced, reproduced and distributed. Materials included information on: community involvement; STIs; empowerment of women; sexual practices; opportunistic infections; condom use; adherence to HIV treatment; Living in a World with HIV/AIDS; condom use; community involvement; VCT; Stigma and Discrimination; diagnosis and treatment of sexually transmitted infections and; PMTCT (encouraging greater involvement of male partners from the time of conception to the birth of their babies).

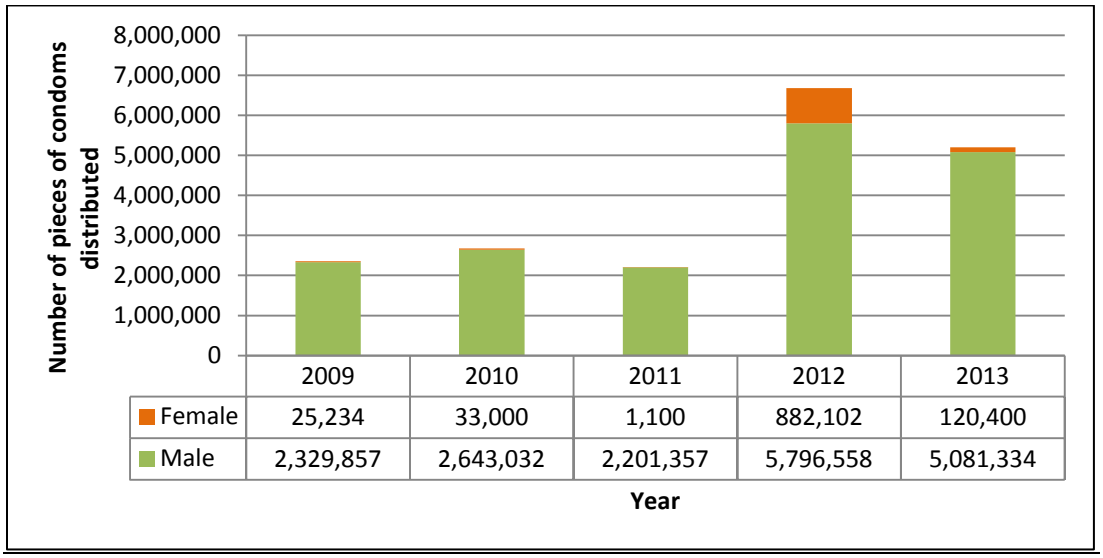
Annual Commemorative Activities Aimed at Prevention
During the reporting period, several national commemorative activities continued and these included World AIDS Day (WAD) observances, Mashramani (National Carnival) celebrations, GUYEXPO and International Women's Day. These National Events generally serve as good media for providing HIV education, sensitisation, and HIV services including testing, screening for STIs and referral to treatment services

Condom Distribution

Over the years, consistent condom use has been promoted by the national programme as a key behavioural and biological prevention strategy, and significant efforts were made to increase the awareness, availability and use of condoms to prevent the transmission of HIV/AIDS and STIs. Condom distribution was effectively done in an effort to reach all ten (10) Administrative Regions during the reporting period. The national programme was also supported by the private sector through the sale of condoms at a reduced cost.

During the reporting period, a total of 12,703,274 (93%) of condoms, including male and female condoms, were distributed through the national programme free of cost, while the private sector distributed 1,024,918 (7%) condoms. This represented approximately twice the amount of condoms distributed through the national programme during the previous reporting period (6,696,650 distributed during 2010-2011) and also a slight increase in the private sector distribution (959,318 during 2010-2011). Figure 5 below shows condom distribution by NAPS which constituted part of the national efforts during the period 2009 – 2013.

Figure 5: ***Condom Distribution Through NAPS During 2009 – 2013***

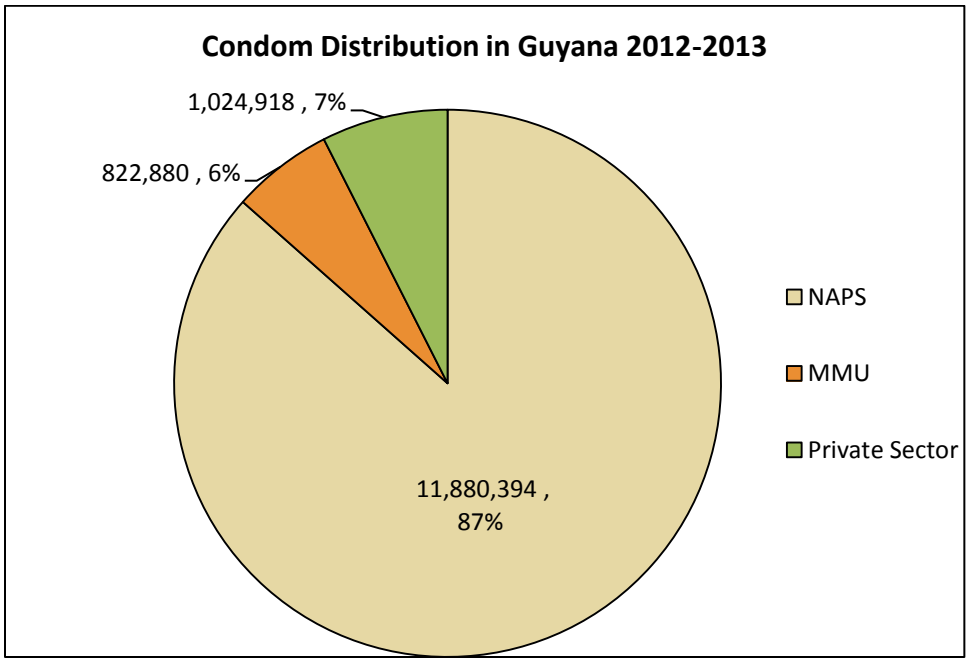


	2009	2010	2011	2012	2013
Female	25,234	33,000	1,100	882,102	120,400
Male	2,329,857	2,643,032	2,201,357	5,796,558	5,081,334

Source: NAPS Programme Reports

Figure 6 below, shows the proportions of the contributions made by the respective partners involved in condom distribution.

Figure 6: ***Condom Distribution in Guyana During 2012 – 2013***



Lubricants were made accessible primarily to the MSM population on a very scale primarily through donations. In 2014, significant support is planned under the Global Fund for the procurement of Lubricants for the MSM population.

Prevention of Mother-to-Child Transmission (PMTCT)

The National PMTCT Programme continues to receive strategic directions from a multisectoral National PMTCT Oversight committee led by the Minister of Health. The programme is poised to report on the elimination of mother to child transmission of HIV in alignment with the MDG goals. In intensifying all efforts to achieve elimination status by 2015, the programme introduced a proactive case management system which seeks to ensure that each HIV infected pregnant women is followed throughout pregnancy, delivery and the post partum period, and is provided with the appropriate care, treatment and support. This system also provides for each exposed infant to be managed up to 18 months, including the mandatory DNA PCR testing. Through this initiative, defaulting mothers are brought back into the programme. To support this effort, a network was established between case trackers and health visitors to facilitate the tracking of clients across regions. Through the case management system, women are also counseled about family planning, including the use of condoms and contraceptives and also about child spacing.

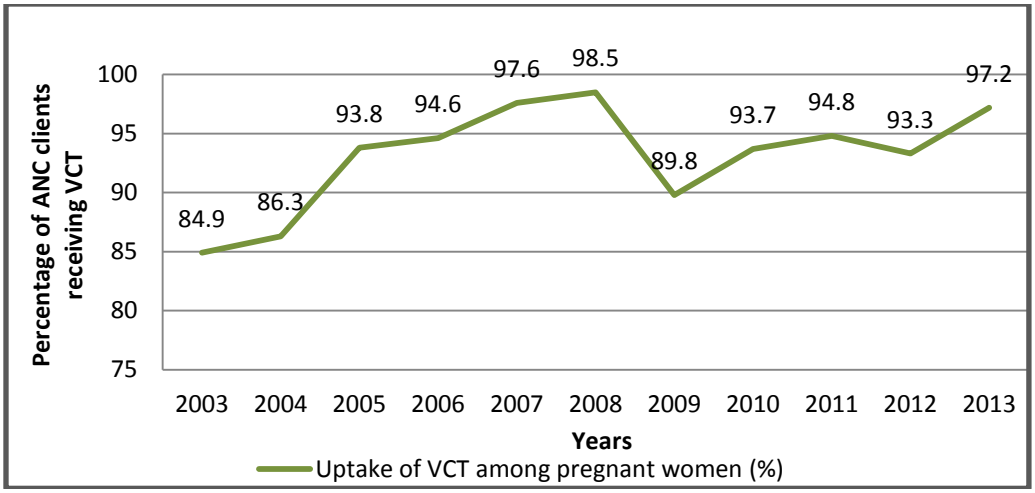
During 2013, the national HIV treatment guidelines were revised to include the introduction of Option B Plus for pregnant HIV positive women. These guidelines also include the mandatory DNA PCR testing of exposed infants at birth then to be repeated before the end

of two months. The guidelines also include for infants, co-trimoxazole prophylaxis, monitoring of growth and development, nutritional assessment and the administering of appropriate vaccines.

During the reporting period, the national PMTCT programme was expanded and this programme has seen increasing success over the years. In 2013, the number of primary sites providing PMTCT services, including antenatal clinics, delivery wards and private hospitals, increased to 187 compared to 183 in 2012. The proportion of pregnant women who accessed PMTCT services in 2012 was 88% compared to 88.7% in 2013. HIV prevalence among women attending antenatal clinics was 1.7% (247/14,580) in 2012 while in 2013, there was a slight increase to 1.9% (279/14,995) (PMTCT programme data). It should be noted that in previous years a low HIV prevalence was recorded among the antenatal population as this indicator was calculated based on women who were newly tested positive in the reporting year. In 2012, the programme began to include women who were previously tested HIV positive and accessed ANC during the reporting period.

Uptake of VCT services among pregnant women was 93.3% in 2012 (PMTCT programme data). This rose to 97.2% in 2013. Figure 7 below shows the trend in VCT uptake during the period 2003 – 2013

Figure 7: ***Trend in VCT Uptake from 2003 – 2013***



Source: PMTCT Programme Reports

The percentage of HIV-positive pregnant women who received ART to prevent mother-to-child transmission increased from 70.1% in 2012 to 73.1% in 2013 (PMTCT & ART Programme data).

Babies born to HIV positive mothers were provided with early HIV diagnosis through DNA PCR testing at the Guyana National Public Health Reference Laboratory which began DNA for Polymerase Chain Reaction (PCR) testing in 2010. In 2012, 1.7% (3/180) of the babies born to HIV-positive mothers were infected with HIV compared to 2.1% in 2013 (4/191) (PMTCT programme data). Exposed infants are currently being tracked at the national care

Box 1: DNA PCR Testing

	2010	2011	2012	2013
DBS specimens received	211	229	281	274
Samples rejected	27	16	18	23
Samples processed	184	213	263	251
Number of positive samples	11	5	3	4
% positive	6%	2.3%	1.7%	2.1%
Babies tested before 2 months	87	102	75	62

and treatment sites through use of the Exposed Infants Register, in addition to the case tracking system. Box 1 shows the trend in DNA PCR testing during the period 2010 – 2013.

Table 9 below shows major trends in the PMTCT programme during the period 2006 – 2013.

Table 9: ***Major Trends in the PMTCT Programme, 2006-2013***

CATEGORY	2006	2007	2008	2009	2010	2011	2012	2013
No. of Sites with PMTCT	92	117	143	157	165	181	183	187
ANC mothers tested for HIV	13,041	13,151	12,528	11,766	11,441	12,635	12,697	13,413
Uptake of VCT among pregnant women (%)	94.6	97.6	98.5	89.8	93.7	94.8	93.3	97.2
*No. of HIV positive mothers	215	176	177	180	164	233	241	279
Prevalence of HIV (%)	1.5	1.3	1.1	1.3	1.2	1.6	1.7	1.9
**Exposed live infants born to HIV positive mothers	126	217	227	169	161	189	177	192

Source: PMTCT database 2006-2013

Male partner involvement

Male partner involvement is measured at the national level through male partner testing which constitutes part of the PMTCT programme's couples counseling and testing initiative. Some 1,554 (10.4%) male partners of pregnant women (14,580) were tested through ANC settings in 2012. Of those males, 3 (0.02%) were found to be HIV-positive. In 2013, a total of 1,379 (9.20%) male partners of pregnant women (14,995) were tested of which 9 (0.06%) were HIV positive. National PMTCT data do not reveal whether male partners of positive women are more likely to get tested. The slight decrease in the proportion of partners tested in 2013 was addressed during the ensuing period through concerted efforts by health care

workers to raise awareness in the attempt to overcome the challenges encountered in engaging partners.

In the ongoing attempt to prevent Mother to Child Transmission (MTCT), the provision of infant feeding counseling and breast milk substitute (BMS) continued with 70.5% (124/176) of the exposed infants being provided with these substitutes in 2012 and 94.4% (167/177) provided with BMS in 2013.

During the reporting period, case trackers continued to track HIV+ mothers and infants to ensure that they were provided with the appropriate care, treatment and support. Defaulting mothers were also followed up and brought back into the programme.

PMTCT feedback meetings and meetings of the PMTCT National Oversight Committee continued to be held with key stakeholders, to discuss coordination issues and also to discuss the successes and challenges within the programme. During 2012, a total of 189 health care workers benefitted from PMTCT refresher training, DNA PCR training, and Rapid Test training. In 2013, over 96 health care workers received training in male partner involvement, safe motherhood, and case tracking. During 2013, health care workers across 7 regions also participated in family planning sensitization sessions aimed at the reduction of repeated pregnancies among HIV positive women. These sessions were delivered with due consideration given to the sexual and reproductive rights of HIV positive women and their partners.

Voluntary Counseling and Testing (VCT) for HIV

The National Voluntary Counseling and Testing Programme continued to receive strategic guidance from the National Steering Committee which convenes quarterly to deliberate on technical and coordination issues.

Using 2006 as a baseline, the VCT programme has expanded from 38 fixed sites and 2 mobile units to 62 fixed sites spread across all ten administrative regions and 1 mobile unit serving the hinterland communities in 2013. Box 2 shows the expansion in VCT services.

Box 2: Expansion in VCT Services

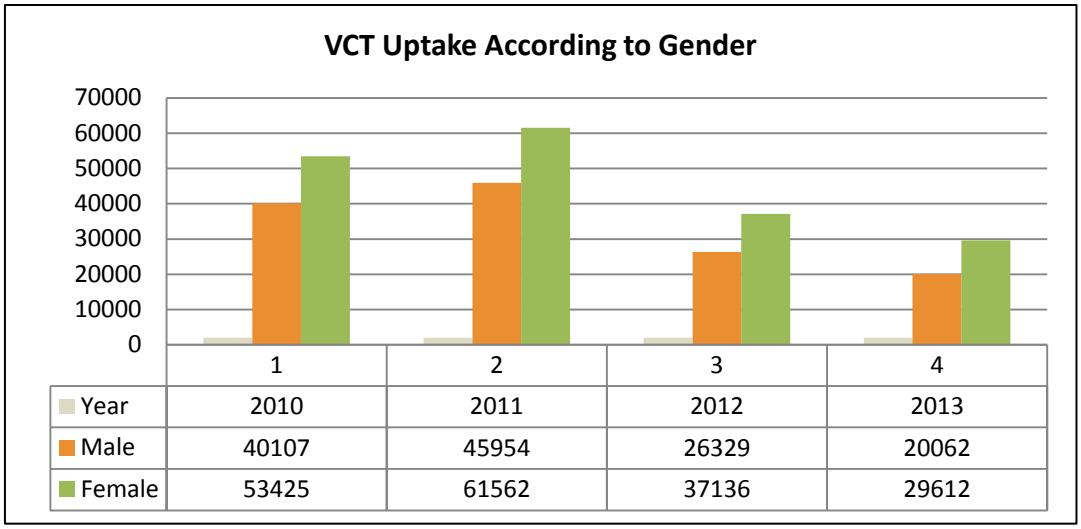
	2006 (Baseline)	2010	2011	2012	2013
Fixed VCT sites	38	75	78	81	62
Mobile VCT units	2	3	3	2	1
Counselor/ testers performing VCT nationally	58	101	104	104	85

A total of 63,465 and 49,674 tests were performed in 2012 and 2013 respectively. Of these 1,072 (1.69%) and 983 (1.9%) individuals were found to be HIV positive in 2012 and 2013 respectively. During 2013, there was increased focus on targeting key affected populations.

During the reporting period, the 25-45 year age group had the highest number of tests (46% in 2012 and 47.4% in 2013) and also comprised the highest percentage found to be HIV positive (2.3% in 2012 and 2.39% in 2013).

More females continued to access VCT services across the country. The proportion to males was 60.3% in 2012 and 59.6% in 2013. Of the persons testing positive, females comprised 49.7% in 2012 and 51.5% in 2013. Figure 8 below shows the number of tests done according to gender during the period 2010 – 2013.

Figure 8: ***Number of Tests done According to Gender During 2010 - 2013***



	1	2	3	4
Year	2010	2011	2012	2013
Male	40107	45954	26329	20062
Female	53425	61562	37136	29612

Source: NAPS VCT Programme report 2013

The decrease in the number of tests done during this period when compared to the previous period, was due mainly to a shift in targeting the general population to a heightened focus on key populations. As such, even though there was a decrease in the number of fixed sites during the period, there were numerous outreaches that targeted key populations.

In bridging the gap between HIV testing and entry into treatment, the Case Navigation programme continued to operate at high volume sites. This resulted in 147 (58%) of 254 newly diagnosed persons from four (4) VCT sites being navigated into the treatment programme in 2012 and 110 (60.4%) out of 182 persons from the same sites being navigated in 2013.

Testing for HIV also occurred in the PMTCT programme and testing is mandatory as part of the screening protocol for blood and blood products at the National Blood Bank. There has been a progressive increase in the number of persons being tested annually in these settings as shown in Table 10. This is attributed mainly to the refocused approach to VCT as testing among blood donors and the antenatal populations continued at high levels.

Table 10: *HIV Testing in Various Settings for the Period 2005-2013*

Testing Setting	2005	2006	2007	2008	2009	2010	2011	2012	2013
VCT	16,065	25,063	48,573	63,876	85,554	93,532	106,491	63,465	49,674
PMTCT	9,675	13,041	12,004	15,702	11,776	11,441	13,490	12,697	13,413
Blood Screening	5,715	6,810	7,104	7,360	7,700	7,654	7,929	7,712	11,148
Total Tested	31,455	44,914	67,681	86,983	105,030	112,627	127,910	83,874	74,235
Total HIV Positive (Notified cases)	809	1,258	993	959	1,176	1,039	972	820	758
Percentage Positive	2.6	2.8	1.5	1.1	1.1	0.9	0.8	1	1

During the reporting period, quality assurance visits were conducted at VCT sites to monitor service delivery and data quality against the VCT standards established by the Ministry of Health. Clients' exit surveys were randomly administered to ascertain their level of satisfaction with the quality of services received. During the period, VCT Qual, a systematic and planned approach to monitoring, evaluating and improving the quality of VCT services, was also finalized. Quarterly Feedback Meetings were held throughout the period with counselor/testers to monitor their progress and to identify challenges, with appropriate actions administered to address these.

Training and Outreaches

In 2012, 31 counselor/testers benefitted from workshops on Communication, 43 benefitted from VCT Cross Cutting Issues while 247 received refresher training. During 2013, the national programme in preparation for the transition of the HIV programme into the primary care setting, conducted national VCT training for 80 health care providers in 4 regions. VCT Refresher Training was also provided to 335 counselor/testers in 7 regions. During the reporting period, the national programme continued to conduct outreach sessions to sensitize the public on HIV prevention and to offer VCT. These sessions were conducted with 28 public and private sector organizations in 2012 and 16 of these organizations in 2013.

Valentine's Day Couples Testing

The annual Valentine's Day Couples Testing, with the support of business partners, has seen significant increases in the number of persons being tested in 2012 and 2013. In 2012, a total of 1,883 persons, including 514 couples received VCT while in 2013, 3,023 persons including 280 couples received VCT on this Day (see box 3). Of these 0.8% (16) and 1.2% (37) were found to be positive and referred for treatment in 2012 and 2013 respectively.

Box 3: Persons Tested During Couples Testing 2008 – 2013

Year	Target	No. of couples tested	No. of persons tested	No. of testing sites
2008	200	104	477	10
2009	200	237	1,176	8
2010	250	296	939	9
2011	300	346	1,022	11
2012	350	514	1,883	13
2013	350	280	3,023	15

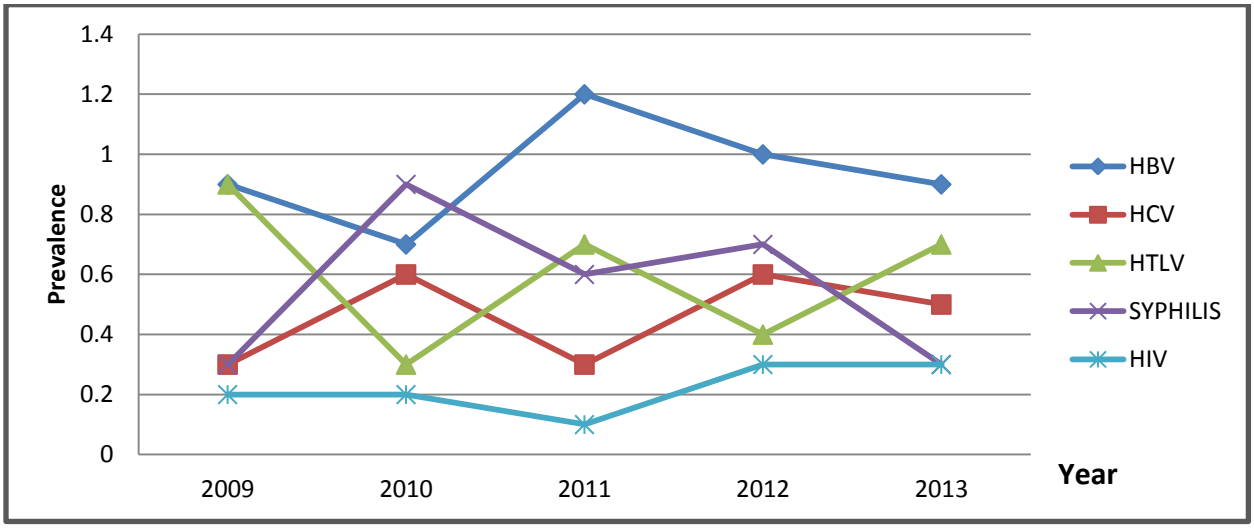
Blood Safety Programme

An adequate and safe blood supply is a crucial element of the national strategy to control HIV. In light of this, in adherence to the National Blood Policy developed and approved during the previous reporting period, all donated blood was screened for infectious markers.

In 2012, 7,712 units of blood were collected (90% voluntary donation) while in 2013, 11,148 units were collected (96% voluntary donation). This indicated a 44.6% increase in blood donations between 2012 and 2013. There has also been an increasing trend with regard to the proportion of units collected by the blood bank from voluntary blood donors over the recent years.

In 2012 and 2013 the proportion of persons testing positive for HIV among all blood units screened remained at 0.3% (21/7,712 in 2012 and 38/11,148 in 2013). Hepatitis B remained the most commonly occurring infectious marker among blood units screened with a proportion of 1.0% in 2012 and 0.88% in 2013. Figure 9 below shows the proportion of infectious markers during the period 2009 - 2013

Figure 9: *Proportion of Infectious Markers 2009-2013*

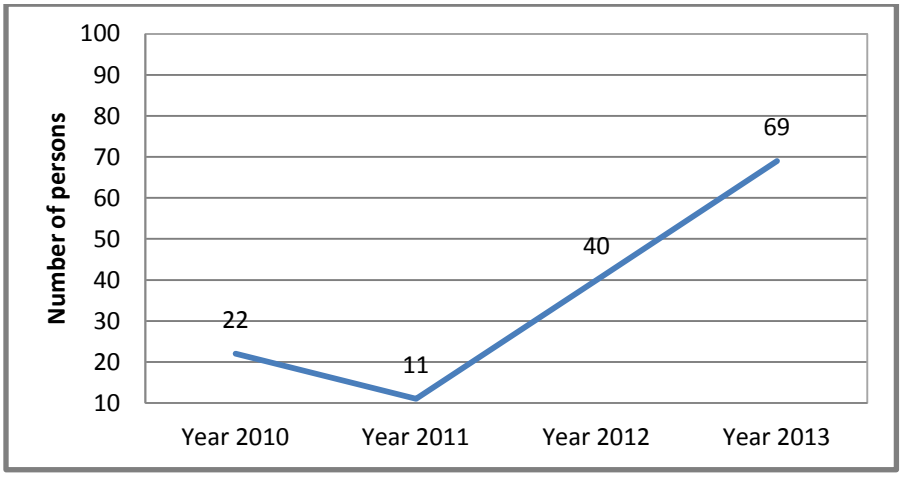


Source: National Blood Transfusion Unit

Post Exposure Prophylaxis (PEP)

During 2012, a total of 19 public health facilities and 4 private hospitals provided PEP services while in 2013, 17 public health facilities and 2 private hospitals provided PEP. In 2012, 4 public sites reported a total of 40 persons provided with PEP while in 2013, 5 public and 2 private sites reported a total of 69 persons provided with PEP (53 for needle stick injury and 16 for sexual assault). Persons were assessed and placed on the required prophylaxis. All PEP sites are fully equipped with a special PEP kit which includes ARVS, medications for emergency contraception and for treatment of other sexually transmitted infections (gonorrhea and chlamydia). The sites are supported with standard operating procedures and quick references. Figure 10 below shows the number of cases reported during the period 2010 – 2013.

Figure 10: *Number of Reported PEP Cases 2010 – 2013*



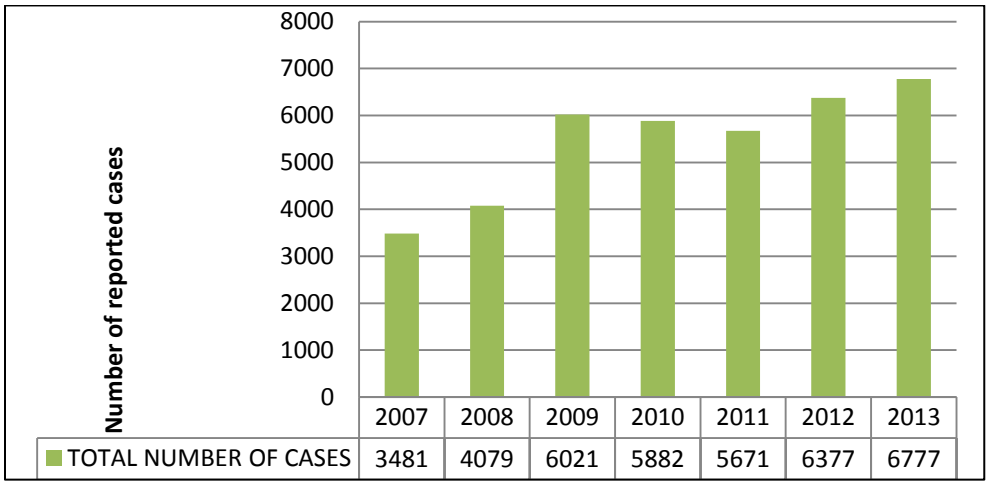
In 2012, 190 persons were trained in the effective delivery of PEP in cases of occupational exposure and sexual assault. This included 55 police officers, and 135 health care workers of different categories. During 2013, 122 health care workers received sensitization training in PEP.

Prevention and Control of Other Sexually Transmitted Infections (STIs)

During the reporting period, efforts to prevent and control STIs continued in accordance with Guyana's Comprehensive STI Strategic and Monitoring and Evaluation Plan 2011-2020. The main goal of the plan is to "reduce the transmission and morbidity and mortality caused by STIs and to minimize the personal and social impact of the infections." This plan was implemented in conjunction with the National Health Sector Strategy 2008-2012 and the new HIVision 2020 which was launched in 2013.

There were 6,777 STI cases reported in 2013 representing an increase from the 6,245 cases reported in 2012 (MoH Surveillance Unit). For the period 2007 – 2013, there has been a steady rise in the number of STI cases recorded due to increased surveillance and reporting. Figure 11 below shows the number of STI cases reported during the period 2007 - 2013.

Figure 11: ***Number of Reported STI Cases 2007 - 2013***



Surveillance Unit, MoH

Genital discharge syndrome (GDS) remains the most frequently reported syndrome (92.8% of STIs in 2012 and 94.7% of STIs in 2013). Cases of genital ulcer disease (GUD) have been decreasing over the past four years (6.5% in 2010 steadily decreasing to 3.8% in 2013) as illustrated in Table 11.

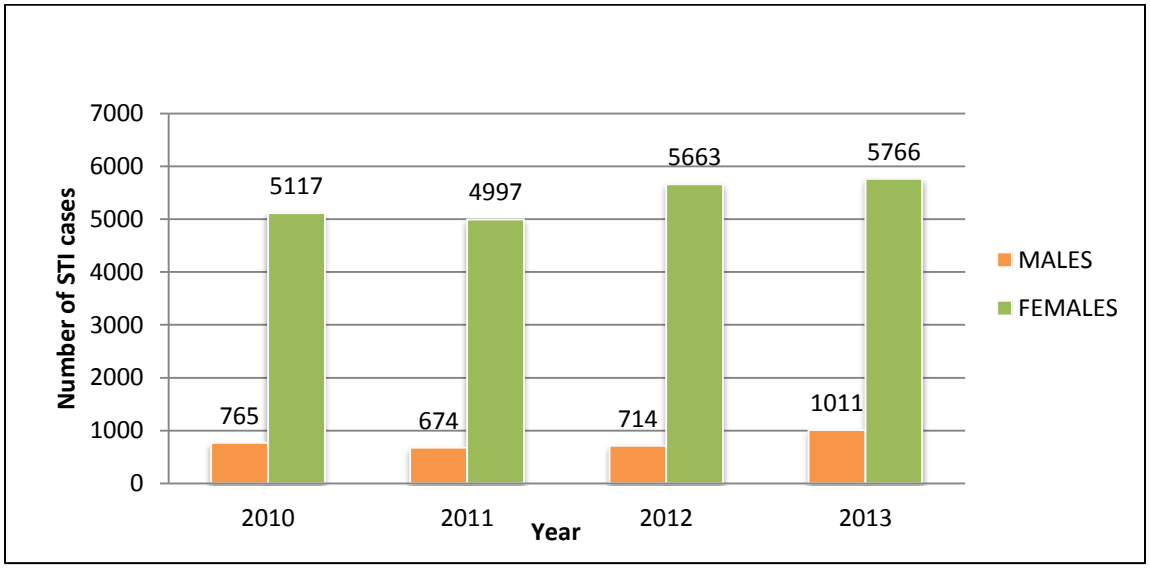
Table 11: *STI by Type 2009 – 2013*

STI	2009		2010		2011		2012		2013	
	No.	%	No.	%	No.	%	No.	%	No.	%
GDS	5,569	92.5	5,419	92.1	5,231	92.2	5920	92.8	6421	94.7
GUD	372	6.2	385	6.5	344	6.1	364	5.7	260	3.8
Gonorrhea	15	0.2	19	0.3	35	0.6	23	0.4	30	0.4
Chlamydia	10	0.2	6	0.1	6	0.1	8	0.1	8	0.1
Syphilis	17	0.3	7	0.1	22	0.4	25	0.4	26	0.4
Trichonomiasis	26	0.4	30	0.5	14	0.2	22	0.3	11	0.2
LGV	1	0.0	0	0	0	0.0	0	0.0	1	0.0
Herpes Simplex	11	0.2	16	0.3	19	0.3	15	0.2	20	0.3
Total	**6,021**	**100.0**	**5,882**	**100.0**	**5671**	**100.0**	**6377**	**99.9**	**6777**	**99.9**

Surveillance Unit, MoH

The majority of the STI cases reported continued to be among females; 89% in 2012 and 85% percent in 2013 (MoH Surveillance data), see figure 12 below. This might be partly due to the increased vulnerability of women to STIs as compared to men and the finding that men are four times more likely to self-medicate than women with regards to STIs and are therefore not captured within the public reporting system (Canadian Society for International Health Study, 2001). Figure 12 below illustrates the gender distribution of STI cases for the period 2010 - 2013.

Figure 12: *Distribution of STI Cases According to Sex 2010 – 2013*



Surveillance Unit, MoH

In 2013 there were 112 cases of HIV co-infection with other STIs compared with 49 co-infected cases in 2012 at the National Care and Treatment Center, the main sentinel site for the monitoring of STIs. This increase could be attributed to the increased surveillance.

During the reporting period, all blood donors were screened for STIs as part of the National Blood Transfusion Protocol. In 2012 the percentage of screened blood that tested positive

for STIs was 2.8% which was the same as for 2013. Hepatitis B remained the most commonly occurring STI.

STI training during the reporting period included a total of 501 persons trained in STI syndromic management during 2012 and 357 in 2013 (see Annex 1 for details of training). A proposal for the roll out of rapid diagnostic testing for STIs was drafted, 25 laboratory technicians were trained in STI testing methods, and 1 laboratory technician was trained in STI molecular diagnostic methods.

Box 4: *Study on the Prevalence of STIs Among the Military*

Study on the Prevalence of STIs Among the Military

In order to better understand the burden of HIV and other sexually transmitted infections (STI) within the Guyana Defence Force (GDF), the GDF, in collaboration with its donor partners and the NPHRL, conducted a cross-sectional study to assess STI seroprevalence and risk behaviours in the military population. Understanding the disease burden and risk factors of the GDF was a critical step in effectively reducing the incidence and impact of these diseases as STI transmission would potentially pose a threat to force readiness. The study consisted of an STI behavioural risk questionnaire, in conjunction with testing for HIV, syphilis, chlamydia, gonorrhea and hepatitis.

The 2012 survey drew attention to a number of issues critical regarding HIV and STI prevention in the GDF population, including: increasing testing for STIs, primarily Chlamydia; increasing testing, vaccinations, and awareness of Hepatitis B; increasing condom availability; changing attitudes towards condom use; encouraging HIV testing and disclosure; decreasing stigma surrounding HIV and; modifying attitudes towards women.

The age of the participants ranged from 18 to 53 with an average age of 25.6 years of the 499 military members who participated. Most of the participants (82.8%) were in the Army and slightly less than half (45.4%) currently held the rank of Private. Overall, 21.4% of participants tested positive for at least one STI and 1.4% were co-infected with an additional STI. The most prevalent STI was chlamydia with 17.65 of those tested, testing positive. Additionally, 4.0% tested positive for Hepatitis B. Only one person tested positive for HIV indicating a low prevalence (0.2%).

Other benefits of the study were that participants obtained knowledge of their HIV and STI status, referrals were offered to all who tested positive and treatment was provided as appropriate.

Screening for cervical cancer

With clear association between cervical cancer and HIV, screening for cervical cancer has been scaled with the expansion to 17 sites in 9 regions in 2013, compared to 4 sites in 1 region in 2009. In addition, screening is done during medical outreaches throughout the country. Visual Inspection with Acetic Acid (VIA) screening was initiated at the Maternity Unit of the National Referral Hospital as part of the Ministry of Health's national cervical cancer management programme which seeks to identify women with a higher risk for

cervical cancer. Through programme outreach, screening is being done at work places and other organisations that have the requisite privacy. FBOs were especially targeted during the reporting period.

The second revision of Guyana's HIV treatment guidelines added VIA as a baseline screening for all HIV infected women. The VIA screening programme is now implemented at all HIV treatment sites through onsite administration using a Single Visit Approach (SVA). In ensuring that this is now a defined standard of care, VIA documentation has been incorporated into the patient monitoring system and the degree of implementation would be monitored through the HEALTHQUAL mechanism.

As part of the VIA process, smaller precancerous lesions are removed using cryotherapy, while larger lesions are removed using Electrosurgical Excision Procedure (LEEP) at the National Referral Hospital. Clients with suspected cancer cells undergo biopsy and are referred to the Oncology Clinic at the referral hospital for management.

During 2012, 6937 persons, including 969 HIV positive patients received VIA. In 2013, 5968 persons, including 648 HIV positive patients received VIA. During the two year period, of the 12,905 persons screened, 1,105 required follow up treatment of which 1,049 accepted. Box 5 shows the number of persons screened and the follow up provided.

During the reporting period, 20 persons were also trained in performing the VIA procedure.

Guyanese girls, aged 11 to 13 years old continued to benefit from the administration of Human Papilloma Virus (HPV) vaccine which was introduced during the last reporting period. This service is provided at health centres and in schools with the consent of parents. To ensure an effective vaccination programme, an accompanying comprehensive Information, Education and Communication programme was developed and implemented. This included the development and distribution of educational brochures, posters and booklets, and mass media activities such as panel discussions, documentaries and others. The IEC materials targeted parents, families, teachers, young girls and the general public.

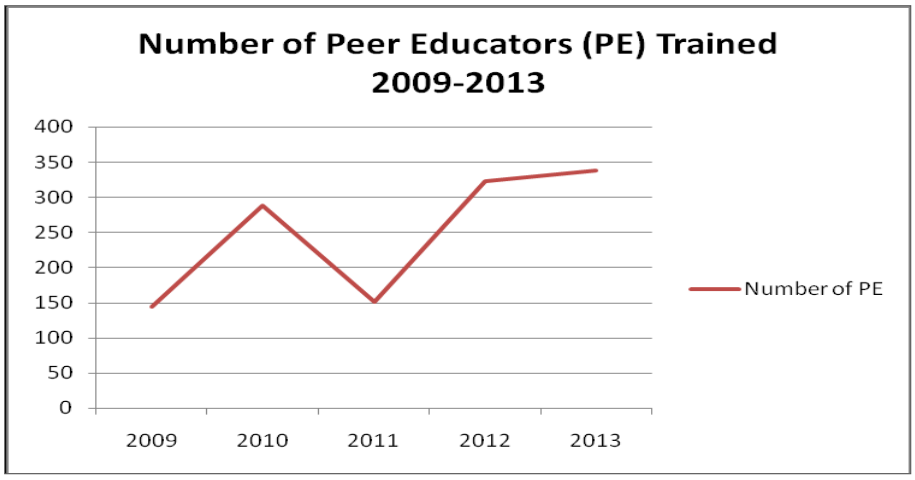
Box 5: VIA Services Provided 2012 - 2013

	2012	2013
Total receiving VIA	6,937	5,363
Number of HIV positive clients who received VIA	969	648
Total of all clients with Positive VIA	639	466
Received cryotherapy	522	353
Received LEEP	26	55
Referred to Oncology	48	45

Community Mobilization

The focus of the community mobilization programme during 2012 and 2013 was training and sensitization of in and out-of-school youth across Guyana, on HIV and AIDS and on the reduction of stigma and discrimination. A total of 323 youth (122 males and 201 females) were trained in 2012 and 338 youth (109 males and 229 females) were trained in 2013. The training focused on HIV transmission, other STIs, prevention strategies including ABC, stigma and discrimination, and peer education. Interactive methods of teaching were employed and IEC materials distributed during the training. These sessions were conducted in collaboration with key stakeholders within the community. In providing training, priority was given to the outlying regions during the reporting period, in view of their limited access to the services of NGOs. Figure 13 shows the number of persons trained as peer educators during 2009 - 2013

Figure 13: ***Number of Peer Educators Trained 2009 – 2013***



Source: NAPS Programme Reports

The process of revising the HIV/AIDS Peer Education manual is currently in progress. Led by a Technical Working Group (TWG), the revision process received inputs from a national consultation and through direct feedback from peer educators. The revision will discuss and include other technical areas such as family planning and substance abuse among others. In addition, the TWG will provide Standards and Guidelines for Peer Education, including the very important criteria for certification and re-certification. These processes will conclude in 2014.

Interventions with Key Populations at Higher Risk

The Guyana National Programme acknowledged the need for a strengthened response to the Key Populations at Higher Risk. These populations in HIVision2020 were defined as *"populations at higher risk of HIV exposure which refers to those most likely to be exposed to HIV or to transmit it due to the number of partners they have or the type of high risk sex they engage in"*. The populations identified included PLHIV, MSM, Sex Workers and their clients, transgender persons, prisoners, miners and loggers.

A National Steering Committee for the Key Population response is coordinated on a quarterly basis and ensures that members of the key population are involved in the planning, design, implementation and monitoring of programmes, particularly those that affect them directly. Specific focus groups sessions were held with female commercial sex workers (FCSWs) (19) and MSM (26) in soliciting inputs into the development of the HIVision2020. On an ad hoc basis, the expertise and experience of the key population is sought for example in 2013, a TWG which was convened to design and implement the third round of the BBSS, included several members of the key populations.

To effectively reach key populations with combination prevention, a key prevention package of service was defined in the national Most at Risk Population(MARPs) guidelines of 2012, and more recently in HIVision2020. This package includes: peer education and outreach; risk reduction counseling and skills building; promotion, demonstration and distribution of male and female latex condoms and water based lubricants; screening and treatment for drug and alcohol abuse; voluntary counseling and testing; STI screening and treatment; HIV care and treatment and; reproductive health services.

Men who have sex with men and female sex workers

During the reporting period, MoH continued to coordinate efforts to address key populations at higher risk, in close collaboration with its partners, including NGOs. Interventions focused on female sex workers (FSWs) through the "Keep the Light On" initiative and on men who have sex with men (MSM) through the "Path for Life" initiative. These groups were known to engage in high risk behavior and the rate of STIs among them was found to be relatively high (BSS Survey 2008/2009 Report). The aim of these initiatives was to prevent the spread of HIV/AIDS among MSMs, FSWs and the rest of the population since it is believed that these two groups serve as a bridge to the rest of the population.

In 2012, a total of 1,631 members of the target group (722 MSMs and 909 FSWs) were reached with an appropriate package of HIV prevention services as defined above. In 2013, there was an increase in the number reached with a total of 1,929 members of the target group (597 MSMs and 1,332 FSWs). Box 6 shows the number of MSM and FSWs reached during the period 2009 – 2013.

Box 6: MSM/FSW population reached 2009 - 2013

Year	FSW	MSM	Total
2009	968	1,375	2,343
2010	1,192	1,354	2,546
2011	1,644	763	2,407
2012	909	722	1,631
2013	1,332	597	1,929

While the numbers reached remained relatively constant during 2009 – 2011, the numbers decreased during the 2012 - 2013 due to the reduction of NGOs working in the targeted areas and the decision to deliver quality service to key populations rather than focus on quantity. In addition during this period there was some intensification of the prevention

response to the mobile and migrant populations. Table 12 below provides a list of the NGOs involved in providing services to key populations during the reporting period.

Table 12: ***NGOs that Provided Services to MSM and FSWs During 2012 - 2013***

NGO	Region	Target Population
Guyana Red Cross	1, 8	FSW
Hope for All	2	FSW, Miners & loggers, Adjacent Populations
Artistes in Direct Support	3, 4	MSM, FSW
Guyana Trans United	3, 4	Transgender
Friends Across Differences	4	FSW, MSW, MSM
SASOD	4	MSM, MSW, Transgender
Guyana Sex Workers Coalition	4, 10	MSW, FSW
United Brick layers	5, Lower 6	MSM, FSW
FACT Swing Star	Upper 6	MSM, FSW, Loggers, Adjacent Populations
Hope Foundation	7	FSW, MSM, Miners, Loggers, Adjacent Populations
Youth Challenge Guyana	8	FSW, MSM, Miners, Loggers, Adjacent Populations
Linden Care Foundation	10	MSM, FSW, Miners, Loggers, Adjacent Populations

Peer education training continued for members of the key populations using the Keep the Light and the Path for Life manuals for the FCSW and the MSM populations respectively. The peer educators were taken primarily from the key populations and they were actively engaged in interpersonal communication (HIV and STI education) and in delivering the key prevention package. Secondary data analysis conducted on the 2009 BBSS provided critical information which guided the revision of the Path for Life manual for the MSM population. After revision these were reprinted and circulated and peer educators were retrained.

In addition to direct service delivery to the key populations through outreaches, significant efforts were made at targeted venues and their proprietors. These venues included hotels, brothels, clubs, bars and a variety of others. To facilitate this, a directory profiling the venues was developed and this is updated on an annual basis. Proprietors and staff of the venues were sensitized on STIs, HIV and AIDS and on stigma reduction. HIV information and condoms are readily accessible at these venues. During 2012, the number of participating hotels/brothels/bars was increased to 20 (compared to 16 in 2011), with the addition of 3 additional regions in Guyana.

To ensure consistent and correct condom use, many teaching aids and demonstration tools are used in the fields. In addition, IEC materials targeting these populations were developed and these comprise part of the prevention package. The distribution of condoms and IEC materials during the

Box 7: Condom Distribution Among MSM/FSWs 2010 - 2013

Year	NGOs	Hotels/ brothels/ bars	Total condoms
2010	235,457	104,052	339,509
2011	126,170	67,904	194,074
2012	149,069	330,421	479,490
2013	2,338,641	330,062	2,668,703

reporting period saw 479,490 condoms and 4,912 pieces of IEC materials distributed among MSM and FSWs in 2012 and 2,668,703 condoms and 329,802 pieces of IEC materials distributed in 2013. Box 7 shows condom distribution among MSM/FSWs through the key populations at higher risk initiative during the period 2010 – 2013. Operational information has shown a larger percentage of the targeted population practising consistent condom use with clients, as reported in the study below. Lubricants were made accessible primarily to the MSM population on a very small scale primarily through donations. In 2014, significant support is planned under the Global Fund for the procurement of Lubricants for the MSM population

HIV testing among MSM and SW is a key component of the prevention package. During the reporting period, VCT outreaches increased with a focus on reaching these populations. To effectively serve the MSM population, the 20 MSM who received VCT training and were certified as counselor testers during the previous reporting period, continued to provide this service to their peers during the current period.

A qualitative assessment conducted during the previous reporting period, revealed that stigma and discrimination within the health care system, prevents many PLHIV, MSM and FSWs from accessing HIV counseling and testing, in addition to the other services offered by health care facilities. As a follow up to this, during the reporting period, stigma and discrimination reduction trainings were conducted for 248 staff members attached to a number of health care facilities in 7 regions of Guyana. These included HIV care and treatment centres. This training was geared towards sensitizing health care workers on how stigma and discrimination can affect individuals. At some of these sessions, participants had an opportunity to meet and speak with FSWs and MSM to learn about their lives and experiences and about the effects of stigma and discrimination on persons seeking care.

During the period, NGO staff who were trained as stigma and discrimination course facilitators also conducted training for Police officers and other law enforcers in the reduction of stigma and discrimination in their dealings with MSM and FSWs. This resulted in a reduction of Police harassment among these key populations.

Empowerment of MSM and FCSW continued with training in many areas such as literacy and numeracy, hair dressing, computer use, and business management, among others skills. Job readiness training was provided to these groups through capacity building in terms of self esteem building, goal setting, resume writing, business management, entrepreneurship skills and other work ethics related aspects. MSM and FCSWs also attended career guidance workshops. During the reporting period, 153 FCSWs were provided with job readiness and business management skills training and 54 either gained employment or started their own small businesses.

A number of support groups of FCSWs and MSM established at the level of the NGOs, continued to meet regularly to strengthen their knowledge of HIV and AIDS, STIs, substance use, stigma and discrimination, and other topics contained in the Keep the Light On and the Path for Life manuals. Additionally the support groups served as a forum for sharing experiences and challenges experienced by group members and it also provided the opportunity for peer to peer support.

The total number of participants trained under the key populations initiatives during the reporting period was 430, including 191 MSM/FSWs and 225 health care workers and 14 miners/loggers. Training focused on HIV/AIDS sensitization and stigma and discrimination. Miners and loggers were included as key populations in this training because of the mobile nature of their jobs, limited access to health care services in the remote regions, and the high frequency of sex work associated with these camps.

During the reporting period, a mapping exercise of FSWs was done in one outlying region in the effort to develop a directory that identified the appropriate place and time to conduct outreaches. Supervisory outreach and evaluation of peer educators was also done by MoH/NAPS and quality assurance assessments were done with all NGOs working with key populations.

Box 8: *Study on Condom Use Among Male and Female Sex Workers*

Study on Condom Use among Male and Female Sex Workers

In September 2012, a qualitative assessment of condom use and negotiation practices among male and female sex workers (SWs) was conducted through a collaborative effort between NAPS and GHARP II. The aim of this study was to explore the factors impacting the ability/willingness of male sex workers (MSWs) and FSWs to use condoms during each sexual encounter. The specific objectives were to: understand the frequency of condom use by SWs during sexual encounters with clients and regular partners; assess the approaches used by SWs to negotiate safer sexual practices with clients and regular partners; determine the challenges for negotiating condom use among SWs, such as language differences, gender differences, risk assessment ability, or alcohol and substance use and; inform strategies to enhance SWs' sense of self-efficacy in adopting consistent and correct condom use. The study was conducted among 85 FSWs from 7 regions of Guyana and 19 MSWs from 3 regions.

The study revealed that: messages about consistent condom use with clients seem to have had the desired effect among FSWs – they reported 100% condom use with clients, except when violence intervened or when they were lulled into a false sense of security due to the familiarity of the client; most of the FSWs did not use a condom when with their regular personal partners – those who did were using it for contraceptive purposes; female condoms were not popular, were not used frequently, were not easily available and little was known about them; male condoms were easily available through brothel owners (who also provided information on HIV), health facilities, friends, and NGOs free of cost and in shops for easy purchase; some CSWs did not have confidence in the quality of the free condoms; most of the FSWs (and not the MSMs) use alcohol or marijuana – as a coping mechanism for the type of work they do; condom use was not consistent among MSMs – they forgo the condom for a higher fee or when the client "look pretty"; there was no stigma associated with either FSWs or MSM purchasing condoms; most clients of MSM and FSWs recognize the importance of using a condom, however there are instances when clients attempt to negotiate sex without a condom, become violent, or have forced sex with the MSM or FCSW; condoms are seen by MSMs and FSWs as protection from unwanted pregnancies and diseases such as HIV but they are not 100% safe since they could burst and; many of the MSM and FSWs described sex work as a means to earn a living and as a stepping stone to other things.

The findings of the study served to inform future strategies for HIV prevention and transmission among MSMs, FSWs and their clients. It was also recognized that such interventions would have to be specially adapted to suit each target group given the observed differences in dynamics with respect to each group.

Interventions among the transgender groups

Whilst HIVision 2020 recognises the transgender groups as a key population and defined them for strategic intervention, little is known of the transgender epidemic in our national context. Under section 153 of the Summary Jurisdiction (Offences) Act, the Laws of Guyana, establish cross dressing as an offence: *"being a man, in any public way or public place, for any improper purpose, appears in female attire or being a woman, in any public way or public place, for any improper purpose, appears in male attire.* In 2010, 4 men were charged for wearing female attire and SASOD on their behalf challenged the appropriate section of the laws of Guyana. During the reporting period the case was concluded and all constitutional redress were denied. SASOD has committed to continue advocating for constitutional reforms in this area and has appealed the case. In similar manner as in the case of MSM and FCSW, this situation could present significant obstacles to accessing of HIV prevention, care, treatment and support services by the transgender population.

Despite the above, during the reporting the transgender population has become more visible and the Trans Guyana United group was formed. At the present time, the group works primarily in some of the coastland regions in HIV sensitization and prevention activities. The BBSS which commenced in 2013 and is expected to conclude in 2014, will provide some amount of baseline data on this population.

Interventions Targeting Migrant/Mobile Populations

Services to the mobile and migrant populations are provided through the health care facilities and NGOs primarily in the hinterland regions of 1, 7, 8 and 9 where the mining and logging industries predominate. During the reporting period the Government of Guyana with support from a donor partner began implementing a Migrant Population Project to enhance the accessibility and the quality of HIV prevention, care and treatment services for migrant and mobile populations in 2011. A Technical Working Group was established with focal persons from: NAPS, the Health Sector Development Unit, Ministry of Amerindian Affairs, International Labor Organization, National Malaria Programme, National Tuberculosis Programme, Ministry of Health, PAHO-WHO, Guyana Bureau of Statistics, Guyana Geology & Mines Commission, Guyana Forestry Commission, Institute of Migration and GHARP II. This group continued to meet during the 2012 – 2013 period.

The Migrant Population Project consists of these components: policy guidelines & legal framework; health financing mechanism and; improvement & adaptation of HIV services to targeted populations. The activities identified for this project were: enhancement of the policy and legal framework constituting the access rights of mobile and migrant populations with regard to HIV & AIDS services at the national level and; identifying and piloting effective financing mechanisms/models to secure the access of mobile and migrant populations to HIV. In 2013, two key assessments were conducted on the legal and policy framework influencing access to HIV services by migrants and on improving access to HIV

services for migrant populations. The recommendations of these assessments are under consideration.

This project, funded by the PANCAP/GIZ initiative is part of a regional initiative. As such, Guyana benefitted from capacity building through a training of trainers workshop on "Stigma, Discrimination, Cultural Sensitivity and Human Rights Related to Health and Migration". This training also sought to finalize the regional training curriculum and manual. As a follow up, Guyana conducted a national workshop and modified and finalized a National curriculum.

In recent years, Guyana's gold and diamond mining industries have expanded rapidly in Regions 1, 7, 8, and 9. Accompanying this expansion is the parallel growth of sex work, which is felt to be contributing to increased HIV and STI incidence among miners. During the reporting period, to address HIV among these mobile and adjacent populations, five NGOs conducted outreach activities in the mining and logging communities using reporting and tracking tools and BCC materials to help strengthen their efforts. In total, the NGOs reached 5,102 miners and loggers with prevention, testing, and/or care and support outreach initiatives. There is ongoing collaboration between the NAPS and the National Malaria Control Programme to achieve efficiency in reaching the mining and logging communities.

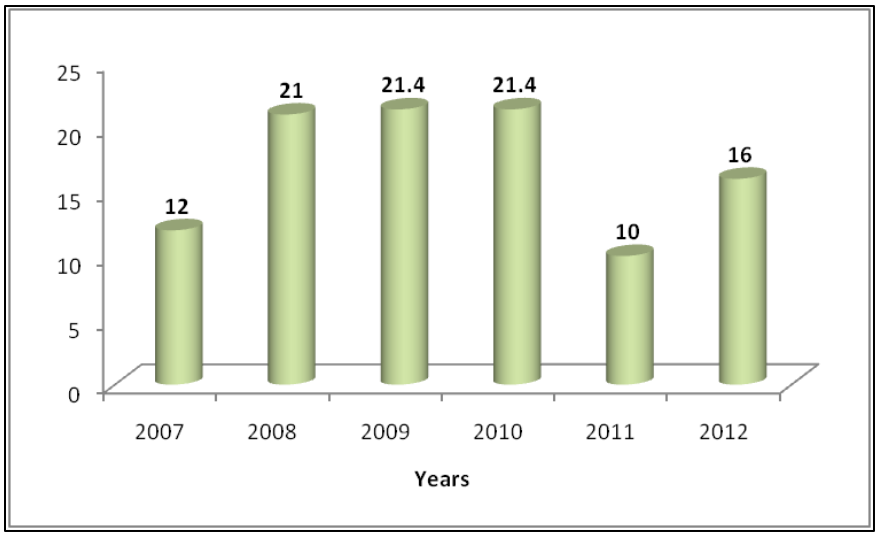
During the reporting period, short culturally appropriate videos were developed for distribution among Brazilian migrants whose influx through the Guyana/Brazil border has been steady within the past few years. These videos depict relevant information on the legalization process, education and health-related issues such as HIV, TB and malaria. The videos also provide guidance on how and where to access the relevant services. Legalization of immigration status is seen to be crucial in avoiding the discrimination that can result from lack of regularization.

Interventions Targeting Prisoners

HIV prevalence among prisoners was found to be 5.2% during a survey conducted in 2004. HIVision 2020, National HIV Strategic Plan (2013 – 2020), identifies prisoners among the key populations at higher risk and aims to provide strengthened HIV prevention, care and treatment services for this population in the effort to ensure equitable access to health services.

During the reporting period, care and treatment services were provided routinely to HIV positive prisoners who are normally escorted to the treatment site nearest to their prison. In addition, the national HIV programme in collaboration with the national TB programme provided on-site HIV/TB education, VCT, and TB testing at six prison locations. In 2012, 43 prisoners tested positive for TB of whom 7 (16%) were found to be co-infected with HIV. During 2013, 708 prisoners were screened for TB of whom 5 were found to be co-infected with HIV. During the period 2007-2012, the HIV/TB co-infection rate in the six prisons fluctuated with a low of 12% in 2007, peaking to a high of 21.4% in 2009 and decreasing to 16% in 2012. Figure 14 below shows the TB/HIV co-infection rate in the prisons during the period 2007 – 2012.

Figure 14: *TB/HIV Co-Infection Rate in Prison During the Period 2007 – 2012*



As part of the package of services provided to prisoners, TB and TB/HIV co-infected patients are routinely monitored by the TB DOTS prison supervisor. Nutritional support is also provided for the TB patients in Georgetown prison.

Prevention Among Youth

HIV prevention among youth remains a priority as whilst knowledge on HIV is reported as high, behavior change remains a challenge. The two rounds of BSS conducted among the in school youth clearly demonstrates this as knowledge of HIV was reported at over 95% (BBSS 2005, BBSS 2009). Further findings however did not bring to bear parallel appropriate behavior since the age of sexual debut decreased from 15 years to 14 years. A more recent study was done among youth during the period 2012 – 2013. This was a qualitative research study on HIV vulnerability among young key affected populations in Guyana, conducted by UNICEF. This study was termed "Most At Risk Adolescent Study". The study gathered information on HIV risk factors from 352 adolescents (124 rural, 88 hinterland and 140 urban) over a three-month period. These adolescents included MSM, in school youth, youth in contact with the law, CSWs and out-of-school youth. The research team also conducted more than 50 interviews with key persons in the adolescents' world including their peers, teachers, employers, parents, probation officers, and religious leaders.

The findings of the above study revealed that the factors that put adolescents at risk of contracting HIV included: early sexual debut (10 – 14 years) and low condom use; on occasions when there was condom use, adolescents preferred to purchase rather than use the free condoms because of lack of confidence in the quality; sexual abuse – "step daddy" rape; teenage pregnancy; absence of comprehensive facilities for victims of abuse; substance abuse with drugs and alcohol being available in schools; peer pressure and bullying; poverty; poor parenting and absent parents due to migration; abandonment; poor communication with parents/guardians; lack of recreational facilities and; in the hinterland regions, the mining sub-culture and fewer services.

Programmatic data from the National Care and Treatment Center during the reporting period indicated that 31% of the persons diagnosed with an STI in 2013 were within the age group of 15-24. This data further supports the importance of maintaining the focus on the youth population. With this evidence, the national HIV programme, including the MoH Adolescent Health Unit, in collaboration with MoE continued to target the youth population.

The health and family life education (HFLE) programme that was piloted during the last reporting period, continued during 2012 and 2013 with the expansion of the programme into 110 secondary schools compared to 70 during the last reporting period. The programme was conducted as a time-tabled subject for 7th and 8th grade students, focusing on life skills education including topics such as: decision-making; self-esteem; disease prevention (include HIV); sexual and reproductive health; anger management; peer pressure; substance abuse and; teenage pregnancy. In support of the HFLE module on sexual and reproductive health, the YES programme (Youth Educators Safe-Guarding our Work Force) was introduced. The goal of this programme is to reduce the vulnerability of in-school youth to HIV; to reduce the number of new infections among in-school youths and; to build the capacity of out-of-school youth to reduce risky sexual behaviours. These sessions are conducted weekly by young adults in the respective schools.

During the reporting period, more than 8,000 students were reached with life skills education and 78 teachers were trained and retrained to deliver the programme in the 7th and 8th grades. The HFLE module was also included in the curriculum at the national teachers' training college. To further boost the HFLE programme, the teaching materials were upgraded with the development of additional posters and text books on life skills education. In order to measure the effectiveness of the HFLE pilot programme, during the reporting period, the Ministry of Education in collaboration with UNICEF conducted an evaluation of the programme. The report of this evaluation is currently being finalized for release.

During 2013, the Adolescent Health Unit of MoH continued to engage adolescents in activities to educate them on sexual and reproductive health, healthy lifestyles and increasing access to essential services through the promotion and implementation of adolescent friendly services. MoH collaborated with UNFPA to reintroduce the Youth Friendly Services Initiative in Primary Health Care facilities. The aim of this initiative was to provide sexual reproductive health services to adolescents in the effort to decrease teenage pregnancy and reduce the incidence of STIs and HIV. Six health centres were chosen to pilot the Youth Friendly Services. The initiative included the training of 16 health care providers and 30 auxiliary staff at these health centers by MoH in collaboration with UNFPA and the Ministry of Education. The sessions focused on youth friendly services, the problems encountered by adolescents and the need for parenting and mentorship.

As part of the Youth Friendly Services Initiative, antenatal clinics for pregnant teenagers were also established at the 6 pilot health centres. In addition to the routine antenatal services, pregnant teenagers attending these clinics were provided with education on: the psychological changes of pregnancy; nutrition; labour; care of the newborn; family planning; self and personal development; reintegration into school and gender based violence. A total of sixty (60) pregnant teenagers benefitted from 11 educational sessions that were also attended by staff. In addition, an open invitation was issued to family members.

During 2013, the WASH Initiative in observance of International Day of Hand Washing, was implemented among 3 schools located in 3 hinterland regions. This was a collaborative effort between the MoH, the Ministry of Education and UNICEF. The aim of this initiative was to promote healthy living within communities through increasing the awareness of WASH and its role in preventing the spread of diseases. A total of 1,055 students benefitted from varying packages of services including: education on personal hygiene, nutrition, sexual reproductive health and gender based violence; eye screening; blood group screening; vaccination and the receipt of personal hygiene items. Sessions were also held with teachers and parents (including dorm parents who manage the dorm), to identify the challenges encountered in dealing with adolescents and the appropriate approaches to be adopted in dealing with these challenges. Similar sessions were also held with the students to identify the challenges that they encountered and ways and means of addressing their needs.

In an effort to promote knowledge among youth on HIV/AIDS as well as the work done by the national programme, NAPS continued to host its annual work study programme for high school students. To date, 87 students have benefitted from this programme since its commencement in 2008. During the reporting period, 15 students received both HIV-related and life skills training from NAPS. During 2012, these students were instrumental in mobilizing resources from the business community to be used for recreational activities for the children of the orphanages. In addition, they performed voluntary work in the Paediatric Ward of the Georgetown Public Hospital, the Palms Institution (a home for the elderly) and assisted in the implementation of the NAPS general programme of work.

Prevention of Gender Based Violence

The Government of Guyana has intensified its response against gender based violence. A National Domestic Violence Oversight/Policy Committee, established by the Ministry of Labor, Human Services and Social Security oversees the effective implementation of the Domestic Violence Policy (2008-2013). The Committee also provides guidance to regional and local domestic violence committees and to monitor and evaluate their work. The Committee comprises senior officials of various Government Ministries (Ministries of Health, Education, Human Services and Social Security) and agencies, civil society and non-government organizations (Help and Shelter, Red Thread) who are involved in programmes aimed at reducing domestic violence, magistrates, the Guyana Police Force, and individuals with appropriate skills and experience.

The public awareness campaign launched by the government during the previous reporting period to facilitate implementation of the Domestic Violence Legislation and the Sexual Offences Legislation, continued during the current reporting period. To support the government's efforts against gender based violence, the Women's Affairs Bureau that forms part of the MoLHSSS structure, continued during the reporting period to engage in public awareness efforts against gender based violence and also continued to provide support to the victims and survivors of gender based violence. To facilitate this latter process, the free emergency 24 hrs hotlines continued to be publicized. During 2013, as part of Guyana's requirements to report to CEDAW (Convention to Eliminate all forms of Discrimination Against Women) on how HIV affects women and girls in Guyana, a workshop on "CEDAW and Gender Dimensions of HIV in the Caribbean" was held in Guyana. This

saw wide participation from governmental and non governmental organizations, civil society partners, PLHIV, women's rights groups and HIV service providers who provided their inputs during the workshop, which focused on human rights and HIV and HIV-related risks that women in Guyana are exposed to, among other topics.

The Men's Affairs Bureau that also forms part of the MoLHSSS structure, continued during the reporting period to address violence against women, with the involvement of men as part of the holistic response. As part of its public education and outreach programme, the Bureau held a number of sensitization workshops across the country, which focused on helping young men understand issues relating to their own gender, such as anger management and self esteem. The workshops also focused on understanding the emotional needs of spouses and the issue of gender equality. These workshops were held in number of schools, prisons, and public places. During the reporting period, the Bureau also worked with men who were involved in situations of domestic violence and assisted them in resolving disputes within their homes.

During the reporting period, MoH continued to support the victims of gender based violence through its programme which focused on primary prevention (promoting awareness at health facilities, schools and within communities), secondary prevention (early identification of GBV) and referral to social, economic and legal support services. The MoH workplan for GBV emerged out of a Gender Challenge Stakeholders Workshop on GBV held in Guyana during the period. A significant achievement during the period was the finalization of the MoH's Sexual and Domestic Violence Protocol for Health Care Workers. The protocol focuses on elements of immediate response to victims of sexual abuse that are the responsibility of health care providers. During the reporting period, more than 250 health care workers from the different regions if Guyana were trained in this protocol.

Additional training for health care workers included the exposure of over 200 healthcare workers from 2 regions of Guyana to the topic of Intimate Partner Violence and the training of health facilities managers in GBV to raise awareness and to build their skills in addressing GBV. Twenty five (25) health care workers involved in health statistics received training on "Advancing in Analysis with a Gender and Ethnic Perspective." The objectives of this training was to strengthen national capacities to analyze health statistics, applying principles of gender and ethnic equity to promote decision-making processes based on information, and monitoring the advance towards gender equality and ethnic equity. During the period, 11 trainers, including persons who work in the field of GBV were trained to use the Gender Based Violence in School Manual which is part of the HFLE training package. Additional Gender Based Violence workshops also including a focus Mental Health, were conducted for over 200 persons involved in providing counseling for victims of GBV.

GBV training for youth included an International Youth Conference Against the Contagion of Violence, and GBV awareness training for over 2,100 students (comprising boys and girls) taken from 17 schools (primary and secondary) from the different regions. In addition, the MoH collaborated with the organizers of a series of under-20 football tournaments in engaging in-school youths of 24 secondary schools in gender based violence awareness sessions as a strategy to promote attitude and behaviour change. An essay writing competition on the topic "the Social Factors Impacting Domestic Violence in Guyana and

Ways of Addressing Those Factors" was also launched targeting in school youth and 39 entries were received.

During the period under review, a number of non governmental entities also provided a range of programmes and services to women and children who were the victims of domestic violence. These included legal assistance through the Guyana Legal Aid Clinic and counseling and temporary refuge through other entities. Help & Shelter, one such entity, as part of its project on the Promotion of Human Rights of Victims of Domestic & Sexual Violence and Child Abuse, provided victims with temporary shelter, face-to-face and hotline counselling services, free court support services, and referral services. The agency also launched the programme "Advancement of Gender Equality and Reproductive Rights." which focused on conducting sensitization sessions in selected workplaces to enhance knowledge of gender equality and reproductive rights, the Domestic Violence Act, and the impact of gender-based violence. In addition, Help and Shelter expanded its community-based initiatives in family planning to support cross-cutting issues of gender, gender-based violence, and community education. During the period, the agency implemented a 10-month GBV awareness project in two communities with the objectives of: increasing knowledge and understanding of GBV, male/female relationships, male norms and behaviours; raising awareness of the relevant legislation; informing of existing agencies involved in GBV reduction; identifying the impact of GBV on the spread of HIV; promoting non-violent and peaceful resolution of conflicts and; building capacity to address GBV.

A priority of the workplace programme during 2012 and 2013 was the integration of gender based-violence and male norms and behaviors into the training curricula given their relation to HIV. Almost 1,490 workers were sensitized on gender issues in relation to HIV and AIDS during the reporting period. Organizations included the Guyana Trades Union Congress (GTUC), the Guyana Sugar Corporation (GUYSUCO) and other public and private sector entities.

Other key Initiatives Implemented Under the National Prevention Programme

Workplace Programme

The thrust of the workplace programme has been to propel enterprises towards sustaining their own programmes through the implementation of comprehensive health and wellness programmes which address issues beyond HIV and which include the promotion of human rights and social security. A priority of the programme is the integration of gender based-violence and male norms and behaviors into the training curricula given their relation to HIV.

A major breakthrough with regard to workplace policy was the tabling in Parliament in January 2014 of the HIV and AIDS Regulations, made under the Occupational Safety and Health Act 1997. During the reporting period work was ongoing in drafting these regulations through collaborative efforts between the Ministry of Labour, MoH, the Attorney General's Chambers, ILO and other key stakeholders. The Draft Regulations were finalized in November 2013, gazetted in December 2013 and tabled in Parliament in January

2014. These Regulations seeks to enforce the National Workplace HIV and AIDS Policy and includes the right of PLHIV to secure employment and be provided with the same health and other benefits accorded to other employees. The next step is to educate the various stakeholders on the requirements of the new Regulations through the active involvement of the MoLHSSS and the Tripartite Committee comprising representatives of the Consultative Association of Guyanese Industry (CAGI) the Federation of Independent Trade Unions of Guyana (FITUG), and the Trades Union Congress (TUC). To this effect, a costed implementation plan for the policy is currently being developed (PEPFAR report).

In 2013, 8 Trade Union representatives from Guyana were beneficiaries in a multi-country capacity building programme regarding a sustainable workplace response to HIV. This programme was for Leaders, Industrial Relations Officers, HIV Focal Persons and HIV Peer Educators from the member organisations of the Caribbean Congress of Labour. During the reporting period, ILO as part of its HIV/AIDS Workplace Education Project provided support to 13 business enterprises in the development and implementation of their HIV and AIDS Policy and Programme.

Training provided during the period included technical assistance to the Guyana Sugar Corporation's Training Centre to improve its capacity to plan and implement successful programmes through Competence Based Education as a way of work. Competence Based Education assists organizations to effectively respond to social issues, including HIV/AIDS through the methodology that is utilized. Twenty (20) persons including lecturers and apprentices were trained in this methodology. Guyana Trades Union Congress organized peer counselling training for 61 of its members in 4 regions of Guyana as part of its capacity building initiative to enhance their skills. These sessions also addressed Male Norms, Gender Based Violence and Coercion and their impact on HIV. Twenty two (22) persons from other business entities also received similar training during the period in the effort to generate sustained behavior change among workers.

The Guyana Business Coalition on HIV and AIDS (GBCHA) continued to be a key agency in supporting the HIV workplace programme in keeping with Guyana's National HIV Policy. With GHARP II support in updating its business plan, membership strategy and industry-specific recruitment materials, the GBCHA membership increased to 47 companies with the addition of 1 new company since the last reporting period. This support continued to increase GBCHA's capacity for multi-sectoral partnerships and approaches for addressing HIV and AIDS in Guyana. During 2012 and 2013, 17 persons and 39 persons respectively from GBCHA member companies were trained as peer educators. Eleven (11) peer educators also underwent refresher training in 2012. In 2012 over 1,005 employees participated in workplace policy implementation and other workplace educational sessions while in 2013, 279 employees and 123 students participated in this type of training. Over 100 employees and 4000 clients received VCT through GBCHA in 2012 while in 2013, 2,110 persons received VCT. In 2013, GBCHA also expanded its work in gender based violence, in workplaces and schools.

The Supermarket Initiative that was launched in 2010 to aggressively promote awareness of HIV and AIDS and general health and wellness, continued during the reporting period with the collaboration of the 10 participating supermarkets. The participating supermarkets were required to identify and assign an employee as a popular opinion leader/focal point

responsible for training staff and reinforcing health prevention information, HIV and general health sensitization sessions for employees of the supermarkets. As part of this initiative, condoms and IEC health materials were also provided for free distribution to the public. Twenty two (22) and 12 supermarket staff were trained in 2012 and 2013 respectively in the basics of HIV, modes of transmission, and stigma and discrimination. In 2013, T-shirts with HIV messages were provided to the staff of 6 supermarkets to be worn on the job to increase HIV awareness.

Reducing Stigma and Discrimination

Like many other countries, stigma related to HIV continues to affect the National Programme in reaching persons who most need prevention, treatment, care and support services. Stigma and discrimination have been identified as significant factors that impede the prevention of the spread of HIV particularly among the LGBT population, specifically the high risk groups. In light of this, Guyana has worked assiduously in combating stigma and discrimination using a multipronged approach.

The high level of political support to the HIV programme and the proactiveness and involvement of leaders in making statements on HIV stigma and discrimination and on accessing services for HIV have been ongoing. This was especially evidenced during the recent tabling in Parliament of the HIV and AIDS Regulations that seek to enforce the National Workplace HIV and AIDS Policy and pronounces on the right of PLHIV to secure employment and be provided with the same health and other benefits accorded to other employees.

Despite the strides made, Stigma and Discrimination remain a key challenge in Guyana, especially among key populations. The national programme continues to address this issue in a comprehensive manner with all stakeholders to ensure that there is unhindered access to prevention, care, treatment and support services. There are efforts within the health sector to incorporate stigma and discrimination modules in all pre-service training curricula and health care staff who work with some of the most at risk populations, specifically MSM and FSWs continue to be trained in stigma and discrimination. As a follow up to a study on stigma and discrimination conducted among health care workers and support staff at health care facilities (see study below), 248 staff of health care facilities in 7 regions received training on the stigma and discrimination policy on HIV that was developed for health facilities following the study. These included staff of HIV treatment centres. These trainings targeted all categories of workers - from the security guards to the physicians. Whilst some training has been conducted among the law enforcement agencies, reports of harassment continued. Similarly, ongoing training is being conducted among the health care workers in ensuring that services are delivered with particular attention to the key population in a non stigmatizing and non discriminatory manner.

At the community level, the national programme has conducted training on reducing stigma and discrimination among young persons and among community opinion leaders. Civil Society Organizations also continue their efforts in relation to key populations and especially address issues of self stigmatization. Targeting the general population, several mass media campaigns were developed and disseminated including public service announcements for

television and radio, posters, brochures and billboards. These efforts seemed to have had some impact over the years in reducing stigma and discrimination within society as evidenced by the overwhelming response to the National Day of Testing and Couples Testing activity whereby couples and individuals from across the Guyana openly participate without fear of stigmatization or discrimination.

During the reporting period, PANCAP embarked on a regional initiative under the theme Justice for All (JFA) that involves Guyana, Jamaica, Grenada and St. Kitts and Nevis for the purpose of sharing experiences and galvanizing support for advocacy efforts to achieve legislative reform aimed at eliminating stigma and discrimination against PLHIV. The aim of the JFA is to promote activities which eliminate stigma and discrimination against PLHIV by 2015 and to uphold the human rights and dignity of all in keeping with the goals of the United Nations Political Declaration. The programme involves holding a series of national consultations with a cross section of stakeholders, leading to one regional consultation in 2014. The expectation of the country consultations is that these countries would devise their own strategies to achieve the desired results by 2015. The regional consultation in 2014 is intended to identify actionable recommendations and a roadmap for the approach to be taken in the post 2015 development agenda.

During the first round of consultations held in 2013 for the JFA initiative, stakeholders generally agreed on the principles for modifying or reforming the legislative instruments for removing discriminatory laws. The recommendations put forward by Guyana during this first round included the need to develop educational programmes designed to eliminate ethnic biases in relation to HIV that have implications for stigma and discrimination, building human capacity and access to information on stigma and discrimination and, developing a more coordinated approach and establishing partnerships between FBOs and specific agencies to promote their involvement in child protection and in providing support to PLHIV. The recommendations also included the need to facilitate greater access to care and treatment for hinterland communities, Universal Adoption of Guyana HIV AIDS workplace policy, acceleration of programmes to sensitize the protective services to the human rights agenda and the abolition of laws that criminalize prostitution and same sex relationships.

A wide range of public and private sector organizations continue to benefit from workplace education programmes implemented by the Ministry of Labor, the Guyana Business Coalition on HIV/AIDS, and the local ILO team. These programmes afford employees training in behavior change communication, peer education and policy development, equipping them with the institutional capacity to create and nurture enabling environments in their workplaces for key populations and PLHIV.

Guyana National Faith Coalition on HIV and AIDS (GFCHA) comprising representatives from 5 different religions in Guyana, has as its mandate to address issues relating to the family as a unit, including issues related to faith and HIV. As such, disclosure and sharing is facilitated at the family level. The GFCHA has trained its core leadership in addressing stigma and discrimination among its constituents and during the reporting period, also trained a total of 507 persons in parenting skills, community life competence, sexual abuse

and gender based violence. All of these sessions included components on HIV prevention and reduction of stigma and discrimination.

Box 9: ***Study on Stigma and Discrimination Among Health Care and Support Service Providers***

Study on Stigma and Discrimination Among Health Care and Support Service Providers

In mid 2011 a cross-sectional survey on stigma and discrimination was conducted among a random sample of 788 health care and support service providers working at public and private health care facilities in seven of the ten Regions of Guyana (2, 3, 4, 5, 6, 7, and 10). The medical health care workers are defined as staff members who come into direct contact with patients these include physicians, nurses, pharmacists, and medical technologists. The support providers include the registration clerks, porters, guards, cleaners, social workers and providers of home based care. Data for this assessment was collected using a structured pre-tested questionnaire and the results of the interviews were entered into an excel spreadsheet and analyzed using EPI-info 7. These results were released during 2012.

The findings among health care workers revealed that: in general, there was a high level of knowledge of HIV found among the different categories of health care workers compared to that found among the general population, even though there were still a few gaps in their knowledge e.g. some felt that HIV could be transmitted through urine and faeces; this lack of correct knowledge appeared to translate into fear which impacted how they treated HIV positive clients; as knowledge increased, fear of casual transmission decreased, as did stigma and discrimination; stigma and discrimination among health care workers appeared to be low with some exceptions; only 72% of the respondents would buy cooked food from a shopkeeper with HIV; only 79% were willing to eat off the same plate with a person who has HIV; there was a higher level of stigma and discrimination among those fearful of giving an injection to an HIV positive, assisting an HIV positive woman in delivery or dressing the wound of an HIV positive person; there was less stigma and discrimination among staff working at facilities that offered VCT; knowing someone with HIV at a personal level, resulted in greater knowledge of HIV, less stigma and discrimination and less blaming.

Findings among the support staff (receptionists, guards, cleaners, etc.) were that: they had the lowest levels of knowledge of HIV; were less accepting of PLHIV and; displayed greater feelings of blaming, shaming and judging when compared to clinical and ancillary health care workers.

In general, staff who had participated in stigma and discrimination training had lower levels of fear of casual transmission of HIV. The overall results of the study pointed to a need for more training in stigma and discrimination among the staff of health care facilities and in particular, for the support staff who were at the front lines at these health care facilities.

NCPI Results for Prevention

Most of the respondents (21/23) from government and all of the respondents from civil society, bilateral agencies and UN organisations noted that Guyana has identified the specific areas of focus for its HIV prevention programmes through the biologic behavioural surveillance survey (BBSS), demographic health survey (DHS), knowledge, attitudes and perceptions (KAP) analyses, special studies, consultations and analysis of programmatic data.

Perception of the extent to which HIV prevention services have been implemented varied significantly among respondents from government, civil society, bilateral agencies and UN organizations. Most respondents (19\23) from civil society, bilateral agencies and UN organisations strongly noted that blood safety measures are being implemented. A majority of respondents from civil society, bilateral agencies and UN organisations (17\19) strongly agreed that condom promotion activities are being implemented. Most respondents (16\23) from government strongly agreed that HIV counselling, IEC risk reduction, prevention for PLHIV and universal precautions in healthcare settings are currently implemented. However, a minority of respondents (8\22) from government, civil society, bilaterals and UN Organizations noted any risk reduction activities being implemented for intimate partners of key populations including, MSM, sex workers and out-of-school youth.

During the last NCPI survey when most respondents (5\6) from civil society, bilateral agencies and UN organisation disagreed that risk reduction for intimate partners of key populations were being implemented, within the last two years, respondents (5\6) from the government agreed that risk reduction for intimate partners of key populations is currently implemented.

A majority of respondents from the government (15\22) and less than half(10\27) from civil society, bilateral agencies and UN organisation strongly agreed that the IEC on stigma and discrimination is currently being implemented. More than half of the respondents (13\22) from government, civil society, bilateral agencies and UN organisation has agreed that school based HIV education for young people is currently implemented. This was in comparison to the previous NCPI where half the respondents (3\6) from civil society, bilateral agencies and UN organisation and less than half (2\6) of respondents from the government disagreed to IEC on stigma and discrimination and school based HIV education for young people being implemented.

National IEC Strategy

All respondents (23\23) noted that Guyana has a policy or strategy that promotes information, education and communication on HIV to the general population. In comparison, all respondents (6\6) in 2011 and a majority in 2009 held this view. All of the respondents reported that the key messages were explicitly promoted, with the exception of:

- Abstinence from injecting drugs
- Avoiding commercial sex
- Avoiding intergenerational sex
- Male circumcision under medical supervision

A majority of the respondents (19\23) compared to all (6\6) in 2011, agreed that Guyana has a policy or strategy promoting life skills based HIV education for young people. Since 2011, most of the respondents (15\22) reported that life skills are delivered in primary and secondary schools and more than half of the respondents (14/22) agreed that life skills are included in teacher's training. Since 2011, a majority of respondents (5\6)noted that the policy or strategy promoting life skills based HIV education for young people include age appropriate, gender sensitive sexual and reproductive health elements.

A majority of the respondents (16\22) reported that there is an HIV education strategy for out of school youth compared to all respondents (6\6) in 2011 and more than half respondents in 2009.

As in the previous NCPI survey, all of the respondents (23\23) reported that Guyana has a policy or strategy to promote information, education and communication (IEC) and other preventative health interventions for key or other vulnerable sub-populations. They further indicated that the IEC strategy is built into the behaviour change strategy.

Respondents noted, many key achievements in the policy efforts in support of HIV prevention since 2009. Government respondents shared the following key achievements:

- Efforts to increase preventive services such as VCT, condom distribution and health education messages.
- Development of Guyana National Prevention Principles, Standards and Guidelines, which was launched in March 2010.
- Launch of the Ministry of Health Policy on Stigma and Discrimination in 2011
- Expansion of prevention campaigns to include women and girls empowerment.

Remaining challenges includes:

- Stigma and discrimination continues to be a challenge to members of key populations thus preventing access to services.
- Absence of key legislation to address cross-dressing and prostitution
- Reaching members of key population in rural and hinterland areas
- Enforcement of the existing policies, laws and regulations; and
- Financial resources to carryout prevention activities.

National Coverage of IEC Services

Since 2011, all respondents (22\22) were in agreement that specific messages were developed for prevention components such as condom use and HIV testing &counselling. More than half the respondents (13\22) reported that prisoners' needs in relation to condom promotion are being promoted in contrast to a minority in 2009. A majority of respondents (17\22) reported that prevention messages are suitably tailored to reduce vulnerability of customers of sex workers, prison inmates and men who have sex with men.

HIV Prevention and the Media

Most respondents (15\23) among government reported that there was an activity or programme to promote accurate reporting on HIV by the media compared to (5\6) of the respondents that held this view in the previous NCPI survey.

Respondents from civil society, bilateral agencies and UN organisations reported the following key achievements since 2009:

- Decrease in HIV prevalence
- Sustained success of PMTCT
- Scaling up of VCT
- Review and implementation of HIV services to serve key populations as part of the National HIV Strategy.

Challenges remaining include:

- Continuation of external funding and sustainability of programmes and strategies to reduce HIV and AIDS;
- Adequate access to Information, Education and Communication by hinterland communities;
- Limited implementation of HFLE and sensitization programs in schools;
- Absence of key legislation to address cross-dressing and prostitution.
- Activities that do not contribute to prevention.
- Stigma and discrimination to members of key populations such as MSM, CSW and transgender persons.

TREATMENT AND CARE

Guyana's National HIV Treatment programme commenced with the first HIV case diagnosed in 1987 being offered care and support services. The treatment programme expanded over the years to include management with antiretroviral therapy and enhanced capacity for the diagnosis of opportunistic infections and for laboratory monitoring of patients.

The National Care and Treatment Reference Group as well as a Special Tuberculosis and HIV Sub Group provide oversight to the implementation of the care and treatment programme. These groups in 2013, also guided the revision of the National Guidelines for Management of HIV-Infected and HIV-Exposed Adults and Children 2010/2011 through the active engagement of members of the broad-based Technical Working Group (National Guidelines Review Committee) set up for this purpose.

With full endorsement of the principle of treatment as prevention, the National Guidelines Review Committee considered as its base reference the revised guidance from WHO and several key decisions were made. These included:

- ✓ The earlier initiation of persons with antiretroviral therapy. The CD4 threshold for initiation was increased to <500.
- ✓ Option B plus currently being practiced within the PMTCT programme has been formally added to the guidelines.

- ✓ The management of TB/HIV co-infection was strengthened with renewed emphasis placed on earlier initiation of antiretroviral therapy.
- ✓ The acknowledgement that HIV and ageing is now a pronounced phenomenon within the National Programme, thus the management of co-morbidities such diabetes, hypertension and other cardiovascular diseases were notably strengthened.

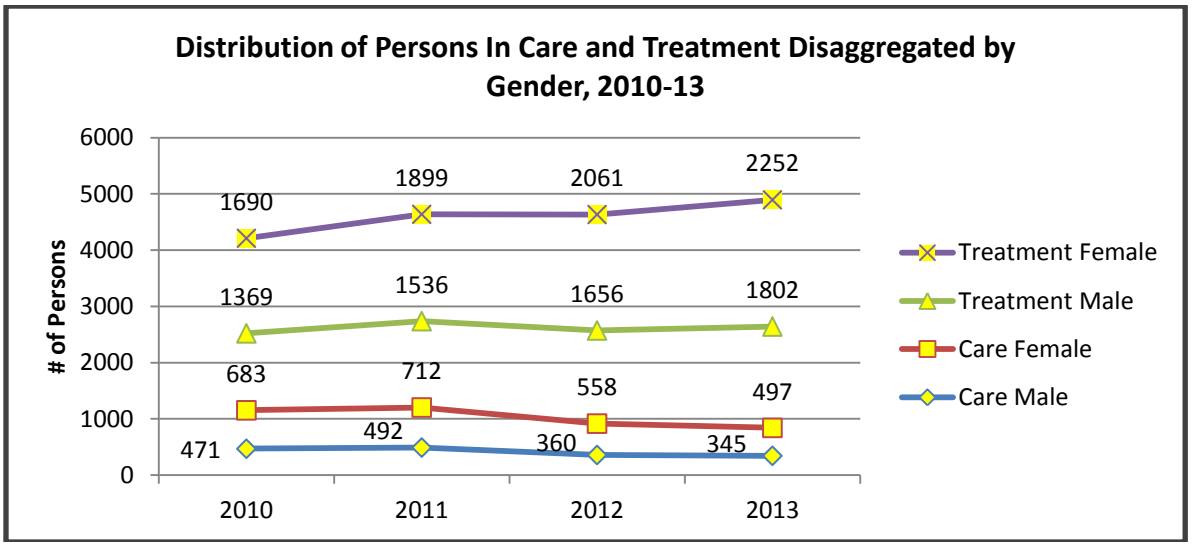
The draft version of the revised guidelines is currently being reviewed for finalization.

The HIV Treatment and Care Programme

The HIV treatment and care programme expanded during the period under review, increasing from 19 facilities in 2012 to 22 facilities in 2013 providing national coverage. During the reporting period, efforts were intensified to integrate the HIV treatment programme within the general health services. Several stand-alone clinics were integrated, including, very importantly, the hinterland clinics.

In 2012, the total number of persons enrolled in the national care and treatment programme was 4,635 persons (56.5% females and 43.5% males). This figure increased to 4,896 (51.1% females and 48.9% males) in 2013. Of the persons enrolled, 5% and 3.2 % were children in 2012 and 2013 respectively. Figure 15 below shows the trend in enrollment by gender during the period 2009 – 2013.

Figure 15: ***Enrollment by Gender for the Period 2009-2013***

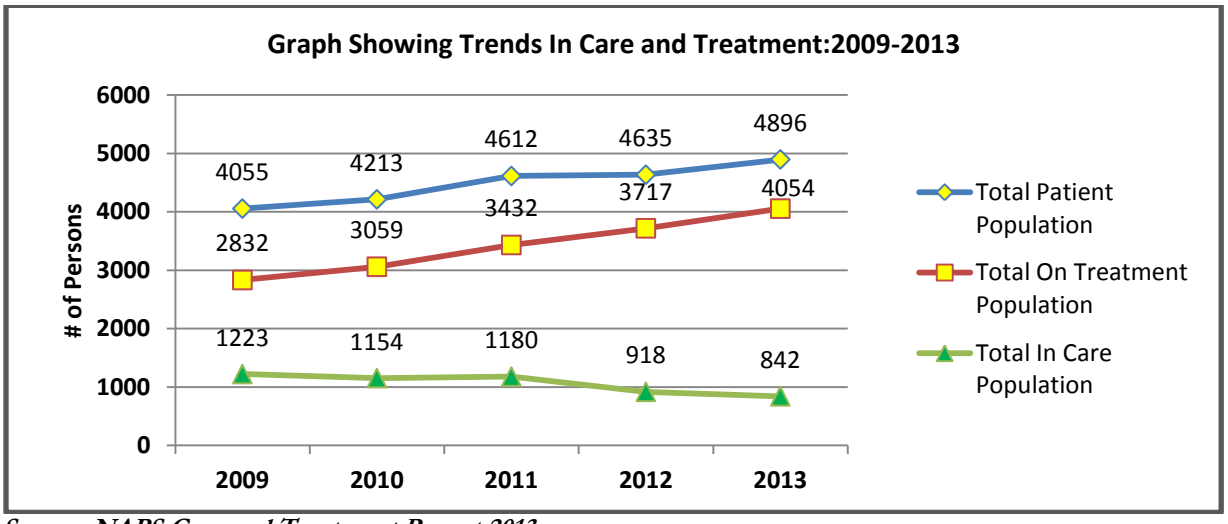


Source: NAPS Programme Reports

In 2012, the number of persons receiving antiretroviral therapy was 3,717 (80.1% of HIV patients) compared to 4,054 (82.8% of HIV patients) in 2013. Of the persons on ART, 90.2% and 89.6 % were on first line therapy in 2012 and 2013 respectively. There has been a steady increase in the proportion of patients on second line therapy, rising from 3.6 % (58/1,611) in 2006 to 10.4% (422/4054) in 2013, with only a slight drop (8.9%) in 2011.

Figure 16 below shows the trend in care (non ART) and treatment (ART) for the period 2009 – 2013.

Figure 16: ***Persons in Care (non ART) and Treatment (ART) for the Period 2009-2013***



Source: NAPS Care and Treatment Report 2013

Table 13 below shows the number of persons on ART from 2003 (ART commenced in Guyana from 2002) to 2013.

Table 13: ***Persons on ART for the Period 2003-2013***

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
Number of persons on ART	123	497	1,002	1,611	1,965	2,473	2,832	3,059	3,432	3,717	4,054
Increase over previous year	NA	374	505	609	354	508	359	227	373	285	337
Percentage (%) increase over previous year	NA	304	101	60.7	21.9	25.8	14.5	8.0	12.2	8.3	9.1

Source: NAPS Care and Treatment Reports

During the period, the construction of the MMU warehouse was completed and its operations were successfully migrated from the old facility. The capacity for quantification of ARVs and other drugs was also built among the technical programme staff. As a result of effective forecasting and compliance with supply planning, there were no stock-outs of ARVs during the reporting period.

National Cohort – Survival and Retention on ART

The 2011 – 2012 national cohort report revealed 525 persons (55% female, 45% male) were initiated on ART in 2011 and some 81.5%. were known to be on treatment and alive 12 months later in 2012. Of the remaining 18.5%, mortality accounted for 6.9%, those who stopped treatment accounted for 3.6% and 7.7% were lost to follow-up. In comparison, the 2012 – 2013 national cohort had a 79.7% (411/516) survivability measure.

Box 10: Twelve month Survivability among the National Cohort

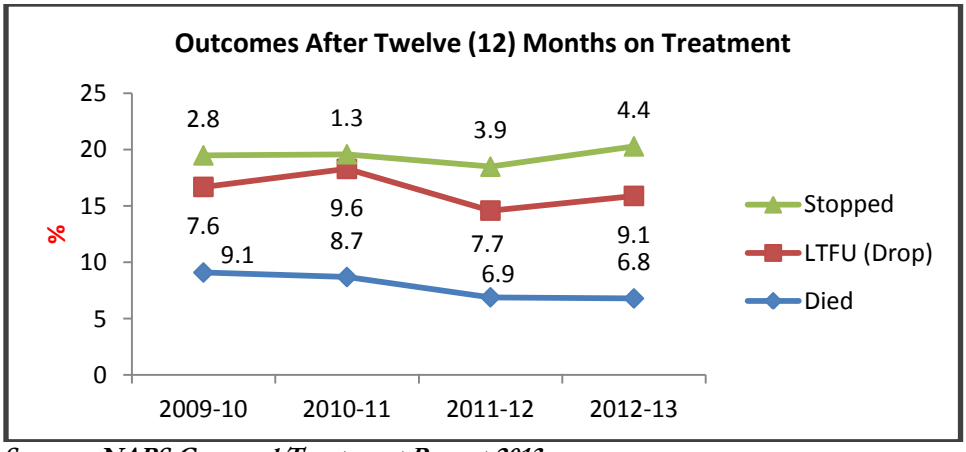
Indicators	2009-2010	2010-2011	2011-2012	2012-2013
Total	80.7%	80.4%	81.5%	79.7%
Adult Male	77.3%	76.9%	80.8%	78.8%
Adult Female	83.4%	83.8%	80.7%	81.4%
Children-Male	90.0%	80.0%	92.9%	66.7%
Children-Female	78.6%	85.7%	94.1%	57.1%

The 2012-2013 12-months survivability and retention on ART represents a reduction from the previous three 12-months cohorts. A closer examination of the data suggests that the reduction is across the board i.e. by male and female and by adult and children. Greater reductions are noted in the 2012-2013 cohort for the children population.

Of the remaining 20.3%, mortality accounted for 6.8%, 4.4% stopped treatment and 9.1% were lost to follow-up. Box 10 shows the survivability and retention on ART by gender and age group for the national cohorts during the period 2010 - 2013.

17 below shows the outcomes after 12 months for the patients who were not included in the survivability measure, due to mortality, loss to follow-up or cessation of treatment.

Figure 17: ***Outcomes After 12 Months Among Patients not Included in the Survivability Measure for 2010 – 2013 Cohorts***



Source: NAPS Care and Treatment Report 2013

There is an apparent association between the reduction in 12-months survival and retention on ART with an increase in the stopped and loss to follow up cases. Importantly there continues to be a decline in the number of deaths.

During the reporting period, in the effort to improve treatment adherence, an adherence manual was drafted and piloted at 3 high volume sites over a period of approximately 4 months. Subsequent to this, the manual was reviewed and finalized with the involvement of social workers, physicians and other members of the multi-disciplinary team. The roll out and implementation is planned for 2014.

During the period, the clinical management of HIV continued to be strengthened with the training of 108 and 102 health care workers in the clinical management of HIV in 2012 and 2013 respectively. To facilitate this, a national group of trainers were identified and are engaged on an ongoing basis in reviewing and updating the training curriculum to ensure that the content remains current and relevant. To support training, a number of clinical/ technical aids were developed and these included posters on paediatric dosages and calculation of creatinine clearance and flip charts showing the algorithm for HIV management among other aids. In addition, 201 health care workers in 4 regions of Guyana were trained in the Integrated Management of Adult and Adolescent Illness (IMAI) health strategy.

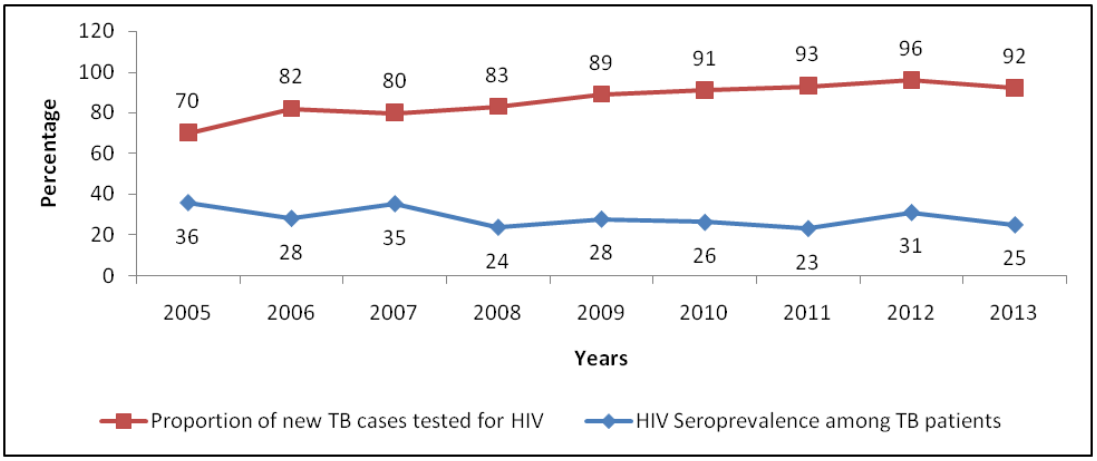
Management of TB-HIV Co-infection

During the reporting period, the TB/HIV committee continued to provide oversight for the TB HIV response as aligned with the WHO 12 Point Policy. This committee comprises representatives from NAPS, the National Tuberculosis Programme (NTP), clinicians from HIV and TB programmes, and representatives of technical agencies such as PAHO and CDC.

During the reporting period, efforts continued towards improving the management of TB-HIV co-infected persons in accordance with the national guidelines. Health care personnel attached to the NTP continued to be trained in the co-management of TB/HIV infection and outreach staff were equipped to provide DOT-HAART services. As stipulated in the guidelines, HIV counseling and testing was routinely provided to TB patients and TB screening was provided to HIV-infected patients.

During 2012, 693 (96%) of the new TB cases were tested for HIV and 213 (31%) were found to be HIV positive. Seventy nine percent (79%) of these TB/HIV cases were placed on ART. In 2013, in comparison, 566 (92%) of the new TB cases were tested for HIV and the co-infection rate found to have decreased to 25% (140 cases). Seventy percent (98) of these co-infected patients were placed on ART. Data for the period 2005 – 2012 indicate that the rate of co-infection fluctuated between 36 % to 31% during that period as shown in figure 18 below.

Figure 18*: HIV/TB Co-infection Among New TB Patients During the Period 2005 - 2013*



Source: NTP Programme records

During the period, the integration of tuberculin skin testing (TST) into the package of services provided at the ART sites was strengthened with a total of 58 healthcare workers trained. This further strengthened the referral process between HIV treatment sites and TB treatment sites.

Other initiatives implemented during the reporting period included the training of 277 staff from 5 regions in the TB/HIV co-management module of the Integrated Management of Adult and Adolescent Illnesses (IMAI). This approach seeks to integrate TB services into the general primary care system. The TB/HIV component of IMAI was introduced in all ten regions of Guyana. During the period, public sensitization sessions on HIV/TB were also conducted and regular outreaches were done in the prisons to screen for HIV and TB. The DOT-HAART manual was also revised and disseminated during the period.

The quality of care provided to TB-HIV co-infected patients was continuously monitored through the Continuous Quality Improvement programme, HEALTHQUAL, which is also used to monitor the quality of services provided to patients attending the HIV treatment sites.

Laboratory Support

The diagnostic capacity of the treatment and care programme continued to be supported by the National Public Health Reference Laboratory (NPHRL). The NPHRL provides CD4 testing for the national treatment programme and began providing early infant diagnosis and viral load monitoring for the national programme in 2010. CD4 testing was also provided by two regional laboratories (New Amsterdam, Region Six, and Linden, Region Ten) and three additional sites where CD4 testing was introduced during the reporting period – Bartica, Suddie, and West Demerara Hospitals. Additionally TB identification and drug safety testing is being conducted. The NPHRL was accredited by the Guyana Bureau of Standards in 2010 and is currently awaiting its International Accreditation.

Monitoring Quality Treatment and Care

The national programme continued to monitor quality care during the reporting period through a series of quality programmes. A revision of the National Guidelines for the Management of HIV Exposed Infants and Infected Adults and Children commenced in 2013 and this took into consideration the new developments in the WHO consolidated guidelines. The revised guidelines will be finalized in 2014.

Patient Monitoring System (PMS)

The Patient Monitoring System which was developed in 2007 continues to be implemented at all treatment sites and this operates as a paper-based system with oversight from the National Level through a PMS Steering Committee. This Committee meets regularly and conducts ongoing regular data verification and validation of monthly cross-sectional and cohort reports and provides mentoring to the site staff through supervisory visits.

In 2013 the PMS was reviewed to incorporate additional documentation facilitating active screening for tuberculosis using the WHO symptomology, Tuberculin skin testing, as well as additional information on HIV and pregnancy.

Through collaboration with the Management Information System (MIS) Unit of the Ministry of Health, a database for the monthly summary report and one for the cohort report were developed and piloted. These are currently being reviewed to ensure that they meet the requirements for reporting.

Supportive Supervision

In 2013, the National Programme formally introduced supportive supervision for the clinical teams. This process is led by experienced HIV clinicians who conduct mentoring, training and chart reviews through a didactic on-site mechanism whereby patients are seen jointly, cases are consulted and discussed, and chart reviews are conducted.

HEALTHQUAL

The National Quality of Care programme, HEALTHQUAL, which commenced in 2008 continued during the reporting period. Four rounds of data audits were conducted among all HIV treatment sites and at selected Well Child, Maternal and Child Health (MCH) sites by the end of year 2012. The fifth and sixth rounds of audits progressed during 2013 focusing on the period July 1st - December 30th, 2012 and January 1st –June 30th , 2013 respectively (results to be made available in the next reporting period).

The results of the first four rounds of the audit with comparisons are seen in Table 14 below.

Table 14: ***Comparison of HEALTHQUAL Indicators, 2008 – 2012***

INDICATORS	January-June 2008 N=1013	July-December 2009 N=1198	January-June 2011 N=1447	January-June 2012 N=1260
Visited in the last six months	88.5 %	87.3 %	85. 1 %	86.8%
CD 4 count in the last six months	82.9 %	77.6 %	80.1 %	73.9
ARV Medication	76.4 %	76.6 %	74.1 %	81.3%
Adherence Assessment	58.3 %	73.4 %	79.0 %	78.2%
Assessed for active Tuberculosis	87.9 %	99.5 %	94.2 %	88%
Cotrimoxazole Prophylaxis	31.3 %	82.3 %	77.9 %	86.5%
Weight Every Visit	80.6 %	93.8 %	93.8 %	90.3%
Height Every Visit	72.2 %	74.4 %	86.7 %	81.4%
Head Circumference	0 %	69.1 %	81.3 %	61%
Weight for Age Plot	11.1 %	76.9 %	72.9 %	49.6%
Developmental Milestone	13.6 %	85.1 %	81.9 %	64.6%
Temperature	41.8 %	72.0 %	86.9 %	86.7 %
Pulse	51.8 %	77.8 %	89.3 %	90.2 %
Blood Pressure	73.1 %	82.0 %	91.3 %	89.9 %

Performance Key

POOR :< 50%		FAIR: 50%-69%		GOOD: 70%-85%		EXCELLENT > 85%	

As shown, a high level of quality performance was maintained in 2012 for most quality measures. The results show significant improvement at the various site levels over the first data audit in 2008. The few decreases in performance among the Well Child indicators for the population of HIV positive children were noted for follow up during the subsequent period.

In recognition of the expanding scope of the HIV treatment programme and particularly that of HIV and ageing, a review of the menu of indicators was conducted with a view to including indicators measuring the quality of care associated with the management of co-morbidities. This process is expected to be concluded in 2014.

Client Satisfaction Survey

The results of the client satisfaction survey conducted and reported during the previous reporting period among HIV-positive patients attending HIV and TB clinics, indicated a relatively high percentage of satisfaction in the areas investigated. These were 93.4 percent in

relation to health services and 95.2 percent in relation to both clinic staff and health facility. The objectives of the survey were to both determine the patients' satisfaction with the services provided and also to adopt the actions necessary for quality improvement. Since the adoption of these actions geared towards quality improvement, NAPS has since conducted another client satisfaction survey during the current period. This survey was conducted at all HIV and TB sites, including private facilities but excluding the hinterland regions. The compilation of the results of this survey is close to completion and the analysis will be presented during the next reporting period.

HIV Drug Resistance Survey

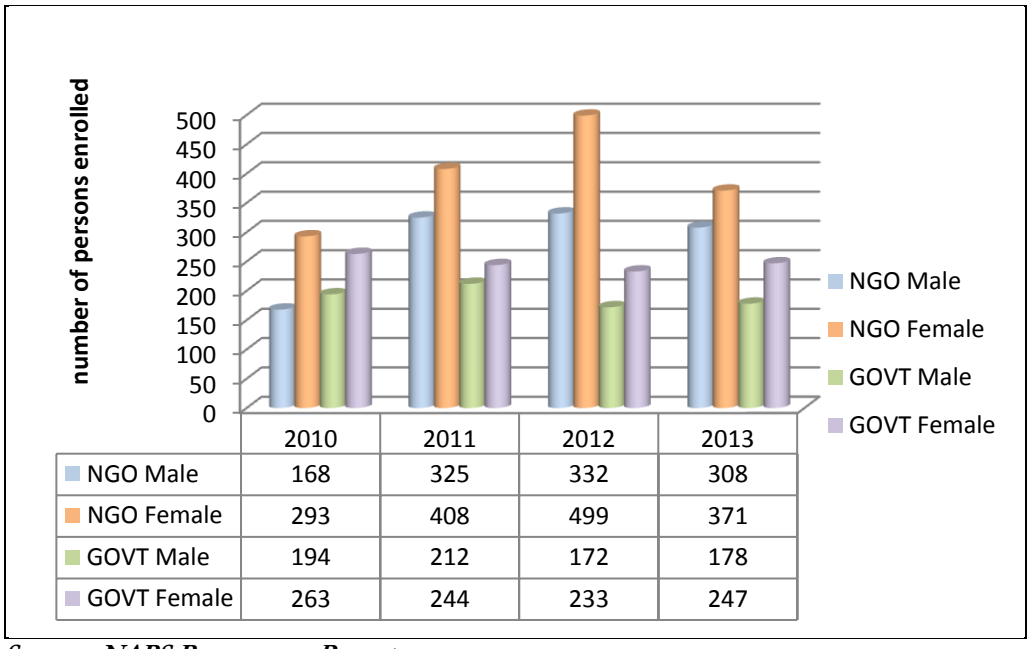
The HIVDR survey conducted at the National Care and Treatment Center, Guyana's largest and most representative HIV treatment, commenced in 2011 and data collection concluded in September 2013. This survey is guided by a National HIV Drug Resistance Working group with technical assistance as required from PAHO/WHO. The data analysis and report is expected to be completed in 2014.

Home Based Care

During the period 2012-2013, twenty (20) sites provided home based care (HBC) services. These included two private hospitals, seven (7) NGOs, and eleven (11) treatment sites. A total of 1236 new persons were enrolled into the HBC programme in 2012 (405 at government treatment sites and 831 at NGOs). In 2013, 1104 new persons were enrolled into the HBC programme (425 at government treatment sites and 679 at NGOs). HBC services included: nutritional support; shelter and care; protection and legal services; general health care; HIV prevention; psychosocial support and; education/vocational training.

In general more clients were enrolled at the NGOs than the treatment sites. The proportion of females to males was also greater at both the treatment sites and the NGOs as illustrated in figure 19 below.

Figure 19: *Patients Receiving HBC Services at NGOs and Government Treatment Sites 2010 – 2013*



	2010	2011	2012	2013
NGO Male	168	325	332	308
NGO Female	293	408	499	371
GOVT Male	194	212	172	178
GOVT Female	263	244	233	247

Source: NAPS Programme Report

In 2012, a total of 145 persons were trained in HBC. This included: HBC Refresher Training for 56 caregivers/volunteers aimed at assessing their knowledge, attitude and practice of basic nursing techniques to meet the needs of the patients; training in PLHIV and Family for 74 clients and caregivers to equip them with knowledge and skills to improve themselves and their family life; training in Family Care Giving for 15 nurses. In 2013, a total of 42 health care providers were trained to improve delivery of efficient and effective HBC services. This included HBC Refresher Training for 22 care givers and clinical training for health care workers to enhance their knowledge and skills in managing HIV/AIDS patients.

NCPI Results for Treatment, Care and Support

V.Treatment, Care and Support

Respondents from government, civil society, bilateral agencies and UN organisations indicated that Guyana has identified the essential elements of a comprehensive package of HIV treatment, care and support services. Such view was held by a majority of respondents (16\17) in 2011. Respondents noted the following prioritised services:

- Access for all
    - Treatment for all who needs it
    - Prevention for all including "Know your Status'
- Access to a Package of Services
    - Diagnosis to care

- ARVs and prophylaxis
- Psychological counselling
- Nutritional services
- Care for reduction and PMTCT

In addition, respondents cited the following as examples of the scaling up of HIV treatment, care and support services:

- Training and deployment of physicians and nurses in HIV management
- Procurement and stocking of HIV medication now currently at second line regimen
- Expansion through decentralization of services to rural and hinterland areas
- Review of the treatment guidelines

Procurement of critical commodities

PEPFAR and the global fund for AIDS, tuberculosis and malaria (GFATM) currently procure and manage all HIV-related commodities through the supply chain management systems (SCMS). Since 2009, most respondents (23\25) noted Guyana has access to regional procurement and supply management mechanism for critical commodities, in particular, condoms, ARVs, testing kits and reagents. More than half of the respondents (4/6) noted that Guyana has a policy for using generic medications or parallel importing of medications for HIV, dependent on the donor funding compared to half (3\6) of the respondents in the previous NCPI who shared this view. It was noted that Guyana is part of a voluntary procurement program, an informal support/collaboration mechanism in place among Suriname, Trinidad and Tobago, Jamaica and Barbados through the UN Agencies where Guyana supports or is supported in times of stock-out.

Table 15: ***National Coverage of Treatment, Care and Support Services***

	Strongly Disagree	Disagree	Agree	Strongly Agree	NA
ARV Theraphy			1	23	
ART for TB patients			3	21	
CP in PLHIV		1	2	20	
Early Infant diagnosis			9	15	
Economic Support		3	15	3	2
Family Based Care and Support		6	12	6	
HIV care and support in the workplace (including alternative working arrangements)		6	11	6	1
HIV testing and counselling for people with TB		2	11	11	
HIV treatment services in the workplace or treatment referral systems through the workplace		5	12	7	
Nutritional care		3	12	2	
Paediatric AIDS treatment		1	7	16	
Palliative Care for children and Adults		3	8	13	
Post delivery ART provisions to women		1	7	16	
PEP for non occupational exposure		1	10	12	1
PEP for occupational exposures to HIV		1	7	15	1
Physchosocial support for PLHIV and their families		5	10	8	
STI management			11	12	1
TB infection control in HIV treatment and care facilities		2	9	13	
TB preventative theraphy for PLHIV			10	14	
TB screening for PLHIV			8	16	
Treatment of common HIV related infections			7	17	
other					

A margin of respondents in the 2012- 2013 (15/24)and 2011 (5\6) noted Guyana's strategy to provide social and economic support to people infected and affected by HIV, indicating that there is:

- Economic support in the form of public assistance monthly for those eligible by the Ministry of Human Services and Social Security (MoHSS).
- Social support - psychological support through counseling on adherence, disclosure, nutritional support.

Respondents from government and non-governmental organizations noted key achievements in the implementation of HIV treatment, care and support programmes since 2009 including:

- Expansion of services at health facilities throughout all regions
- Improved survivability, prevalence and patient retention treatment rates
- Strengthened adherence through case management system
- TB/HIV co-infected patients accessing treatment
- Sustained success in Universal Access to PMTCT services achieved (currently at 92%; WHO universal access is 80%).

Remaining Challenges include:

- Timely procurement of drugs to avoid stock out of ARVs;
- Adequate access to nutritional support;
- Expansion of HIV treatment, care and support systems in the workplace;
- Adequate funding and human resources
- Coverage of services to rural and hinterland areas

MITIGATION

Support to Orphans and Vulnerable Children (OVC)

The OVC steering Committee that was reconstituted in 2010 with members representing a broad range of disciplines required for the OVC program, continued its coordinating function in 2012. This committee continued to guide both the Ministry of Health's OVC response in addition to providing guidance for its constituent member organizations. In 2013, with the discontinuation of donor funding for the OVC component, the committee held its last meeting and transferred responsibility for hosting meetings to the Ministry of Human Services.

The OVC policy that was drafted during the previous reporting period, continued to guide the national efforts to provide services to OVC. In the attempt to avoid stigmatization of children infected with HIV, the government's Child Care Protection Agency (CCPA) integrates these children into their overall programme for children requiring care, with due regard paid to their specific medical needs (all children entering care under the CCPA are required to do a medical). In 2013, the MoLHSSS signed a Memorandum of Understanding with Forward Guyana and Childlink Inc for a One Stop Advocacy Centre for Children's Rights. This one stop centre is intended to facilitate children who are the victims of rape, in telling their story only once, without having to rehash their experiences on multiple occasions to the different authorities. At this One Stop Centre, victims tell their story in the presence of all of the relevant authorities and follow up action is taken. This collaborative inter-agency effort is currently in its pilot stage with 2 NGO-based centres in operation.

During the reporting period, the Government of Guyana with private sector support, provided assistance to orphanages in the form of much needed equipment and infrastructural upgrading in observance of the Minimum Operational Standards & Regulations for Children Homes in Guyana. The specific standards observed were: Standard 20 (Accomodation & Facilities) which states that "The Home provides a safe, adequate and secure physical environment that cultivates a domestic, instead of an institutional atmosphere and facilitates internal and external interaction" and: Standard 21 (Protection from Fire and Disasters) which states that "The Home has security measures, emergency procedures, takes all necessary precautions to protect children from fire, flood and the elements and provides a safe living and working environment."

During the reporting period, in the effort to contribute towards the mental and physical well-being of children, including those in the orphanages the national programme undertook a number of activities including: with private sector support, hosting of its annual Christmas

party for the children at the HIV treatment sites; organizing one-day outings for 892 children (with private sector support); supported the children's kite flying efforts and; facilitated 167 children from 11 orphanages in benefitting from the Guyana Watch Medical Outreach Program (a US based non-profit organization). This was also in keeping with the Minimum Operational Standards & Regulations: Standard 6 (Recreation) which states that "The Home facilitates the children's participation in sport and leisure activities and; Standard 19 (Health) which states that "Children's health needs are monitored through regular medical checks."

In the effort to strengthen the recording and reporting process of the Children's Homes, MoH printed admission registers, distributed these among the 25 children's homes across the country and provided the requisite training in their use to 21 orphanage staff. During the reporting period, the staff of these orphanages were also provided with capacity building training on issues related to children including: building self esteem; dealing with delinquency; "be safe" techniques; rights and responsibilities of the child and the care giver; adolescents and HIV/STIs and; mental health for care givers. In addition, several IEC campaigns were developed and disseminated by the National Commission on the Rights of the Child, in increasing awareness of the Protection of Children, including those infected/affected by HIV.

MoH also complimented the government's school uniform voucher program by providing school amenities to 319 infected/affected children from the government treatment sites, with the aim of ensuring equal access to education. In addition, 20 adolescents from the National Care & Treatment Centre were provided with capacity building training. Topics included: journey of life training; creating memory and hero books; adherence and; art and craft as a relaxing tool.

During the reporting period, Help & Shelter completed the implementation of a project to promote the rights of children through the provision of support services and public education. The general objective was to use a rights-based approach to strengthen child protection systems, policies and mechanisms which were established to provide services for children whose rights have been violated. The project included the provision of counselling services for children who survived abuse. It involved parents, and service providers from the education, health, judicial, and social service sectors, FBOs, etc., in order to increase awareness with regard to child protection. The project was instrumental in bringing about an evidence-based model of parenting that challenged the culturally entrenched views regarding the use of corporal and other punitive forms of disciplining children.

Five NGOs among others provided support for youth programs and after-school sessions for orphans, vulnerable children, and HIV-positive youth during the reporting period. These programs were designed to help children improve their academic performance and social skills and offered a series of services including mentoring, counseling, homework assistance, and skills training in information technology, numeracy, and literacy. One NGO piloted a programme for 50 out-of-school girls, including 10 HIV-positive girls. Depending on their ages, they were either provided with funding, materials, or support to return to school or were linked to skills training programs and job placement opportunities.

During the reporting period, a total of 122 persons were trained in a range of topics related to child care including; parenting techniques; sign language; child abuse; capacity building

and; HIV, STIs and other diseases. The target group included social workers, parents from the HIV treatment sites, NGOs, staff of the Child Care & Protection Agency, and staff of the New Opportunity Corps. Twenty four (24) social workers from HIV treatment sites and NGOs were trained on Guyana's Child Protection Laws which include: (a) Adoption of Children Act, (b) Domestic Violence Act (c) Sexual Offences Act, (d) Child Care & Protection Agency Act, (e) Status of Children Act and (f) Protection of Children Act.

NCPI Results for OVC

A majority of respondents (21\24) from government and (19\23) from civil society, bilateral agencies and UN organisations indicated that they aware of Guyana's policy or strategy to address HIV/AIDS related needs of orphans and vulnerable children (OVC) which includes an operational definition. In 2011, a majority of respondents (9\11) from civil society, bilateral agencies and UN organisations along with all respondents(6\6) for government officials held this view. In 2009, more than half the respondents held this view in contrast to all respondents in 2007 who reported that they were unaware of a policy to address OVC including an operational definition.

The majority of respondents (20\22) from government and less than a half of the respondents (11\23) from civil society, bilateral agencies and UN organisations indicated that Guyana has a national action plan specifically for orphans and other vulnerable children. In 2011, (5\6)government officials reported that Guyana has a national action plan specifically for orphans and other vulnerable children in contrast to more than a half of the respondents (6\11) from civil society, bilateral agencies and UN Organizations who indicated that they did not know such plan in place.

The Government of Guyana has continued its commitment to provide financial and legislative support to orphanages across Guyana. The Child Protection Act of 2009 offers protection to orphans and vulnerable children. There are six (6) orphanages that are supported through government funding and donor funding. Charitable organizations support an additional eighteen (18) orphanages in Guyana.

Since 2009, key achievements in the implementation efforts of HIV prevention, treatment, care & support for OVC includes:

- New legislation, such as the Child Protection Act, has guaranteed protection for orphans and vulnerable children.
- More OVC have access to HIV treatment, care and support thus reducing the HIV prevalence and incidence among children.
- Caregiver or foster programs aim to integrate children into the home setting
- Most Orphanages have been renovated and equipped to meet the minimum operating standards and regulations for children's homes;
- Continued support for the child protection unit of the Ministry of Human Services and Social Security;
- Continued provision of capacity building to staff of orphanages;
- Continued economic support for persons living with HIV, including children;

- Capacity building for parents through the development of parenting skills and techniques and skills building for children, particularly those who are not academically inclined;
- School amenities programme continued;
- Introduction of support group for HIV positive adolescents; and
- General support group, including both positive and negative OVC.

Challenges remaining include:

- Adequate technical support in the area of child psychology and child psychosocial support;
- Adequate continued funding and sustainability of programmes and strategies to mitigate the impact of HIV and AIDS;
- Adequate coordination;
- Limited mapping of OVC;
- Living accommodation for OVC; and
- Adequate nutritional support.

Psychosocial Support to Persons Living with HIV

Several initiatives which began in the last reporting period continued during the current reporting period. These included Public Assistance through the MoLHSSS, psychosocial support through support groups at HIV treatment sites, and nutritional support through the Food Bank.

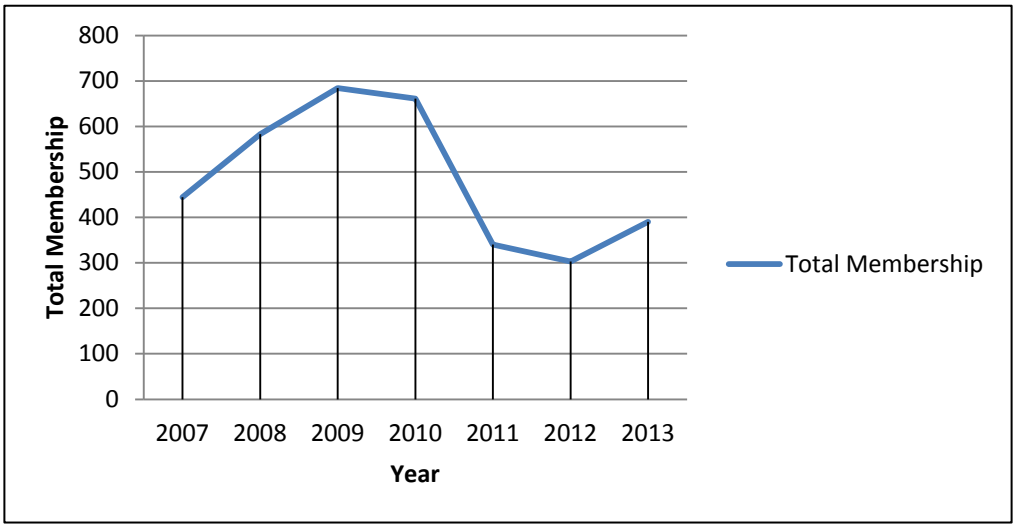
Public Assistance

Eligibility for public assistance provided by the Ministry of Labour, Human Services and Social Security (MoLHSSS) to PLHIV and their affected family members, is determined by both a means test and the CD4 level of PLHIV as a measure of their physical capacity to earn an adequate living. Eligible persons and their family members are provided with public assistance for a period of six months then their situation is evaluated to determine the need for continued assistance. The public assistance provided to PLHIV and persons affected, is at the same level with the general public assistance support. During the reporting period, weekend live-in camps for PLHIV and their family members were also held by the MoLHSSS for the purpose of observing the interactions between PLHIV and their family members, and providing one-on-one counselling on psychosocial issues identified.

PLHIV Support Groups

During the period, the HIV/AIDS support group programme which commenced in 2004, continued at HIV treatment sites. The number of support groups increased from 11 in 2012 to 13 in 2013. In 2012, the 11 support groups had a total membership of approximately 303 persons (34% males, 66% female) while in 2013 the membership increased to 390 (28% males, 72% females). It was noted that commencing from around 2010, the membership of the support groups began to decline (see figure 20 below) and innovative ways are now being explored to attract and retain support group members.

Figure 20: ***Membership of the Support Groups – 2007 – 2013***



Source: NAPS Programme Reports

The support groups continued to provide a forum for PLHIV to discuss common challenges and experiences. During these sessions, topical issues were also discussed. These include: Domestic Violence; Adherence; Prevention with Positives; Suicide Prevention; Nutrition; Herbal Cure for HIV; Parenting Skills; Healthy Lifestyles; Sexually Transmitted Infections and; Stigma & Discrimination. The groups were also engaged in recreational activities and skills building and income generation activities including craft production, and garment construction.

In 2012, a Guyana Services Directory, listing governmental and non governmental organizations that offer services for persons living with/affected by HIV/AIDS was produced and distributed. This directory is intended to be used by health care and other support personnel in referring PLHIV and family members for the requisite services.

In 2013, a national conference was hosted for 50 support group members to explore ways and means of ensuring the sustainability of support services for PLHIV in light of the decreasing donor funding. It also focused on identifying the gaps in the national care and treatment programme, developing recommendations to address these, and the need for PLHIV to take responsibility for their own health. The theme of the conference was "Motivation Towards Positive Living, Supporting Sustainability". The specific objectives were to: Reinforce positive living among PLHIV; increase the self sufficiency of support groups of PLHIV; share best practices on sustainability; empower PLHIV to address mental health, domestic violence and other social issues and; build capacity among PLHIV to network with key social and private sectors in order to access the relevant services.

During the reporting period, with some assistance provided through the national programme, the capacity of the support group members was strengthened in the effort to empower them to achieve sustainability within their own lives. Training was provided to support group members in the areas of craft and art production, garment construction and furniture construction, among other things. With the skills gained, a number of PLHIV

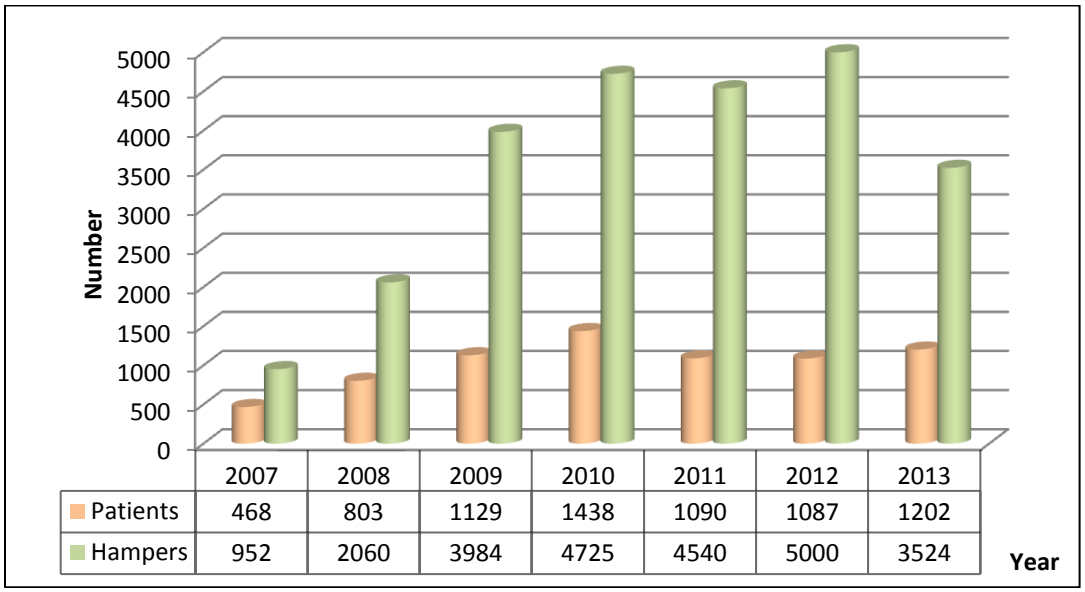
were able to embark on income generation activities during the period. In addition, one support group was provided with grass-cutting machinery to facilitate its venture into the provision of sanitation services which generated employment for a number of its group members on an ongoing basis. Assistance was also provided in finding employment for group members within various business establishments. Other income generation activities embarked upon by support groups included cake sales, the hosting of small-scale entertainment events, etc. In-house efforts among group members to support one another included the contribution toward food baskets for members, provision of clothing through formation of clothing banks, and penny banking to raise seed money for small-scale business activities.

Nutritional Support for Persons Living with HIV/AIDS

The Food Bank which was established in September 2006, continued to provide nutritional support for HIV and HIV/TB co-infected patients. During 2012, 1087 patients received a total of 5000 food hampers, an increase of 460 hampers (10.1%) when compared to 2011. During 2013, 1,202 patients received 3524 hampers, a reduction of 1476 (5.94%) hampers when compared to 2012 however the annual average number of hampers per patient increased from 2 in 2007 to 3 in 2013. This was due to procurement challenges resulting from staff reduction within the procurement unit and more importantly, a revision of the eligibility criteria as well as the criteria for discontinuation of support. Eligibility for nutritional support includes economic, social and medical reasons. Such support is intended for six months after which eligibility is again reviewed and a decision made whether to continue providing support.

The years 2007- 2010 showed a steady increase in patients that accessed the Food Bank, with fluctuations during the period 2011 – 2013. The trend in distribution between 2007 and 2013 is illustrated in Figure 21. This illustrates that a total of 7217 HIV patients, including HIV/TB co-infected patients, received 24,785 food hampers during the years 2007 – 2013.

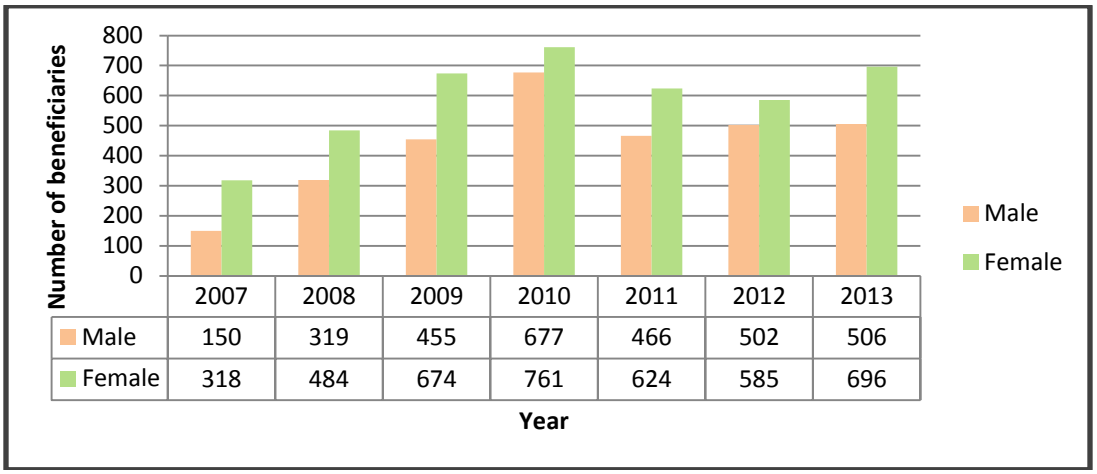
Figure 21: ***Nutritional Hamper Distribution 2007 – 2013***



The vast majority of beneficiaries to the Food Bank were unemployed and within the age group 30-49 years, accounting for 54.83% of all beneficiaries in 2013. During 2013, 22% (264/1202) of the beneficiaries were single parents, slightly higher when compared to 18.5% (201/1087) in 2012. During 2012, 37.1% of the Food Bank beneficiaries were HIV/TB co-infected patients. This was reduced in 2013 with the co-infected population accounting for 18.9% of the patients.

During the period 2007 – 2013, females continued to be the major beneficiaries of the programme as illustrated in Figure 22 below. Females totalled 4142 (57.39%) while males totalled 3075 (42.61%).

Figure 22: ***Hamper Distribution by Sex 2007 – 2013***

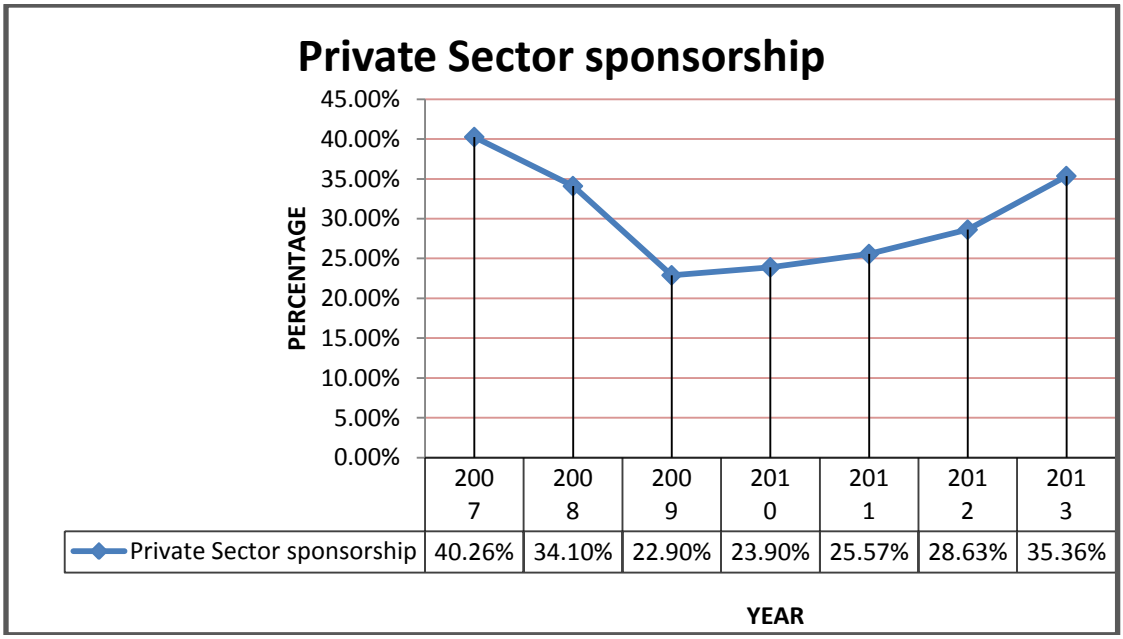


	2007	2008	2009	2010	2011	2012	2013
Male	150	319	455	677	466	502	506
Female	318	484	674	761	624	585	696

Source: NAPS Programme Reports

There was a steady increase in private sector sponsorship of the food bank during the period 2009 – 2013. The year 2013 also witnessed one of the highest private sector contributions towards the food bank (35.36%) compared to 28.63 % reported for 2012. See figure 23 below which illustrates the private sector sponsorship.

Figure 23: *Private Sector Sponsorship of Hampers During 2007 – 2013*



Other Nutritional Support Initiatives

Training on the Nutrition and HIV algorithm was provided to 20 social workers from the care and treatment sites through collaboration with the Caribbean Food and Nutrition Institute (CFNI) and the staff of the Food Policy Division of MoH. The FAO/WHO manual (booklet) on nutritional care and support for people living with HIV/AIDS - "Living well with HIV/AIDS" was also adapted to suit the Guyana context.

IV. BEST PRACTICES

4. Ride for Life – Transitioned to Country Ownership in the Move Towards Sustainability

The annual Ride for Life which commenced in 2007 to increase HIV awareness and knowledge, has of 2013 been fully transitioned to the Ministry of Culture Youth and Sports (MCYS) after many years of funding through the Global Fund. The MCYS with its strong involvement in the lives of youth, is seen to be strategically poised to take over the reins for coordinating the Ride for Life. This seamless transition is also a reflection of Guyana's move towards sustainability of the HIV response in light of reducing donor funding for the HIV response globally, and the increasing need for countries to assume ownership of those activities previously funded by external sources. The MYCS has pledged its commitment to fund and to continue its collaboration with the Ministry of Health (MoH) and other partners in ensuring the continuity of the Ride for Life over the coming years.

The goals of the Ride for Life are also to increase HIV/AIDS activism and volunteerism among participants to become ambassadors in the fight against HIV/AIDS. The idea of the Ride was borne out of the recognition that youth between the ages of 10-19 are especially vulnerable to HIV and other social and health issues. Cycling is a popular and relatively well developed sport in Guyana and cyclists are seen as role models, especially among young males. The popular view is that by engaging cyclists and their fans in the HIV response, the message will be further spread among youth in Guyana and other participating countries.

Since its commencement, the Ride for Life has seen the participation of over 525 cyclists taken from Guyana and 9 other Caribbean countries, the USA, Canada and the United Kingdom. The Ride covers approximately 246 miles across Guyana and it is broken up into five stages. Each year, prizes totaling over US 7,000 are distributed among winners. During the Ride, the cyclists trained in advance as peer educators, interact with peers and fans to transfer knowledge of HIV. At the beginning and end of every stage of the race, NGOs provide VCT, HIV sensitization, IEC materials, condoms, and edutainment. Senior MoH officials also imparts HIV prevention messages. During the 2012 and 2013 Rides for Life, over 5,400 condoms and 700 pieces of IEC materials were distributed.

The Ride for Life is planned and implemented by a steering committee headed by the Minister of MYCS and comprising representatives from MYCS, MoH, the Guyana Cycling Federation (GCF), the President Youth Award Guyana, the Chief Cycling Coach, and the head of the National Sports Commission. MYCS is responsible for organizing the race while each participating body has assigned duties. The race is promoted in the media through private sector support and promotional materials such as T-shirts, etc., are distributed.

The Ride for Life serves as a model for demonstrating how political leadership, multisectoral collaboration and community involvement can be engaged in the fight against HIV. This model emphasizes how utilising the relative advantages of the different agencies can have a summative effect that far exceeds the sum of their individual efforts in preventing HIV. Further, the increasing interest demonstrated by the national cycling fraternities and clubs

within the entire Caribbean region, illustrates the potential for the Ride for Life to become a regional race.

5. Couples Testing – A Successful Approach for Increasing Male Participation in VCT

On St. Valentine's Day in 2008, the Ministry of Health National AIDS Programme Secretariat (NAPS) launched its novel initiative of offering voluntary counseling and testing (VCT) to couples. This was launched under the theme "Test of Love." Using the media to publicize the initiative, along with mobilization within the communities, persons were encouraged to access VCT along with their partners. The idea behind this initiative was to encourage greater involvement of males in seeking testing since programmatic data revealed that more females seek VCT than males. In addition, the act of couples seeking testing together would be a demonstration of love and commitment in which they agree to be counseled together, have their risk assessments done together, and share their results – regardless of whether positive or negative. A benefit of this sharing would be to facilitate partner support in seeking HIV care and treatment by those testing positive – without having to hide one's status. This would also positively impact adherence.

The locations selected for Couples Testing are usually areas that are heavily trafficked by a mixture of the population and these include shopping centres, market places, bus parks, and NGO locations. The venues are decorated with the Valentine theme, flyers are distributed and couples are encouraged to come in for testing. Group counseling is conducted due to the large numbers and during these sessions HIV education is provided, condom demonstrations are done, and condoms and IEC materials are distributed. Each couple is then invited to do their risk assessment together. During this process, intimate details of each other's lives are shared followed by testing, sharing of results and post test counselling. Couples are generally consulted about their willingness to share their results and over the years, most partners have been willing to do so. Couples tested are provided with incentives via a raffle. These incentives which are donated by the private sector, include romantic dinners, food hampers, gift certificates and even Blackberry phones. To date a total of 75 incentives were donated since the commencement of the initiative.

Couples Testing is offered in 7 of the 10 regions in Guyana. The number of couples seeking testing has skyrocketed from a meager 104 couples in 2008 to 514 in 2012, the highest number of couples tested to date.

A spin-off of Couples Testing is also that a number of single individuals seek testing since a ready opportunity is provided. To date, 8,520 persons including 1,777 couples have received VCT through this initiative. During 2012, persons tested during this one-day activity constituted 3% of the overall total number of persons tested for the entire year while in 2013, the proportion tested was 6.1% of the annual total. Box x shows the numbers of couples and individuals tested during Couples Testing for the period 2008 – 2013.

Box 3: Persons Tested During Couples Testing 2008 - 2013

Year	Target	No. of couples tested	No. of persons tested	No. of testing sites
2008	200	104	477	10
2009	200	237	1,176	8
2010	250	296	939	9
2011	300	346	1,022	11
2012	350	514	1,883	13
2013	350	280	3,023	15

6. Innovativeness Towards Sustainability - Plus Point's Trail Blazing Efforts as a PLHIV Support Group

Plus Point is one of 13 PLHIV support groups currently existing in Guyana. As with all other support groups, the aim of the group is to provide a forum for its members to discuss common experiences, to share knowledge, to engage in recreational activities and to become involved in skills building and income generation activities. The group was formed in 2005 with a membership of 40 persons which has now increased to a total of 50 persons. Over the years, Plus Point has experimented with a number of income generation efforts, however its recent venture to generate income has surpassed that of all the other support groups in Guyana. At a PLHIV conference held in 2013, it was agreed that this venture would be used as a best practice to be shared with the other groups as a model to be replicated.

Plus Point has ventured into contracts with the Linden Town Council, the Linden Hospital Complex and the Linden Town Week committee to provide environmental maintenance services. In addition, the group submitted and won a bid for providing these services around the market area to the tune of $US 1,000. Added to this, whenever there are special activities within the hospital and around the town, PLHIV are employed on a needs basis. The members of Plus Point rotate in providing their services in the attempt to allow each member an equal opportunity to earn. A major achievement of these ventures is the securing of permanent jobs within some of these entities: one porter and one maid attached to the hospital and one security guard attached to the Town Council.

Plus Point's business ventures have resulted in both the psychological and economic upliftment of its members whose quality of life has improved significantly. Members can now acquire basic amenities such as food items, bicycles/motor cycles to move around, invest their earnings to become self employed, and even commence building a home. Of the income generated by the group, 25% of the earnings is put towards supporting group members in the form of transportation to attend clinic, hospitalization costs and other forms of support. A major achievement of Plus Point's venturing out is that its members HIV status is known and accepted by their contractors thereby overcoming the barrier of stigma and discrimination and increasing accepting attitudes towards PLHIV.

Future plans of Plus Point include the securing of house lots for its members through the Central Housing Authority and further income generation activities including block building, livestock rearing, and the formation of a co-op society.

While the efforts by other support groups over the years to support their members have included penny banking, the purchase of school items, donation of food items, garment production and arts and craft production, these activities have not had the same impact as Plus Point's recent ventures. In keeping with the decision made at the 2013 PLHIV conference, exchange visits have commenced between Plus Point and the other support groups so that these groups could learn from the Plus Point experience. These heightened efforts by support groups to increase their sustainability have become even more crucial within the current environment of decreasing donor funding to provide support services for PLHIV.

V. MAJOR CHALLENGES AND REMEDIAL ACTIONS

Whilst acknowledging the major progress made by the Government of Guyana in its response to HIV, the Guyana AIDS Response Progress Report **2010-2011** identified the following challenges to achieving the targets set in the June 2011 Political Declaration on HIV and AIDS and also the MDG targets. These include:

1. **Reducing Financial Resources and Sustainability -** Guyana over the years has received significant external support for its HIV response. Over the recent 5 years funding has been decreased with the close out of the World Bank Multi-country AIDS programme. PEPFAR in its second phase has recommitted to Guyana through a similar bilateral arrangement however with reductions in the yearly amount of funds allocated. This new environment has directed the Government of Guyana in placing high on its priority the issue of sustainability of its HIV response. In this regard, Guyana conducted in collaboration of USAID, an HIV sustainability assessment (HAPSAT). Key areas were explored, including human resources for clinical services (TB, HIV treatment, PMTCT, VCT and others), training and availability of ARVS. Based on the findings, several recommendations were put forward. The Ministry has made significant advances in addressing some of these for examples task shifting among clinical staff and cross training between TB and HIV outreach staff, VCT and PMTCT personnel. Despite these, transitioning staff and other donor funded support from projects to the Public Service and Ministry of Health System still present challenges.

2. **Stigma and Discrimination:** Guyana continues to report progress in reducing stigma and decimation. The comparisons of the two biological and behavioral surveillance surveys have shown an increase in accepting attitudes towards HIV infected persons. Much progress has been made among health care workers as the programme has invested heavily in in-service training of clinical teams. A stigma and discrimination policy was developed and is being rolled out to all treatment sites. The National Week of HIV testing and the openness of Guyanese in seeking HIV testing is another hallmark indicative of the reducing HIV stigma and discrimination. Whilst the progress is noted, we are cognizant that Stigma and Discrimination still remains an issue at all levels, within our homes, in our communities, in our workplaces and elsewhere. The National Programme would continue to work in facilitating an enabling environment and in empowering all stakeholders in reducing stigma and discrimination.

3. **Understanding and Reaching the Most at Risk populations:** Guyana in its BCC strategy has defined priority groups for action including sex workers and men who have sex with men as some of the most at risk populations. There is information available on these populations through two rounds of biological and behavioral surveillance surveys. There is also additional qualitative information on these groups in further addressing stigma and discrimination and access to services. With this, Guyana has been successful in programming for these populations as demonstrated in the reducing HIV prevalence among the female sex worker population and to a lesser extent among men who have sex with men. Despite the progress noted, it is clear that the there remains significant knowledge gaps among these populations. Additionally, information is available for only a few of Guyana's geographic regions and little is known about clients sex workers.

Whilst attempts were made to model the size of these populations, a clear estimate is still not available. To be better able to reach these populations with prevention and other services, it is critical to have a comprehensive understanding of their behaviors and that of their clients in all ten regions of Guyana. As Guyana prepares for its third round of BBSS among the MARPS, it is important to conduct a critical examination of the methodology to facilitate this.

HIV Prevention among Youth has come into sharp focus over the past three years as the Surveillance Department of the Ministry of Health has reported an increase in the proportion of annual HIV cases among the 15-19 age group. Parallel to this, a comparison of the two rounds of the BSS conducted among in and out of school youth showed an increase in high risk behaviors and a decrease in the use of condoms. The School Health Survey, the Tobacco survey and other related studies have also shown that the levels of undesired behaviors such as alcohol consumption, and tobacco use are high. In intensifying the response to youth, a National Youth Reference Group was established by the NAPS and a School Health Committee was formed jointly between the Ministry of Health and the Ministry of Education. Programming has intensified particularly for in- school youth in a structured manner, however key challenges still exist and would be the focus of the national programme over the medium term. An important component would be the roll out of the Health and Family Life Education programme.

4. **Reaching the Mobile Populations:** Guyana's hinterland regions (regions 1, 7, 8 and 9) are known for mining activities including gold, diamond and other natural resources. Recognizing the high risk behaviors involved with these types of professions, Guyana conducted 2 surveys among the miners and confirmed in the findings that this group and their social networks are important target audiences for HIV prevention activities. The Ministry of Amerindian Affairs, the Ministry of Local Government and the Guyana Geology and Mines Commission were key in targeting these populations. CSOs were funded and strategic alliances were formed to provide prevention services including voluntary counseling and testing. Over the past two years, Guyana has witnessed the rapid expansion of the mining activities with new geographic areas being explored. Accompanying this is the parallel growth of sex work in these communities. The rapid growth of the mining industry has seen in some cases unplanned movement of mining camps across regions and also within regions. These issues, coupled with the difficulties of the terrain, continue to present challenges in reaching the miners and their social networks. Guyana would continue to ensure that the programmes addressing this population are robust and could adequately address their needs considering their unique dynamics.

5. **TB/HIV co-infection:** The National Tuberculosis Programme has intensified its work in this area and has received additional funding support from two rounds of the Global Fund and from the PEPFAR programme. The national programme also continues to benefit from technical support from partners such as PAHO. All combined, significant strides have been made in ensuring that HIV positive persons are screened for TB and that persons with TB/HIV co-infection receive appropriate management. While the TB/HIV co-infection rate remains high, the Ministry of Health will continue to enhance TB infection control in all settings, ensuring that all TB/HIV co-infected individuals

have access to ARVS as part of their management and that all HIV infected persons are screened and managed according to protocol.

In response to the challenges identified, the national programme committed to taking remedial action to address some of the challenges mentioned above. These remedial actions are reflected in the 16 below.

Table 16: ***Remedial Actions in Response to Challenges***

Challenges	Remedial Actions
1. Reducing Financial Resources and Sustainability	Despite the reducing financial resources during the reporting period, the National Response saw the recommitment from PEPFAR and the approval from the Global Fund for Phase 2. There is however a high level of recognition of the need for transitioning and sustaining the response at the desired levels, to maintains the gains achieved and to further impact on the epidemic. With the PEPFAR support transitioning implementation to a technical assistance programme, consideration is being given to the need for absorption of critical human resources as well as many of the implementation initiatives supported by PEPFAR. In relation to the Global Fund and the mandatory requirement for 50% funding to be allocated to the key populations response, similar consideration for absorption is necessary. The gap created by these programmes with the contextual shift has to be understood. The NASA conducted for 2011 and 2012 and the anticipated costing of the HIVision 2020, will serve as additional tools to better understand the costing of the programme and thus the gap created as a result of reduced funding. The Government of Guyana has made significant strides in addressing transitioning and sustainability as follows: An agreement was reached with the PEPFAR programme in 2013 with regard to transitioning the procurement of second line and paediatric ARVs to the government. This process of transitioning will be a phased one commencing in 2014. The transitioning of ART consumables such as those for CD4 testing, has been partially transitioned from the donor to the government. Approval for a three-year HR transition plan for the period April 1st 2014 to March 31st 2016 has been given and the planning process for this has commenced.
2. Stigma and Discrimination	A major achievement during the reporting period was the work done in drafting the HIV and AIDS Regulation that seeks to enforce the National Workplace HIV and AIDS Policy. This Regulation was recently tabled in Parliament. The rollout of the stigma and discrimination policy at all treatment sites continued

Challenges	Remedial Actions
	during the period, in addition to the provision of stigma reduction training to all categories of staff at these sites. The focus of the training was to promote the delivery of health care services in a non judgmental and non discriminatory manner. Efforts also commenced within the health sector to incorporate stigma and discrimination modules within all pre-service training curricula. Mass media campaigns aimed at educating the public and the training of specific target groups e.g. law enforcement officers in the attempt to reduce harassment of MSM and FSWs, continued. During the period, PANCAP also embarked on a regional initiative (Justice for All) that involves Guyana and has as its purpose, the sharing of experiences and galvanizing support for legislative reform aimed at eliminating stigma and discrimination. A formal system for redress will be developed in the next reporting period.
3. Understanding and Reaching the Most at Risk populations	The third BBSS that is currently ongoing presents the opportunity for a greater understanding of the key populations, particularly MSM, FCSW, Miners and Loggers. This BBSS is being conducted in all ten regions of Guyana and it includes a PLACE methodology. This exercise is very extensive and it will provide the necessary data for size estimation as well as the Modes of Transmission Study. It is expected that the process will be completed by the end of June 2014. In addition, during the reporting period, numerous outreaches, especially within the outlying regions, were conducted to target the key populations, in particular MSM and FSWs, for the purpose of providing a complete package of services. There continues to be significant levels of stigma and discrimination toward the key population that hinders access to services. This is being addressed in a comprehensive manner.
4. Reaching the Mobile Populations	HIVision 2020 has identified this group as a key population at higher risk. The National Programme is engaged in a more targeted response to the mobile and migrant populations. The BBSS which commenced in 2013 will conclude in 2014 and this will provide extensive baseline data for understanding the knowledge, attitude and practices within this population. The data will also assist in understanding the factors that affect their access to services. Under the Global Fund Grant a sub recipient was identified to target this population, particularly in the hinterland regions of 1, 7, 8 and 9. It is anticipated that this initiative will commence in mid 2014. The PEPFAR programme has also provided support to various NGOs to provide services in those regions where the mobile populations are being targeted.
5. TB/HIV Co-Infection	Collaboration between the National Tuberculosis Control Programme and the NAPS was intensified during this reporting

Challenges	Remedial Actions
	period and aligned to the WHO 12-points policy. The reduction in TB/HIV co-infection rates from 2012-2013 is noted with caution as the rates remain at high levels. Despite this, the progress noted could be attributed to the proactive measures continued in screening HIV patients for TB and vice versa. Follow up treatment continued based on the outcomes of this screening and the management of co-infection was further strengthened with renewed emphasis placed on earlier initiation of antiretroviral therapy, as stipulated in the revised HIV treatment guidelines. There were also heightened efforts to train health care facilities staff in the Tuberculin Skin Testing so as to further strengthen the referral process between HIV treatment sites and TB treatment sites. Targeted efforts continued to screen key populations at higher risk for TB e.g. prisoners. Public education efforts aimed at TB awareness also continued during the period.

Despite the progress referred to above, many of the challenges reported during the previous reporting period remain since long term solutions are required. In addition to these, new challenges were identified during this reporting period and these include:

1. **Access to the hinterland communities:** The difficulties associated with the geographic terrain as well as the mobility of the miners and loggers present significant challenges in delivering the key prevention package of services. Donor funded programmes continue to fund NGOs to work in these communities. The PANCAP/GIZ project is also working in ensuring that these populations receive culturally appropriate services. During the reporting period, significant strides were made in transitioning a centrally operated mobile treatment unit to fixed treatment sites within the hinterland regions. This model of integration is also challenged by the lack of adequate support, as limited laboratory infrastructure often requires the shipment of samples to the NPHRL for processing. This too poses additional difficulties associated with the logistics of sample collection, storage, shipment, processing and return of results.

2. **Repeated pregnancies among the HIV positive pregnant women.** Data over the last 3 years indicate that among the antenatal population testing HIV positive, the majority are actually know HIV positive women. This sub population is increasing annually, thus showing an increase in the HIV prevalence among the antenatal population. Parallel to this, the number of new HIV positive cases is reducing. To better understand this phenomenon, the PMTCT programme has initiated research for which results will be made available in 2014. Without the data, considerations have already been given to intensification of counseling and the introduction and roll out of family planning services to the HIV positive women.

3. **Retention of patients on ARVs and other treatment outcomes**: The 2012-2013 12-months survivability and retention on ART represented a reduction from the previous three 12-months cohorts. A closer examination of the data suggested that the reduction was across the board i.e. by males and females and by adults and children. Greater reductions were noted in the 2012-2013 cohort for the children population. There was an apparent association between the reduction in 12-months survival and retention on ART, with an increase in the stopped and loss to follow up cases, even though there continued to be a decline in the number of deaths over the years. In 2013, the national programme formally introduced supportive supervision for the clinical teams throughout Guyana. Through this process, experienced HIV clinicians conducted mentoring and training through a didactic on-site mechanism whereby patients were seen jointly and cases discussed. This also included a mandatory chart review, especially for children. This process will continue during the upcoming period, in addition to strengthened efforts for tracking defaulters and promoting adherence to treatment.

4. **Laboratory support for the ART Programme:** The National Public Health Reference Laboratory continues to serve the HIV programme and also to provide quality assurance to regional labs. During the reporting period many challenges were encountered that resulted in gaps in laboratory monitoring of patients in care and on treatment. The NPHRL experienced significant attrition of highly skilled technical persons. This situation is currently being considered in the wider MoH discussion on transitioning of staff. The staff issue was compounded by the difficulties experienced with the supply chain management systems resulting in interruptions of critical services. Efforts are being made to strengthen this area as PEPFAR now supports a highly skilled warehouse manager positioned at the National Warehouse, and SCMS continues to provide high quality technical assistance and implementation throughout the supply chain. The NPHRL works with a network of regional and district laboratories in collaboration with the Department of Standards and Technical Services. These laboratories are also faced with the same issues. The Department of Standards and Technical Services has commenced the drafting of a National Laboratory Strategy while at the same time a strategy is also drafted for the NPHRL. Both strategies will be finalized and implementation started in 2014.

5. **Data collection system:** The data collection system is clearly outlined in the Operational Plan to the National M&E Plan for all sub programmes with the HIV response. Over the years the data collection system was refined on several occasions to adequately capture information to enhance service delivery and clinical monitoring in addition to ensuring that the system was robust enough to facilitate donors, international and other reporting requirements. The system has evolved into a comprehensive one collecting huge volumes of data. This system being a manual paper based system is labour intensive for data collection, data entry and analysis and it leaves much room exists for human error. There are several stand alone data bases that provide limited utility. This situation has to be addressed if the monitoring and evaluation system is to remain robust and relevant.

VI. SUPPORT FROM COUNTRY'S DEVELOPMENT PARTNERS

The progress reported herein is directly related to the significant amount of 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 II, Supply Chain Management Systems (SCMS), Positively United to Support Humanity (PUSH), US Department of Defence.

- The Global Fund to Fight AIDS, Tuberculosis and Malaria

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

- Pan Caribbean Partnership against HIV/AIDS (PANCAP)

- Deutsche Gesellschaft fur Internationale Zusammenarbeit (GIZ)

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 training, and curricula development;

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

3. Maintaining 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. Harmonization of donor reporting commitments to facilitate a single national report to fulfill 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 are integrally linked to HIV such as mental health, substance abuse, and domestic violence are addressed.

VII. MONITORING AND EVALUATION ENVIRONMENT

Monitoring and Evaluation continued to play an integral role in the management of the HIV and AIDS response in order to track and report on the successes and weaknesses of the national programme. Coordination of the HIV M&E agenda in 2012 and 2013 was led by the NAPS M&E Unit with support from technical partners in the local UN and PEPFAR/ USAID offices who were fully represented on the Monitoring and Evaluation Reference Group which aims at streamlining monitoring and evaluation efforts among the various partners.

The following are key areas of progress during the past two years:

- **Capacity Building:** The NAPS staff participated in a Data Demand and Use Workshop which also had the participation of staff from the wider Ministry of Health. Twenty-four (24) persons including staff who manage data and data systems, programme managers, and decision makers benefitted from this training. Twenty four (24) key MoH personnel (including NAPS staff) also benefitted from training in descriptive statistics which included training in basic descriptive analysis of information collected to inform program planning and resource allocation. In addition, to complement the launch of the HIVision 2020, a two-day target setting workshop was conducted for programme implementers involved in the HIV response. During the reporting period, the NAPS M & E lead also attended a GHARP II training programme on Research Methodologies and Data Analysis.

- **HIV Surveillance:** During the period, the revised HIV Case Surveillance Form as well as the new surveillance system were rolled out at the national level. The Case Surveillance form had been previously adjusted to match the WHO Revised Clinical Staging for HIV and Case Definitions and the surveillance database is being updated to accommodate this revised form. During the rollout, training was conducted for some 228 health care workers in 8 regions to ensure a smooth transition in the implementation of the updated form with the aim of improving the completeness and timeliness of HIV/AIDS case reporting. To monitor this, quarterly quality assessments were conducted and these also included checking the data for representativeness, accuracy and validity. Emerging issues were addressed as the period progressed. A SWOT analysis in relation to the use of the new surveillance system was also conducted and SOPs relating to the system were launched.

- **Revision of the M & E System:** The M & System was revised to facilitate reporting on HIV testing among key populations. This group was especially targeted during the reporting period for the receipt of prevention, care and treatment services.

- **Data Quality Assessment:** A data verification visit was conducted by the Global Fund in 2012 and this revealed that the M & E system produced reliable data for the three

indicators assessed and that there was no data quality issues. In addition, the routine verification of all data received from the NAPS Programme Coordinators formed part of the regular activities of the M & E Unit.

- **HIV Prevalence Estimation Exercise:** The M&E Unit was provided with training in the SPECTRUM/EPP for the national estimation exercise and draft estimates were developed for Guyana by the NAPS team. These Estimates are now being produced yearly by countries with training and mentorship from UNAIDS and its partners. In the development of the Estimates during the review period, it was necessary to conduct consensus meetings with various stakeholders including the broader MoH, donor partners and civil society to solicit their comments which were taken into consideration when NAPS along with experts from UNAIDS, developed the final HIV estimates for publication in the 2013 Global Report.

- **Surveys:** Work commenced for the third BBSS among key populations at higher risk for HIV. The PLACE methodology is being used for the survey and technical assistance is provided by MEASURE Evaluation through PEPFAR/USAID. The M & Unit coordinated the four Technical Working Groups convened – key stakeholders who work with: miners; loggers; sex workers and; MSM. During the reporting period a number of planning meetings were held on the survey protocol (which received approval from the local IRB), and an assessment visit was made by a multi-sectoral team to a logging community (Mabura Hill) to discuss with loggers the purpose of the survey and to obtain feedback on the protocol. Sensitization visits were also done in 4 additional regions. BBSS field staff training was conducted and the survey pilot was launched in Region 8-Madhia and the appropriate changes made to the data collection tools. During the upcoming period, the BBSS will be done in two phases: (1) Loggers and Miners – with the support of the Bureau of Statistics that has good knowledge of the field and (2) Sex Workers and MSM. In addition to the BBSS, M & Staff were also involved in the HIV Drug Resistance Survey (update provided under a separate heading). During the period, the Antenatal Care survey protocol was also finalized and this received the Guyana IRB approval. The protocol was later forwarded to CDC Atlanta for approval and the suggested amendments are in progress.

- **Reports:** Staff were integrally involved in the collection, collation and presentation of data for: the GARPRs 2012 and 2013; NAPS Annual Report; Global Fund Semester reports; the Mid Term Review (MTR) of the Ten Targets under the 2011 UN General Assembly Political Declaration on HIV/AIDS; the draft Proposal for the Phase 2 of the Global Fund HIV RCC Grant; HIVision strategic information component and; the Drug Resistance Survey.

NCPI Results for Monitoring and Evaluation

VI. Monitoring and Evaluation

A majority of respondents recognized the importance of strategic information in coordination and integration of efforts in national HIV/AIDS response. Most of these respondents noted that Guyana has developed a national monitoring and evaluation (M&E)

plan for the period 2013- 2020. Some challenges noted by the respondents in the development or implementation of the M&E plan for HIV were as follows:

- Consistency of reports
- Sustainable financial and human resources
- Data sharing by members of civil society organizations
- Harmonization of data by partners and stakeholders.

Less than half of the respondents (9/19) reported that *'most partners'* have harmonised and aligned their M&E requirements with the national M&E plan. This is compared to a majority of respondents (5\6) in the previous NCPI that held this view. A minority of respondents in 2009 reported that most partners have harmonized and aligned their M&E plan with the requirements of the national plan, whilst half of the respondents in 2007 held this similar view.

A large margin of respondents (5\6) agreed that the national M&E plan includes a data collection strategy. In relation to guidelines for tools of data collection, a majority of respondents (16\19) agreed to the presence of data collection tools. In 2011, all the respondents (6/6) noted the presence of a data collection strategy. A majority in 2009, and half of the respondents in 2007 held the similar view. A majority of respondents (15\19) noted data dissemination and use of a strategy was present in the national plan compared to more than half of the respondents (4/6) in 2011 and a majority of respondents in 2009. A large margin of respondents (15\19) reported a data analysis strategy in the plan, compared to half of the respondents (3\6) in 2011 that shared this view and a unanimous agreement among respondents in 2009. The majority of respondents (17\19) reported HIV drug resistance surveillance was included in the national plan compared to more than half of the respondents (4\6) in 2011 that shared this view.

More than half the respondents (13\19) noted a budget was present for implementing the M&E plan. In comparison, all respondents (6\6) in 2011 and a majority of the respondents in 2009 reported there was no budget for implementing the M&E plan. Almost all of the respondents (18\19) indicated their uncertainty with regard to an estimated amount for the budget of the M&E plan, compared to half (3\6) of the respondents in 2011who estimated the budget was between 1.5 – 10.0 percent of the total HIV programme funding.

National M&E Unit

A margin of respondents (13\19) reported the presence of a functional national M&E unit, compared to all respondents (6\6) in 2011, and a majority of the respondents in 2009 and 2007 that held the same view. However, respondents identified the following obstacles:

- Lack of human resources or technical personnel;
- Culture of M&E has not been accepted by staff and stakeholders;
- Data quality;
- Submission of reports to the unit in a timely manner;

Most respondents (14\19) reported that the M&E unit was based at the national AIDS programme secretariat (NAPS). In 2011,a majority of respondents (4\6) held this same view. However, they were varying perceptions among respondents as it relates to the number of

staff in the unit, some indicated three to four permanent staff members while others noted uncertainty in the number of permanent and temporary staff members.

A large margin of respondents (14\19) noted the presence of a mechanism in place to ensure that all key partners submit their M&E data and reports to the M&E Unit for inclusion in the national M&E system. In 2011, half the respondents agreed that mechanisms were in place to ensure that all key partners submit their M&E data and reports to the M&E unit for inclusion in the national M&E system. Half the respondents in 2009 and all respondents in 2007 disagreed that such mechanisms were in place.

Some of the major challenges cited by respondents in this area include:

- Data is paper based
- Data being stored manually
- Quality of data
- Timeliness of submissions
- Human resource capacity
- Accuracy of data

Monitoring

Most of the respondents (18\19) reported that the current HIV programme is being monitored. Most of the respondents (17\19) agreed that coverage is being monitored by sex and geographical area compared to all of the respondents in 2011 who shared this view. Most respondents, since 2011, reported that monitoring was done by population; particularly key populations such as MSM, CSW, transgender, prisoners, women and children, where the data is being utilised for policy and programme decisions.

National M&E Coordination

Most respondents, (11\19) as in 2011 (5\6)noted the presence of a national M&E committee or working group that meets regularly to coordinate M&E activities. This committee is called the monitoring & evaluation reference group (MERG

A majority of respondents (14\19) noted the presence of a central national database with HIV-related data, compared to less than half (2\6) in 2011 who held this view and a minority of respondents who held this view in 2009. The respondents reported that the national database is located and managed by NAPS compared to respondents in 2011 who indicated that it was located at the health information and statistical unit at the Ministry of Health. Most respondents agreed that the database consists of:

- Surveillance data including co-infection, mortality and prevalence rates
- Data on Key populations:
    - Geography; and
    - Demographics;

In comparison, respondents in 2009 reported that the central national database with HIV related data consists of an EXCEL spreadsheet, which was managed by the M&E Unit of the National TB Programme.

National Health Information System

Half the respondents (9\19) noted the presence of a functional health information system at the national and subnational level. In comparison, (10\19) respondents and less than half (2\6) respondents have agreed to the presence of the health information system, a national and sub national level. Most respondents(17\19)since 2011, noted that Guyana publishes an M&E report on HIV, including HIV surveillance data at least once a year, compared to 2009 when half of the respondents shared this view.

Culture of Data Use

Most respondents (5\6) in 2012 and (18\19) in 2014) indicated that M&E data are used for programme improvement and resource allocation. All respondents (19\19) reported that data was used to develop and revise the national HIV response. Examples of data use include:

- Programme planning purposes
- Prevention of duplication efforts
- Programme effectiveness and efficiency
- Identify target or key populations
- Identify gaps, for example during the national week of testing, it was illustrated that services were not adequately accessed in regions three and five. This information was used to plan outreach activities in those regions;

Main challenges include:

- Perception of M&E needs to change;
- Utilization of data in programme planning;
- Human resources to be trained in M&E;
- HIV surveillance data needs to be done yearly, the BBSS is not done regularly and the demographic household survey was done only once in 2009; and
- Verification of programme data.

Half the respondents (3\6) reported that M&E training was conducted at the national level, while less than half of the respondents (2\6) reported that training was done at the sub national level and service delivery level, including civil society. In comparison, less than half the respondents in 2009 reported the presence of a plan for increasing human capacity at the national level and all agreed there was no plan at the sub national level. Less than half the respondents agreed that M&E training was conducted at the service delivery levels.

More than half the respondents noted that other M&E capacity building activities were conducted compared to half of the respondents (3\6) in 2011 that shared this view.

Since 2009, most respondents noted there were many key achievements in the HIV-related monitoring and evaluation:

- Improved data collection
- Improved data sharing mechanisms
- M&E Framework in HIVision 2020
- Expansion and increase of the number of people on treatment;

- Availability of HAART;
- Collaborative efforts to synchronize HIV / TB prevention and treatment services;
- A staffed and functional National M&E unit;
- Central database development in progress;
- Development and harmonization of the core indicators;
- Some accuracy in the routine collection and validation of data; and
- Strengthening of the data verification system.

Remaining challenges include but are not limited to:

- Lack of a centralized database;
- Data collection still manual at individual clinics and centres;
- Adequate human resources;
- Coordination with other M&E units;
- M&E unit functioning as a national M&E clearing house;
- Data quality;
- Data accuracy;
- Timeliness in submission of reports to the unit;
- Technical support;
- Analysis of data;
- Capacity to deliver M&E; and
- Implementing and rolling out the central database for HIV.

ANNEXES

ANNEX 1: Training Activities Conducted During the Reporting Period

Region	Topic	Number of Persons Trained	Target Audience	Training Category
Leadership and Coordination				
7 Regions	Leadership development	235	Health care and other staff	Leadership development
	TOT Leadership development training	25		
	Sustainable community change	129	Community members	
	Community Life Competence	145	Community members	Life skills
	Life skills	14	Work study students attached to NAPS	
	Journey of Life – identifying and using community resources	22	Social workers attached to treatment sites and also NGOs	Resource mobilisation
Prevention				
	Adolescent health	60	Adolescents	Adolescent health and youth friendly health Services
2, 3, 4, 5, 6, 9, 10	Adolescent health and Youth Friendly services	46	16 health care workers and 30 auxiliary staff	
	Gender based violence	123	Students	Gender based violence
	Gender based violence	150	Community members	
	TOT Workshop to introduce the use of the GBV in school manual (part of the HFLE manual)	9	Civil society, social worker, health education officers, MoLHSSS personnel	
2, 3, 4, 10	Gender based violence	3,560	Students of 40 schools	

Region	Topic	Number of Persons Trained	Target Audience	Training Category
3, 4, 10	Gender based violence	194	Health care workers including PMTCT, VCT and HBC staff	
	Gender based violence	30	Children of prisoners	
	Gender based violence	1,599	Employees in various workplaces	
4	Gender based violence and mental health	136	Counselors of victims of domestic violence	
4, 6, 10	Sexual and domestic violence protocol for health care workers	130	Health care workers including 12 midwives	
	Health and family life education	78	Teachers	Health and family life education
	Health and family life education	8,000	Students	
2, 3, 4,5,6,7,10	Stigma and Discrimination reduction	248	Health care workers	Stigma and discrimination reduction
	Stigma and discrimination reduction	19	Course facilitators taken from NGOs	
2, 4, 6, 7, 10	HIV/AIDS sensitization and stigma and discrimination	1,091	661 in and out of school youth, 191 MSM/FSW, 225 health care workers, 14 loggers/miners, 12 supermarket staff	HIV sensitization and stigma and discrimination
	Workplace education programmes including healthy lifestyles and HIV	2,373	Employees in workplaces	Workplace wellness
1, 2, 6, 10	PMTCT	134	PMTCT staff, physicians, pharmacy staff	PMTCT
3, 4, 6, 10	PMTCT refresher training	72	Health care workers	

Region	Topic	Number of Persons Trained	Target Audience	Training Category
2, 8	PMTCT/Safe motherhood	27	Health care workers	
2, 8	Male partner involvement	16	Health care workers	
	Communication	31	Counselor/testers	Voluntary Counselling and Testing
	VCT	126		
	VCT and cross-cutting issues	43	Counselor/testers	
2, 3, 4, 5, 6, 7, 10	VCT refresher training	335	Counselor/testers	
	Vaginal Inspection with Acetic Acid	20	Health care staff	Vaginal Inspection with Acetic Acid
	Fluorescence microscopy	6	Laboratory technicians	STI trainings
	STI molecular diagnostics	1	Laboratory technician	
	STI testing	25	Laboratory technicians	
1, 2, 3, 4, 5, 6, 7, 8, 10	STI syndromic management	858	762 Health care workers, 80 teachers and 16 Environmental Health personnel	
	Peer Education	117	Trades Union members and other employees (through the GBCHA)	Peer education
All 10 regions	Peer education	907	In and out of school youths and adults. NGOs	
1, 2, 3, 4, 5, 7	Post exposure prophylaxis	312	55 Police officers and 257 health care workers	Post Exposure Prophylaxis
Treatment and Care				

Region	Topic	Number of Persons Trained	Target Audience	Training Category
	Clinical training in HIV	210	Physicians	Clinical management of HIV
3, 4, 5, 6, 10	IMAI	277	Health care workers	IMAI
	IMAI and TB/HIV	147	Health care workers	
	IMAI training of trainers	22	Physicians	
	TB infection control	30	Health care workers	TB infection control
	Tuberculin Skin Testing	48	Health care workers	
3	Dry Blot Spot/Rapid Test	17	Health care workers	Laboratory training
4	CD4 testing	7	Laboratory technician	
2,3,4,6,7,10	Client and caregivers training	136	PLHIV and caregivers	Home based care
	Family care giving	15	Nurses	
2,3,4,6,7,10	HBC refresher training	78	Caregivers and volunteers	
All 10	SOPs for standard drug registries		Health care workers	Pharmaceutical record keeping-SCMS
7, 8, 9	WASH in schools	1,055	Students (from mainly secondary schools)	Hygiene and sanitation
Support Services				
4	Capacity building and coping skills	20	Adolescent clients of NCTC	
2	Psychosocial interventions for addressing the needs of adolescents	30	Staff of NOC	Psychosocial Support
	Care and support for OVC	23	Staff of 19 orphanages	OVC care and support

Region	Topic	Number of Persons Trained	Target Audience	Training Category
	Child protection	77	Nurse supervisors and social workers	
	Child protection laws	24	Social workers from HIV care and treatment sites	
	Child sexual abuse	80	Community members	
	Parenting	132	Community members	
	Positive parenting techniques	21	Parents attending HIV treatment sites	
	Training in the use of registers at orphanages	19	Caregivers	
	Positive Health, Dignity and Prevention	223	PLHIV	Positive Health, Dignity and Prevention
	Entrepreneurship skills training for FSWs	15	NGO staff	Skills training
	TOT workshop on job readiness	27	Nurse supervisors and social workers	
	Job readiness and skills training	338	153 FSW, 98 PLHIV, 37 OVC and 50 out-of-school youth females	
	Sign language	34	Social workers	Support to persons with disabilities
Strategic Information				
	HIV case surveillance	72	Health care workers	HIV case surveillance
2, 3, 4, 5, 6, 10	Revised HIV case surveillance form		Health care workers	
	Advancing in analysis with a gender and ethnic perspective	25	Statisticians	Data analysis and management
	Data demand and use	24	MoH personnel	

Region	Topic	Number of Persons Trained	Target Audience	Training Category
	Descriptive statistics	24	Health care workers	
Total number of persons trained		**24,696**		

ANNEX 2: Core Indicators for Global AIDS Response Progress Reporting

Targets	Indicator	Data origin	Period	Value	Numerator	Denominator	Remarks
Target 1: Reduce sexual transmission of HIV by 50 percent by 2015 General Population	**1.1** Percentage of young women and men aged 15-24 who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconception about HIV transmission	DHS	2009	51.10%	1524	2983	No new survey. No updating required
	Males	DHS	2009	46.60%	559	1200	
	Females	DHS	2009	54.10%	965	1783	
	Males 15-19	DHS	2009	44.50%	307	689	
	Males 20-24	DHS	2009	49.40%	252	511	
	Females 15-19	DHS	2009	53.10%	540	1016	
	Females 20-24	DHS	2009	55.40%	425	767	
	1.1.1 Percentage who correctly identify that the risk of HIV transmission is reduced by having sex with one non- infected partner	DHS	2009	81.30%	2425	2983	No new survey
	Males	DHS	2009	83.80%	1006	1200	
	Females	DHS	2009	79.60%	1419	1783	
	Males 15-19	DHS	2009	81.40%	561	689	

Targets	Indicator	Data	Period	Value	Numerator	Denominat	Remarks
	Males 20-24	DHS	2009	86.90%	444	511	
	Females 15-19	DHS	2009	78.80%	801	1016	
	Females 20-24	DHS	2009	80.60%	618	767	
	1.1.2 Percentage who correctly reported that consistent condom use reduces the risk of HIV transmission	DHS	2009	83.30%	2485	2983	No new survey
	Males	DHS	2009	83.50%	1002	1200	
	Females	DHS	2009	83.20%	1483	1783	
	Males 15-19	DHS	2009	84.40%	582	689	
	Males 20-24	DHS	2009	82.40%	421	511	
	Females 15-19	DHS	2009	81.80%	831	1016	
	Females 20-24	DHS	2009	85.00%	652	767	
	1.1.3 Percentage who correctly reported that a healthy looking person can have HIV	DHS	2009	86.30%	2575	2983	No new survey
	Males	DHS	2009	86.30%	1036	1200	
	Females	DHS	2009	86.30%	1539	1783	
	Males 15-19	DHS	2009	83.80%	578	689	
	Males 20-24	DHS	2009	89.60%	458	511	

Targets	Indicator	Data	Period	Value	Numerator	Denominat	Remarks
	Females 15-19	DHS	2009	84.90%	863	1016	
	Females 20-24	DHS	2009	88.10%	676	767	
	1.1.4 Percentage with knowledge that mosquitoes cannot transmit HIV	DHS	2009	71.80%	2142	2983	No new survey
	Males	DHS	2009	67.50%	810	1200	
	Females	DHS	2009	74.70%	1332	1783	
	Males 15-19	DHS	2009	63.90%	440	689	
	Males 20-24	DHS	2009	72.40%	370	511	
	Females 15-19	DHS	2009	76.00%	772	1016	
	Females 20-24	DHS	2009	73.00%	560	767	
	1.1.5 Percentage with knowledge that sharing a meal cannot transmit HIV	DHS	2009	84.90%	2533	2983	No new survey
	Males	DHS	2009	82.00%	984	1200	
	Females	DHS	2009	86.80%	1549	1783	
	Males 15-19	DHS	2009	80.70%	556	689	
	Males 20-24	DHS	2009	83.80%	428	511	
	Females 15-19	DHS	2009	86.90%	883	1016	
	Females 20-24	DHS	2009	86.80%	666	767	
	1.2 Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15	DHS	2009	13.60%	407	2983	No new survey

Targets	Indicator	Data	Period	Value	Numerator	Denominat	Remarks
	All females	DHS	2009	10.10%	180	1783	
	All males	DHS	2009	18.90%	227	1200	
	Females 15-19	DHS	2009	10.30%	105	1016	
	Females 20-24	DHS	2009	9.80%	75	767	
	Males 15-19	DHS	2009	15.70%	108	689	
	Males 20-24	DHS	2009	23.20%	119	511	
	1.3 Percentage of adults aged 15-49 who have had sexual intercourse with more than one partner in the last 12 months	DHS	2009	4.90%	417	8518	No new survey
	All Females	DHS	2009	1.30%	65	4996	
	All Males	DHS	2009	9.90%	352	3522	
	Females 15 – 19	DHS	2009	1.10%	11	1016	
	Females 20 – 24	DHS	2009	1.50%	12	767	
	Females 25 - 29	DHS	2009	2.20%	15	658	
	Females 30 - 39	DHS	2009	1.60%	22	1342	
	Females 40 - 49	DHS	2009	0.40%	5	1213	
	Males 15 - 19	DHS	2009	8.00%	55	689	
	Males 20 - 24	DHS	2009	18.40%	94	511	

Targets	Indicator	Data	Period	Value	Numerator	Denominat	Remarks
	Males 25 - 29	DHS	2009	9.50%	44	462	
	Males 30 - 39	DHS	2009	10.10%	100	990	
	Males 40 - 49	DHS	2009	6.40%	56	870	
	1.4 Percentage of adults aged 15-49 who have had more than one sexual partner in the past 12 months who report the use of a condom during their last intercourse ***Note**: There were fewer than 25 unweighted cases for females 15-19 and 20-24, 25-29, 30-39, 40-49, and have been suppressed in DHS report.*	DHS	2009	-	-	-	No new survey
	All Females	DHS	2009	-	-	-	
	All Males	DHS	2009	65.50%	228	348	
	Females 15 -19	DHS	2009	-			
	Females 20 – 24	DHS	2009	-			
	Females 25 – 29	DHS	2009	-			
	Females 30-39	DHS	2009	-			
	Females 40-49	DHS	2009	-			

Targets	Indicator	Data	Period	Value	Numerator	Denominat	Remarks
	Males 15-19	DHS	2009	85.80%	47	55	
	Males 20-24	DHS	2009	70.40%	66	94	
	Males 25-29	DHS	2009	-76.70%	34	44	
	Males 30-39	DHS	2009	56.60%	57	100	
	Males 40-49	DHS	2009	43.40%	24	55	
	1.5 Percentage of women and men aged 15-49 who received an HIV test in the past 12 months and know their results	DHS	2009	24.80%	2110	8518	No new survey
	All Females	DHS	2009	27.00%	1349	4996	
	All Males	DHS	2009	21.60%	761	3522	
	Females15-19	DHS	2009	21.90%	223	1016	
	Females 20-24	DHS	2009	39.30%	301	767	
	Females 25-29	DHS	2009	36.40%	240	658	
	Females 30-39	DHS	2009	27.70%	372	1342	
	Females 40-49	DHS	2009	17.60%	213	1213	
	Males15-19	DHS	2009	13.50%	93	689	
	Males 20-24	DHS	2009	23.60%	121	511	

Targets	Indicator	Data	Period	Value	Numerator	Denominat	Remarks
	Males 25-29	DHS	2009	29.20%	135	462	
	Males 30-39	DHS	2009	22.60%	224	990	
	Males 40-49	DHS	2009	21.60%	188	870	
	1.6 Percentage of young people aged 15-24 who are living with HIV *Note: Data not disaggregated by sex*	ANC Programme data		1.9%	279	13,841	Data reported is from the total pregnant woman population and is not only reflective of women 15-24. Additionally, the reported data reflects women who were newly tested HIV positive during the reporting period as well as women with known HIV positive status who accessed ANC services.
Sex Workers	**1.7** Percentage of sex workers reached with HIV prevention programmes			21.4%	42	196	**No New Survey.** This indicator is measured by two questions The Peer Educator Programme entails distribution of condoms, IEC materials and referral to HIV testing sites.
	Percentage who know of place in community to access HIV test	BBSS	2009	54.00%	108	200	

Targets	Indicator	Data	Period	Value	Numerator	Denominat	Remarks
	Percentage who have been reached by a "Keep the Light on Programme" Peer Educator within the last 12 months	BBSS	2009	38.80%	76	196	This question was used to measure outreach to FSWs. The Peer Educator Programme entails distribution of condoms, IEC materials and referral to HIV testing sites.
	1.8 Percentage of sex workers reporting the use of a condom with their most recent client	BBSS	2009	94.20%	180	191	No new survey
	1.9 Percentage of sex workers who have received an HIV test in the past 12 months and know their results	BBSS	2009	83.90%	131	156	No new survey
	1.10 Percentage of sex workers who are living with HIV	BBSS	2009	16.60%	30	181	No new survey
Men who have sex with men	**1.11** Percentage of men who have sex with men reached with HIV prevention programmes	BBSS	2009	-	-	-	**No new survey**. This indicator is measured by two questions. The composite could not be calculated since one if the questions was not asked in the BBSS 2009.
	Percentage who know of place in community to access HIV test	BBSS	2005	17.20%			This question was not asked in the 2009 BBSS
	Percentage who have been reached by a Peer Educator within the last 12 months	BBSS	2009	68.70%	90	131	The Peer Educator Programme entails distribution of condoms, IEC materials and referral to HIV testing sites.

Targets	Indicator	Data	Period	Value	Numerator	Denominat	Remarks
	1.12 Percentage of men reporting the use of a condom the last time they had anal sex with a male partner Regular partner	BBSS	2009	79.70%	51	64	**No New survey.**
	Non-regular partner	BBSS	2009	75.00%	30	40	
	Commercial partner	BBSS	2009	84.20%	16	19	
	1.13 Percentage of men who have sex with men that have received an HIV test in the past 12 months and know their results	BBSS	2009	72.30%	73	101	No new survey
	1.14 Percentage of men who have sex with men who are living with HIV *Note: Data not disaggregated by age group*	BBSS	2009	19.40%	21	108	No new survey
Target 2: Reduced transmission of HIV among people who inject drugs by 50 percent by 2015	**2.1** Number of syringes distributed per person who injects drugs per year by needle and syringes programmes	-	-				Target 2 is Not applicable to Guyana
	2.2 Percentage of people who inject drugs who reported the use of a condom at last sexual intercourse	-	-				
	2.3 Percentage of people who inject drugs who reported using sterile injecting equipment the last	-	-				

Targets	Indicator	Data	Period	Value	Numerator	Denominat	Remarks
	time they injected						
	2.4 Percentage of people who inject drugs that received an HIV test in the past 12 months and know their results	-	-				
	2.5 Percentage of people who inject drugs who are living with HIV	-	-				
Target 3: Eliminate mother-to-child transmission of HIV by 2015 and substantially reduce AIDS-related maternal deaths	**3.1** Percentage of HIV-positive pregnant women who received antiretrovirals to reduce the risk of mother-to-child transmission	ANC Programme Report	2013	109%	205	188	Numerator collected from care and treatment programme. Data is included on Single dose nevirapine which came from the PMTCT programme. Denominator from Spectrum
	No. newly initiated on ART during current pregnancy				77		Using Programme data for number of HIV + pregnant women (121 newly testing positive and 158 known positive.) Programme Coverage is 73.48%
	Already on ART before current pregnancy				94		
	Maternal triple ARV prophylaxis (prophylaxis component of WHO Option B, WHO Option A or WHO 2006 guidelines)				25		
	Single dose nevirapine (with or without tail) ONLY				9		
	Other (please comment: e.g. specify regimen, uncategorized,						

Targets	Indicator	Data	Period	Value	Numerator	Denominat	Remarks
	etc.)						
	***Note**: **Numerator** is number of pregnant women who received ARV drugs during the past 12 months to reduce mother-to-child transmission and **Denominator** is the estimated number of HIV-positive pregnant women within the past 12 months*	**Modeled using Spectrum**					
	3.2 Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth	NPHRL & PMTCT data	2013	32.5%	62	191	Numerator collected from NPHRL; denominator from PMTCT (number of HIV positive women who delivered. 62 samples were processed within 2 months; 170 between 2 to 12 months and 19 samples beyond 12 months.
	3.3 Mother-to-child transmission of HIV modeled	Modeled using Spectrum		1.59%	3	188	Numerator and denominator derived from Spectrum
Target 4: Have 15 million people living with HIV on antiretroviral	**4.1** Percentage of eligible adults and children currently receiving antiretroviral therapy	NAPS Programme Reports	2013	79.1%	4,054	5124	Denominator represents Estimates for Adults and Children needing ART generated in Spectrum

Targets	Indicator	Data	Period	Value	Numerator	Denominat	Remarks
treatment by 2015	***Note: Numerator*** *is number of adults and children currently receiving ARV combination therapy in accordance with the nationally recognized approved treatment protocol at the end of the reporting period and* ***Denominator*** *is estimated number of eligible adults and children*	Modeled using Spectrum					
	4.2 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 16 cohorts after 12 months on treatment. The cohorts cover the period January to December 2010.*	Patient Monitoring System (NAPS	2013	79.70%	411	516	
	Females >15	PMS (NAPS)		81.4%	223	274	
	Females <15	PMS (NAPS)		57.1%	4	7	
	Males >15	PMS (NAPS)		78.8%	178	226	
	Males <15	PMS (NAPS)		66.7%	6	9	
Target 5. Reduce tuberculosis deaths in people living with HIV by 50 percent by 2015	**5.1** Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV	Chest Clinic Programme Reports		49.00%	98	200	Numerator reflects number of co-infected patients at TB sites who commenced ART. Programme data shows that there were 140 co-infected patients in 2013. Programme coverage is therefore 70%.

Targets	Indicator	Data	Period	Value	Numerator	Denominat	Remarks
	Number of adults and children with HIV infection who received antiretroviral combination therapy in accordance with the nationally approved treatment protocol (or WHO/UNAIDS standards) and who were started on TB treatment (in accordance with national TB programme guidelines), within the reporting year						
	Note: *Denominator: WHO estimated number of incidence TB cases in people living with HIV*						Denominator is WHO published data for 2012
Target 6: Reach a significant level of annual global expenditure (US22-24 billion) in low and middle-income countries	**6.1** Domestic and international AIDS spending by categories and financing sources	-					NASA report is appended to the online submission of the GARPR.
Target 7: Critical Enablers and Synergies with Development Sectors	**7.1** National Commitments and Policy Instruments (prevention, treatment, care and support, human rights, civil society involvement, gender, workplace programmes, stigma and discrimination and monitoring and evaluation)	Key informant interviews					Responses from the NCPI Questionnaire have been inputted in the online reporting tool.
	7.2 Proportion of ever-married or						

Targets	Indicator	Data	Period	Value	Numerator	Denominat	Remarks
	partnered women aged 15-49 who experienced physical violence from a male intimate partner in the past 12 months						Data not available. The DHS 2009 asked about women's attitude towards wife beating: 16.3% of women 15-49 agree with at least one specified reason.
	7.3 Current school attendance among orphans and non-orphans aged 10-14	-					Indicator relevant but data not available
	7.4 Proportion of the poorest households who received external economic support in the last 3 months	-					Indicator relevant but data not available
Target 8: Eliminating Stigma & Discrimination	**8.1** Percentage of women and men aged 15–49 who report discriminatory attitudes towards people living with HIV	DHS 2009	women	20.10%	10	4848	The DHS measured this indicator using 4 questions
	Numerator: Number of respondents (aged 15–49 years) who respond "No" or "It depends" to any of the two questions: *Would you buy fresh vegetables from a shopkeeper or vendor if you knew that this person had HIV? (Yes; No; It depends; Don't know/ Not sure)1* *Do you think children living with HIV should be able to attend school with children who are HIV negative? (Yes; No; It depends; Don't know/ Not sure)*		men	23.90%	8	3430	

Targets	Indicator	Data	Period	Value	Numerator	Denominat	Remarks
	Denominator: Number of all respondents aged 15–49 years who have heard of HIV						

Annex 3: Core Indicators for Universal Access Reporting

	Indicator #	Indicator	Data Source	Period	Value	Comments
Target 1. Reduce sexual transmission of HIV by 50 percent by 2015 Testing & Counseling	**1.16**	**HIV Testing and counseling in women and men aged 15 and older**	VCT and PMTCT Programmes	Jan-Dec 2013		Total Number of persons tested (63,402) represents testing through VCT sites (49,674 with 983 positives) and pregnant women tested in the ANC/PMTCT setting (12,349 with 121 positives) AND male partners of pregnant women who were also tested in the ANC/PMTCT setting (1,379 with 9 positives)
		Number of women and men aged 15 and older who received HIV testing and counseling in the past 12 months and know their results	VCT Programme	Jan-Dec 2013	63402	
		HIV+ out of number tested	VCT Programme	Jan-Dec 2013	1113	
		Number of pregnant women aged 15 and older who received testing and counseling in the past 12 months and received their results	PMTCT Programme	Jan-Dec 2013	12349	
1.17 Sexually Transmitted Infections (STIs)	**1.17.1**	**Percentage (%) Percentage of women accessing antenatal care (ANC) services who were tested for syphilis at first ANC visit**	ANC Programme	Jan-Dec 2013	82.71	

	Indicator #	Indicator	Data Source	Period	Value	Comments
		Numerator Number of women attending first visit ANC services who were tested for syphilis			12403	
		Denominator Number of women attending first visit ANC services			14995	
	1.17.2	**Percentage of antenatal care attendees who were positive for syphilis**	ANC Programme	Jan-Dec 2013	0.10	
		Numerator Number of antenatal care attendees who tested positive for syphilis			12	
		Total			NA	
		15-24			NA	
		25+				
		Denominator Number of antenatal care attendees who were tested for syphilis			12403	
		Total				
		15-24			NA	
		25+			NA	
	1.17.3	**Percentage (%) Percentage of antenatal care attendees positive for syphilis who received treatment**			Data is not available on how many women received treatment.	The Guidelines (Family Health Manual 2012) require that treatment is provided to all women who test positive for syphilis. Therefore all 12 women who tested positive would have received treatment. The PMTCT Programmes and MCH plan to
		Numerator Number of antenatal care attendees with a positive syphilis serology who received at least one dose of benzathine penicillin 2.4 mU IM				

	Indicator #	Indicator	Data Source	Period	Value	Comments
		Denominator Number of antenatal care attendees with a positive syphilis serology				initiate the process of reviewing and merging the ANC and PMTCT monthly reporting tools to integrate, sustain and strengthen existing data collection methods in 2014
	1.17.4	**Percentage (%) Percentage of sex workers (SWs) with active syphilis**	BBSS	2004/5	15.41	BBSS 2009: 8.5% of sex workers self reported sores or boils on their vagina or anus.
		Numerator Number of sex workers who tested positive for syphilis	BBSS	2004/5	47	
		Denominator Number of sex workers who were tested for syphilis	BBSS	2004/5	305	
	1.17.5	**Percentage men who have sex with men (MSM) with active syphilis**	BBSS	2004/5	10	BBSS 2009: 4.6% of MSM self reported sores or boils on their penis.
		Numerator Number of men who have sex with men who tested positive for syphilis	BBSS	2004/5	8	
		Denominator Number of men who have sex with men who were tested for syphilis	BBSS	2004/5	80	
	1.17.6	**Number of adults reported with syphilis (primary/secondary and latent/unknown) in the past 12 months**	MOH Surveillance data	Jan-Dec 2013	26	Data reflects all Syphilis cases reported to the MOH surveillance Unit among adults. Disaggregation of data based on stage is not available. There were 13 cases among males and 13 cases among

	Indicator #	Indicator	Data Source	Period	Value	Comments
						females.
		Number of adults reported with syphilis during the reporting period			26	
		Number of individuals aged 15 and older	2002 Census		448,012	
	1.17.7	**Number of reported congenital syphilis cases (live births and stillbirths) in the past 12 months - Guyana**	MOH Surveillance data	Jan-Dec 2013	0	
		Number of reported congenital syphilis cases (live births and stillbirths) in the past 12 months			0	
		Number of live births				Data not currently available on Live births
	1.17.8	**Number of men reported with Gonorrhoea in the past 12 months**	MOH Surveillance data	Jan-Dec 2013		
		Number of men reported with Gonorrhoea in the past 12 months			19	
		Number of males aged 15 and older	2002 Census		207,028	
	1.17.9	**Number of men reported with urethral discharge in the past 12 months**	MOH Surveillance data	Jan-Dec 2013	922	Data reflects Genital Discharge (901), Gonorrhea (19)and Chlamydia (2)

	Indicator #	Indicator	Data Source	Period	Value	Comments
		Number of men reported with urethral discharge in the past 12 months			922	
		Number of males aged 15 and older	2002 Census		207,028	
	1.17.10	**Number of adults reported with genital ulcer disease in the past 12 months**	MOH Surveillance data	Jan-Dec 2013	260	62 males and 192 females
		Number of adults reported with genital ulcer disease during the reporting period			260	
		Number of individuals aged 15 and older	2002 Census		448,012	
Target 3: Eliminate new Infections among Children	**3.4**	**Percentage of pregnant women who were tested for HIV and received their results - during pregnancy, during labour and delivery, and during the post-partum period (<72 hours), including those with previously known HIV status**	PMTCT/ANC Programme	Jan-Dec 2013	82.40%	Denominator is the actual number of women attending antenatal care in 2013
		Numerator Number of pregnant women who were tested for HIV in the last 12 months and received their results - during pregnancy, during labour and delivery, and during the post-partum period (<72 hours), including those with previously known HIV status				
		Total number tested (including previously known positives)			14577	
		Total number tested and received results (including previously known positives)			12356	
		Total number testing positive (including previously known positives)			279	

	Indicator #	Indicator	Data Source	Period	Value	Comments
		(a) Total number of pregnant women attending ANC who were tested during ANC and received results or knew their positive status.				
		Number tested (including previously known positives)			13413	
		Number tested and received results (including previously known positives)			11192	
		HIV+ out of number tested (including previously known positives)			255	
		(a.i) Number of pregnant women with unknown HIV status attending ANC who were tested during ANC and received results				
		Number tested			11613	
		Number tested and received results			11034	
		HIV+ out of number tested			97	
		(a.ii) Number of pregnant women with known HIV+ infection attending ANC for a new pregnancy				
		Number of HIV+ pregnant women			158	
		(b) Number of pregnant women with unknown HIV status attending L&D (labour and delivery) who were tested in L&D and received results				
		Number tested			901	
		Number tetsted and received results			901	
		HIV+ out of number tested			19	
		(c) Number of women with unknown HIV status attending postpartum services within 72 hours of delivery who were tested and received results				
		Number tested			263	

	Indicator #	Indicator	Data Source	Period	Value	Comments
		Number tetsted and received results			263	
		HIV+ out of number tested			5	
		Denominator Estimated number of pregnant women			14995	
	3.5	**Percentage (%) Percentage of pregnant women attending antenatal care whose male partner was tested for HIV in the last 12 months**	PMTCT/ANC Programme	Jan-Dec 2013	9.2	The number of males tested is a reflection of the number tested at the PMTCT programme. These male partners could have been tested independently at any other HIV testing site. The reporting system of the PMTCT programme does not capture this information. It is assumed therefore that this is an under representation.
		Numerator Number of pregnant women attending antenatal care whose male partner was tested in the last 12 months			1379	
		Denominator Number of pregnant women attending antenatal care			14995	
	3.6	**Percentage (%) Percentage of HIV-infected pregnant women assessed for ART eligibility through either clinical staging or CD4 testing**				Based on the national Guidelines all HIV positive pregnant women are eligible for treatment.
		Numerator Number of HIV-infected pregnant women assessed for ART eligibility				
		Disaggregation by method of assessment				
		Clinical staging only				
		CD4 testing				
		*Women who were assessed both by CD4 testing and by clinical staging should be counted only once, as having been assessed by CD4 testing.				
		Denominator Estimated number of HIV-infected pregnant women				

	Indicator #	Indicator	Data Source	Period	Value	Comments
	3.7	**Percentage (%) of infants born to HIV-infected women (HIV-exposed infants) who received antiretroviral prophylaxis to reduce the risk of early mother-to-child- transmission in the first 6 weeks (i.e. early postpartum transmission around 6 weeks of age)**	PMTCT Programme	Jan-Dec 2013	100.5	There were 192 live births to HIV positive women in 2013, all of these infants received NVP and AZT at L&D. There was one twin delivery during the reporting period.
		Note. Ideally countries should capture the percentage of infants who received ARV prophylaxis. If this is not possible then countries should record the percentage of infants who were started on or provided with ARV prophylaxis.				
		Numerator Number of infants born to HIV-infected women who received antiretroviral prophylaxis to reduce early mother-to-child transmission (early postpartum, in the first 6 weeks)			192	
		Denominator Estimated number of HIV-infected pregnant women giving birth			191	
	3.8	**Percentage (%) of infants born to HIV-infected women (HIV-exposed infants) who are provided with antiretrovirals (either mother or infant) to reduce the risk of HIV transmission during the breastfeeding period.**			100	The PMTCT guidelines recommend 100% replacement feeding to all HIV+ women who deliver. However, 4 women chose to breast feed on the L&D ward.
		Numerator Number of infants born to HIV-infected women who are breastfeeding and provided an antiretroviral intervention (i.e. maternal or infant ARVs) to reduce mother-to-child transmission through breastfeeding.			4	
		Denominator (Estimated) number of infants born to HIV-infected women who are breastfeeding			4	

	Indicator #	Indicator	Data Source	Period	Value	Comments
	3.9	**Percentage (%) Percentage of infants born to HIV-infected women started on cotrimoxazole (CTX) prophylaxis within two months of birth**	PMTCT Programme	Jan-Dec 2013	80.1	The denominator represents the actual number of HIV+ women who delivered in 2013. Numerator is the number of exposed infants who received CTX within 6 weeks of birth.
		Numerator Number of infants born to HIV-infected women started on CTX prophylaxis within two months of birth			153	
		Denominator Estimated number of HIV-infected pregnant women giving birth			191	
	3.10	**Distribution of feeding practices (exclusive breastfeeding, replacement feeding, mixed feeding/other) for infants born to HIV-infected women at DTP3 visit**	PMTCT Programme	Jan-Dec 2013		Data represents feeding practices for infants born to HIV+ women at 3 month visit.
		Exclusive breastfeeding			0	
		Replacement breastfeeding			103	
		Mixed feeding/other				
		Uncategorized/other				
		Number of infants born to HIV-infected women assessed for and whose infant feeding practices were recorded at DTP3 visit			103	
	3.11	**Number of pregnant women attending ANC at least once during the reporting period**	ANC Programme		14995	
Target 4: 15 million people accessing treatment	**4.2b**	**Percentage of adults and children with HIV still alive and known to be on treatment 24 months after initiation of antiretroviral therapy (among those who initiated antiretroviral therapy in 2011)**	ART Programme	Jan 2011-Dec 2013	71.8	

	Indicator #	Indicator	Data Source	Period	Value	Comments
		Numerator Number of adults and children who were still alive and known to be on treatment 24 months after initiation of antiretroviral therapy			400	
		Denominator Number of adults and children who initiated antiretroviral therapy during 2011 or the specified period (including those who have died since starting therapy, those who have stopped therapy, and those recorded as lost to follow-up at month 24)			557	
		*Additional info In addition to 'alive and on ART', please report other outcomes at 24 months after initiating treatment				
	4.2c	**Percentage of adults and children with HIV still alive and known to be on treatment 60 months after initiation of antiretroviral therapy (among those who initiated antiretroviral therapy in 2008)**	ART Programme		61.9	
		Numerator Number of adults and children who were still alive and on antiretroviral therapy 60 months after initiating treatment			453	
		Denominator Number of adults and children who initiated antiretroviral therapy during 2008 or the specified period (including those who have died since starting therapy, those who have stopped therapy, and those recorded as lost to follow-up at month 60)		Jan 2008-Dec 2013	732	

	Indicator #	Indicator	Data Source	Period	Value	Comments
		Additional info In addition to 'alive and on ART', please report other outcomes at 60 months after initiating treatment				
	4.3a	**Health facilities that offer antiretroviral therapy**	ART Programme	Jan-Dec 2013		There are 20 fixed sited and a mobile facility that serves 4 hinterland regions. In terms of health centre type, the unspecified includes the mobile facility and the national care and treatment centre which is the largest care and treatment site in the country.
		Numerator Number of health facilities that offer antiretroviral therapy (ART) (i.e. prescribe and/or provide clinical follow-up)			21	
		Disaggregation by public/private: Public			19	
		Private			2	
		Unknown/unspecified				
		Disaggregation by health centre type: Hospital			11	
		Health centre			6	
		ANC			10	
		TB Service			11	
		STI			6	
		Unknown/unspecified			2	
	4.3b	**Health facilities that offer paediatric antiretroviral therapy**	ART Programme	Jan-Dec 2013		All the HIV care and treatment facilities offer pediatric ART.
		Numerator Number of health facilities that offer paediatric antiretroviral therapy (ART) (i.e. prescribe and/or provide clinical follow-up)			21	

	Indicator #	Indicator	Data Source	Period	Value	Comments
		Disaggregation by public/private: Public			19	
		Private			2	
		Unknown/unspecified				
	4.4	**Percentage of health facilities dispensing antiretrovirals (ARVs) for antiretroviral therapy that have experienced a stock-out of at least one required ARV in the last 12 months**			0	
		Numerator Number of health facilities dispensing ARVs that experienced a stock-out of at least one required ARV in the last 12 months			0	
		Denominator Number of health facilities dispensing ARVs			21	
	4.5	**Late HIV diagnoses: Percentage of HIV positive persons with first CD4 cell count < 200 cells/µL in 2013**	National Public Health Reference Lab	Jan-Dec 2013		
		Number of HIV-positive people with first CD4 cell count <200 cells/ µl in 2013				
		Total number of HIV-positive people with first CD4 cell count in 2013				
	4.6	**Number of adults newly enrolled in pre-antiretroviral therapy (pre-ART) during the reporting period**	ART Programme	Jan-Dec 2013	672	

	Indicator #	Indicator	Data Source	Period	Value	Comments
		Number of adults newly enrolled in HIV care (pre-ART or ART) during the reporting period			1183	
	4.7	**a. percentage of people on ART tested for viral load (VL) who have an undetectable viral load in reporting period (2013)**				
		Numerator number of people on ART tested for viral load in the reporting period with suppressed viral load (i.e. ≤ 1000 copies)				
		Denominator number of people on ART tested for viral load in the reporting period				
		b. percentage of people on ART tested for viral load (VL) with VL level below ≤ 1,000 copies after 12 months of therapy (2013)				
		Numerator number of people tested after 12 months therapy for VL and have suppression (VL ≤ 1000 copies) during the reporting period				
		Denominator Number of people tested after 12 months therapy for VL during the reporting period				
Target 5: Avoid TB Deaths	5.2	Percentage of adults and children living with HIV newly enrolled in care who are detected having active TB disease				Data is not currently available on the number of newly enrolled patients in the ART programme with active TB. However for 2013, there were 140 co-infected patients out of 566 tested for TB
		Total number of adults and children newly enrolled in HIV care who are diagnosed as having active TB disease during the reporting period				

	Indicator #	Indicator	Data Source	Period	Value	Comments
		Total number of adults and children newly enrolled in pre-ART care or on ART during the reporting period				and HIV (25%)
	5.3	**Percentage of adults and children newly enrolled in HIV care starting isoniazid preventive therapy (IPT)**	ART and Pre ART registers, TB Programme	Jan- Dec 2013	16.23	
		Numerator Number of adults and children started in HIV care during the reporting period ('in HIV care' includes people in the pre-ART register and people in the ART register) who also start (i.e. are given at least one dose) isoniazid preventive therapy			192	
		Denominator Number of adults and children started in HIV care during the reporting period ('in HIV care' includes people in the pre-ART register and people in the ART register)			1183	
	5.4	**Percentage (%) of adults and children enrolled in HIV care who had TB status assessed and recorded during their last visit**	ART and Pre ART registers,	Jan- Dec 2013	45.98	Data reflects number of patients who had a TST done during the reporting period. The Care and Treatment Data Collection Tools (ART and Pre-ART registers) have been revised in 2013 to collect data on TB screening at each visit. These tools have been rolled out in 2014. Based on most recent HEALQUAL Audit, 88% of patients
		Numerator Number of adults and children enrolled in HIV care ('in HIV care' includes people in the pre-ART register and people in the ART register) , who had their TB status assessed and recorded during their last visit during the reporting period			2251	

	Indicator #	Indicator	Data Source	Period	Value	Comments
		Denominator Total number of adults and children in HIV care in the reporting period ('in HIV care' includes people in the pre-ART register and people in the ART register)			4896	had their TB status assessed (n=1260)

ANNEX 4: 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) NAPS	Yes
c) Others (key stakeholders)	Yes

2) With inputs from

Ministries	Yes
Education	Yes
Health	Yes
Labor and Human Services	Yes
Foreign Affairs	No
Others	No
Civil Society Organizations	Yes
People living with HIV	Yes
Private sector	Yes
United Nations Organizations	Yes
Bilaterals	Yes
International NGOs	Yes
Others (please specify)	No

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

Forum comprised representatives of the Government, private sector UN agencies, bilateral Agencies, NGOs, FBOs, and persons living with HIV.

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.- Programme Manager, National AIDS Programme, Ministry of Health Guyana

ANNEX 5: National Commitments and Policy Instrument (through CRIS)

Country: Republic of Guyana
Name of the National AIDS Programme Secretariat Officer in Charge: Dr. Shanti Singh-Anthony, M.D., M.P.H.
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ANNEX 6: Contributors to the Reporting Process

Country Team

1. Dr. Shanti Singh - Programme Manager, NAPS
2. Dr. Roberto Luiz Brant Campos, UNAIDS Country Director
3. Dr. Morris Edwards- Director, Disease Control, MoH
4. Ms. Desiree Edghill - Civil Society Representative
5. Ms. Fiona Persaud - M&E Lead, NAPS
6. Ms. Yaye Kanny Diallo - M&E Advisor, UNAIDS, Guyana
7. Ms. Preeta Saywack - Strategic Information Officer, PEPFAR
8. Dr. Rosalinda Hernandez - FCH/HIV/STI Advisor/PAHO/WHO
9. Ms. Diana Dhanraj - National TB Programme
10. Ms. Shamin Williams - PMTCT Programme, MoH
11. Mr. Nicholas Persaud - Care & Treatment Coordinator, NAPS
12. Ms. Mena Carto - Consultant, Country Progress Report
13. Mr. Collin Haynes - NCPI Consultant

NCPI Interviewees

1. Dr. Leslie Ramsammy- Chair, GFATM CCM
2. Dr. Shanti Singh - Programme Manager, NAPS
3. Dr. Shamdeo Persaud - CMO, MoH
4. Ms. Fiona Etwaroo - M&E Lead, NAPS
5. Dr. Ruth Ramos – Director, National Care and Treatment Centre
6. Dr. Jeetendra Mohanlall – Programme Manager, National TB Unit
7. Ms. Jennifer Ganesh - BCC Coordinator, NAPS
8. Mr. Nazim Hussain - Community Mobilization Coordinator, NAPS
9. Dr. Ruth Ramos - National Care and Treatment Centre
10. Dr. Morris Edwards – Director, Disease Control, MoH
11. Ms. Shevonne Benn- Home Based Care Coordinator, NAPS
12. Ms. Deborah Success - VCT National Coordinator, NAPS
13. Ms. Nafeeza Ally- Social Services Coordinator, NAPS
14. Mr. Somdatt Ramessar - Food Bank Manager, NAPS
15. Mr. Nicholas Persaud - Care & Treatment Coordinator, NAPS
16. Dr. Janice Woolford – Director, Maternal & Child Health, MoH
17. Mr. Joseph Hamilton, MP- MP for Health
18. Hon. Pauline Sukhai - Minister of Amerindian Affairs
19. Hon. Jennifer Webster- Minister of Human Services and Social Security
20. Ms. Alisha Pompey- President's Youth Award PYARG, Ministry of Culture, Youth & Sport
21. Dr. Nadia Liu – Director, National Blood Transfusion Services
22. Dr. Nadira Ramcharran – Director, National Public Health Reference Laboratory
23. Ms. Beverly Lovell- HIV Programme Manager, Department of Defence
24. Mr. Michael Khan- CEO, Georgetown Public Hospital Corporation

25. Mr. Olato Sam - Chief Education Officer, MoE
26. Ms. Merica George – Prevention Coordinator, Artistes in Direct Support
27. Ms. Goldie Scott - Executive Director, Volunteer Youth Corps
28. Ms. Annette Jaundoo - Executive Director, FACT
29. Ms. Ashanta Moses – Manager, Guyana Red Cross HIV/AIDS Programme
30. Ms. Patricia Bisnauth Sheerattan - Programme Manager, Guyana Responsible Parenthood Association
31. Mr. Ivor Melville - Project Coordinator, Hope Foundation
32. Dr. Roberto Brant Campos - Country Director, UNAIDS
33. Ms. Jewel Crosse – UNICEF
34. Dr. Rosalinda Hernandez- FCH/HIV Advisor, PAHO/WHO
35. Ms. Preeta Saywack, Strategic Information Officer, PEPFAR
36. Ms. Edris George - PEPFAR/USAID
37. Mr. Sean Wilson - ILO
38. Mr. Crystol Albert - G+
39. Mr. Joel Simpson- SASOD
40. Quincy Gulliver McEwan- Guyana Trans United
41. Ms. Sheila Fraser - Guyana Responsible Parenthood Association
42. Ms. Nicole Cole and Allister Collins - Guyana Faith Coalition on HIV/AIDS
43. Ms. Hazel Maxwell - Benn Managing Director, Linden Care Foundation
44. Ms. Sadie Amin - Guyana Association of Women Lawyers
45. Ms. Eulanie Ouseley- Torreazo - United Bricklayers
46. Mr. Flavio Rose - Guyana Peace Corps
47. Mr. Dmitri Nicholson - Executive Director, Youth Challenge Guyana
48. Ms. Babsie Giddings - UNFPA
49. Ms. Suzanne French - Guyana Business Coalition on HIV/AIDS
50. Ms. Miriam Edwards - Guyana Sex Worker Coalition
51. Mr. Clarence Young - Phoenix Recovery Centre
52. Mr. Dereck Springer – Director, PANCAP
53. Ms. Kathy Groomes – PEPFAR/CDC

Participants at the Consensus Meeting

1. Dr. Shanti Singh-Anthony, Program Manager, MoH/NAPS
2. Mr. Michael Rohoman, Officer Manager, MoH/NAPS
3. Ms. Nafeza Ally, Social Services Coordinator, MoH/NAPS
4. Ms. Elizabeth Mc Almont, MARPS Officer, MoH/NAPS
5. Mr. Somdatt Ramessar, Food Bank Manager, MoH/NAPS
6. Mr. Murvin Chalmers, Data Entry Clerk, MoH/NAPS
7. Ms. Jennifer Ganesh, Prevention Coordinator, MoH/NAPS
8. Ms. Fiona Persaud, M & E Lead, MoH/NAPS
9. Mr. Nazim Hussain, Community Mobilization Coordinator, MoH/NAPS
10. Ms. Roslyn Allen, Hotline Facilitator, MoH/NAPS
11. Ms. Denise Leitch, Hotline Facilitator, MoH/NAPS

12. Ms. Shevonne Benn, HBC Coordinator, MoH/NAPS
13. Mr. Delon Braithwaite, VCT Qual Officer, MoH/NAPS
14. Ms. Romona Morgan, STI Coordinator, MoH/NAPS
15. Dr. Shamdeo Persaud, Chief Medical Officer, MoH
16. Mr. Premchand Persaud, Economist, MoH
17. Mr. Joseph Hamilton, Parliamentary Secretary, MoH
18. Dr. Ertenisa Hamilton, Focal Point, Adolescent Health, MoH
19. Ms. Bendita Lachmansingh, Epidemiologist, MoH
20. Mr. Curtis Charles, Economist, MoH
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22. Ms. Astrid Lynch, TB/HIV Coordinator, NTP
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24. Ms. Dinte Conway, Head, Special Projects, MoLHSSS
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44. Ms. Suzanne French, Executive Director, GBCHA
45. Ms. Shondell Belfield, Executive Director, Hope for All
46. Ms. Dorothy Fraser, Secretary General, Guyana Red Cross
47. Mr. Schemel Patrick, Advocacy & Communication Officer, SASOD
48. Ms. Michelle Mason, Administrator, NAMILCO
49. Mr. Parvesh Bhola, Assistant Store Keeper, NAMILCO
50. Ms. Odelyn Parker, Reporter, NCN
51. Mr. Ramdayal, Communications Officer, GINA
52. Mr. Neil Marks, Reporter, Capitol News
53. Mr. Nickhail Jaundoo, Reporter, News Update
54. Ms. Mena Carto, GARPR Consultant