

2015

GUYANA AIDS RESPONSE PROGRESS REPORT

Republic of Guyana

Reporting Period: January - December 2014



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Presidential Commission on HIV and AIDS

FOREWORD

Guyana AIDS Response Progress Report 2014 provides us once more with another opportunity to assess the progress made towards achieving the bold targets set in June 2011 Political Declaration on HIV and AIDS and its Millennium Development Goal Six (MDG 6) of halting the spread and beginning the reversal of HIV and AIDS. Importantly it allows us to critically assess and understand the challenges and the gaps in the response and to develop strategies for responding. This is a critical year not only for the AIDS progress report and MDG 6, but for taking stock of all the MDGs. Parallel to this report therefore the Government of Guyana with its stakeholders have been critically examining the MDGs, reviewing the degree of achievement, highlighting success stories, understanding the challenges and more importantly developing the roadmap for the future, as we enter into the post 2015 era of Sustainable Development Goals (SDGs).

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

Guided by HIVision 2020, Guyana continues to deliver a comprehensive multi-sectoral response with involvement of a variety of partners and stakeholders. Civil Society Organisations have been instrumental in ensuring that prevention services reach the key populations. The community of people living with HIV and AIDS has maintained its focus on advocacy and on providing psychosocial support and empowerment for their constituency. The Private Sector has extrapolated best practices of the private public partnership in the HIV response to broader health issues whilst continuing to support the response. The donor community has maintained its support for Guyana and has worked assiduously in ensuring that there is smooth transitioning of their support to Government, a key ingredient to sustainability. Our technical partners - local, regional and global, continue to provide important technical guidance to the programme.

HIV prevention programmes continue with National Coverage and with greater emphasis on reaching the key populations at higher risk. In fact 2014 has been an exceptional year in working with and reaching the key populations. With continued support from our partners, the national programme has reached greater numbers of men who have sex with men, female commercial sex workers, transgender persons, miners and loggers. The investment over the years in prioritizing the key populations has yielded good results as evident in the reduced HIV prevalence among these populations in the findings of the Biological and Behavioural Surveillance (BBSS) findings released in November 2014.

Other prevention programmes continue to show good progress with greater than 95% uptake of HIV testing among the antenatal populations, sustained HIV testing for the general population, 100% screening of blood and blood products, continued training and sensitization of the young persons, persons in the workforce and the general population. Condom programming and cervical cancer screening continued in 2014, building on the gains in previous years.

Guyana's HIV treatment programme continues to deliver the highest quality of care to persons living with HIV with the great majority of those persons (85.2%) on antiretroviral therapy, achieving universal coverage for ART. There continues to be favorable treatment outcomes with increasing survivability and reduced AIDS related deaths.

TB/HIV co-infection, still a public health problem has seen significant progress with continued high uptake of HIV testing of greater than 91% among the TB patients and a reducing co-infection rate from 31% in 2012 to 22% at the end of 2014. There is increasing coverage of TB/HIV co-infected patients on antiretroviral therapy.

Laboratory support to the programme continued with the strengthening of TB diagnosis among HIV patients through the introduction of state of the art technology of Gene Xpert. Critically, the programme is now equipped to better understand the burden of multidrug resistant tuberculosis among TB patients as well as TB/HIV co-infected patients.

There continues to be concerted efforts in strengthening the HIV surveillance system with a revision of the system in 2014, thus enabling the reporting of HIV, advanced HIV, and AIDS cases. Planning has started with partners in the development of an Electronic Medical Record System and a Health Information System.

Notwithstanding our achievements, 2014 recorded its own challenges - particularly those of transitioning which affected the work force and implicitly health service delivery. Other challenges are noted in the report to which the Ministry will work with all stakeholders in addressing as we move forward. Despite these, 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 such as gender based violence.

In the face of the reducing donor funded resources for the national HIV response, we will focus our efforts at ensuring that our programmes are transitioned to full local ownership while maintaining a comprehensive evidence-based scope and scale. The Government of Guyana commits to ensuring that no baby is born HIV positive, that every Guyanese knows their HIV status, having available and accessible HIV prevention methods, and that every person infected with HIV will continue to receive the highest quality of care and treatment. I am confident that this approach, implemented through the strategies of HIVision 2020 and in collaboration with all partners and stakeholders, will accelerate the path of reversal of the HIV epidemic and guarantee us an AIDS free Guyana. The Government of Guyana stands committed.

I wish to thank all partners, donors, civil society organizations, people living with HIV and AIDS, members of the key populations, health care workers, policy makers and everyone who has contributed to the HIV response.

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ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome	GUD	Genital Ulcer Disease
ABC	Abstain, Be faithful, Condomize	GUM	Genito-Urinary Medicine
ANC	Antenatal Clinic	GINA	Guyana Information Agency
APC	Advancing Partners and Communities	HAART	Highly Active Antiretroviral Therapy
ART	Antiretroviral Therapy	HBC	Home-Based Care
ARV	Antiretroviral	HDI	Human Development Index
BCC	Behavior Change Communication	HFLE	Health and Family Life Education
BMS	Breast Milk Substitute	HIV	Human Immuno-deficiency Virus
BBSS	Biological and Behavioral Surveillance Survey	HIV DR	HIV Drug Resistance
CARICOM	Caribbean Community	HPV	Human Papilloma Virus
CBOs	Community-based Organizations	HSDU	Health Sector Development Unit
CCM	Country Coordinating Mechanism	HTC	HIV Testing and Counseling
CCPA	Child Care Protection Agency	HTLV	Human T-Lymphotropic Virus
CDC	US Center for Disease Control and Prevention	HVOP	HIV Other Prevention
CSO	Civil Society Organization	IEC	Information, Education, Communication
CSS	Client Satisfaction Survey	ILO	International Labor Organization
CSW	Commercial Sex Worker	IPT	Isoniazid Preventive Therapy
DHS	Demographic Health Survey	IYCF	Infant and Young Child Feeding Practices
DOTS	Direct Observed Therapy	JFA	Justice for All
DNA	Deoxyribonucleic Acid	LEEP	Electrosurgical Excision Procedure
EMR	Electronic Medical Record	LGBT	Lesbian, Gay, Bisexual and Transgender
FBO	Faith-based Organization	LTFU	Loss to Follow Up
FCSW	Female Commercial Sex Worker	MARPs	Most At-Risk Populations
FSW	Female Sex Worker	MERG	Monitoring and Evaluation Reference Group
GARPR	Global AIDS Response Progress Report	M&E	Monitoring and Evaluation
GBCHA	Guyana Business Coalition on HIV/AIDS	MIS	Management Information Systems
GBoS	Guyana Bureau of Standards	MMU	Materials Management Unit
GBV	Gender Based Violence	MoLHS&SS	Ministry of Labor, Human Services and Social Security
GDF	Guyana Defence Force	MoH	Ministry of Health
GDP	Gross Domestic Product	MOU	Memorandum of Understanding
GDS	Genital Discharge Syndrome	MSM	Men Who Have Sex with Men
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria	MSW	Male Sex Worker
GFCHA	Guyana National Faith Coalition on HIV and AIDS	MTCT	Mother-to-Child-Transmission
GIZ	Deutsche Gesellschaft für Internationale Zusammenarbeit	MYCS	Ministry of Youth Culture and Sports
GoG	Government of Guyana	NAC	National AIDS Committee
GRPA	Guyana Responsible Parenthood Association	NAP	National AIDS Programme
GSWC	Guyana Sex Worker Coalition	NAPS	National AIDS Programme Secretariat
		NASA	National AIDS Spending Assessment
		NBTS	National Blood Transfusion Service

NCTC	National Care and Treatment Centre	USAID	United States Agency for International Development
NGOs	Non Governmental Organizations		
NLID	National Laboratory for Infectious Disease	VCT	Voluntary Counseling and Testing
		VIA	Visual Inspection with Acetic Acid
NPHRL	National Public Health Reference Laboratory	WAD	World AIDS Day
		YES	Youth Educators Safe Guarding over Workforce
NTP	National Tuberculosis Programme		
OIs	Opportunistic Infections		
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		
PHDP	Positive Health, Dignity and Prevention		
PITC	Provider-Initiated Testing and Counseling		
PLACE	Priorities for Local AIDS Control Efforts		
PLHIV	Persons Living with HIV		
PMS	Patient Monitoring System		
PMTCT	Prevention of Mother-to-Child-Transmission		
PUID	Personal Unique Identifier		
RACs	Regional AIDS Committees		
RCC	Rolling Continuation Channel		
SASOD	Society against Sexual Orientation Discrimination		
SCMS	Supply Chain Management Systems		
SPSS	Statistical Package for Social Sciences		
SRH	Sexual and Reproductive Health		
STIs	Sexually Transmitted Infections		
SVA	Single Visit Approach		
SW	Sex Workers		
TB	Tuberculosis		
TWG	Technical Working Group		
UBL	United Brick Layers		
UNAIDS	Joint United Nations Programme on HIV and AIDS		
UNDP	United Nations Development Programme		
UNESCO	United Nations Education Scientific and Cultural Organization		
UNFPA	United Nations Population Fund		
UNICEF	United Nations Children Fund		

I. STATUS AT A GLANCE

Inclusiveness of Stakeholders in the Report Preparation

The preparation of the Guyana AIDS Response Progress Report (GARPR) for the 2014 reporting period was led by a broad-based country team comprising key stakeholders involved in the national response to HIV (see Annex 5) along with the Monitoring and Evaluation Reference Group (MERG). The country team held ongoing meetings to discuss the indicators that Guyana would report on, the report preparation process, and also to provide feedback on the various sections of the GARPR as they were being drafted.

The inputs of other 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. Upon request, these agencies submitted their individual progress reports for incorporation into the overall GARPR. During this period, there was ongoing verification of the data provided and continuous communication with partners who remained engaged throughout the review process. Prior to the finalization of the GARPR, a broad-based consensus meeting was held with key stakeholders (see Annex 5) to present a summary of the draft that was circulated prior to the meeting and to obtain the feedback of partners. This feedback, along with additional feedback received after the meeting, were taken into consideration in finalizing the GARPR for submission to the Joint United Nations Programme on HIV and AIDS (UNAIDS).

Parallel to the process of developing this narrative report, the National AIDS Programme Secretariat (NAPS) worked with relevant stakeholders in addressing the data requirements for the report, and submitted this data online using the UNAIDS reporting format. This also included an ARV Use Report Form from WHO as well as an updating of policy issues. Further, a country team comprising representatives from NAPS, PMTCT (MoH), Surveillance Unit (MoH), UNAIDS and CDC, developed the HIV country estimates.

Status of the Epidemic

Based on the UNAIDS 2013 estimation exercise, Guyana's adult HIV prevalence is 1.4%. There has been a steady reduction in the prevalence of HIV among the general population from 2004, when it was 2.4 percent.

At the end of 2014, a total of 751 cases of HIV were diagnosed compared with 758 cases reported in 2013. This continues to represent a significant reduction when compared to the 1,176 HIV cases reported in 2009.

While the trend since 2010 has shown a greater number of reported HIV cases among females compared to males, the male female ratio once again increased in 2013 to 1.01, continuing into 2014 with a male female ratio of 1.09 (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 1.4 in 2014 as occurred in 2013.

The highest number of reported cases of HIV in 2014 occurred in the 25-49 age-group accounting for 61.7% (463/751) of all cases compared with 67.7% in 2013. 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 1.2% of the reported HIV cases in 2014 compared to 0.7% in 2013. Persons 50 years and above accounted for 17.9% of all cases of HIV in 2014 compared to 14.1% in 2013 (MoH Surveillance Unit).

Region 4 continued to have the highest proportion, of all HIV cases in 2014 with 72.8% of all cases compared with 75.4% in 2013 (MoH Surveillance Unit). The relatively higher notification of cases in Region 4 can be attributed to the larger population size and the higher concentration of HIV services, including counseling and testing.

The proportion of all deaths attributable to AIDS has been declining steadily from 9.5% in 2002 to 4.8% in 2012 (preliminary data from MoH Statistics Unit).

HIV prevalence among pregnant women was 1.9% (293/15,494) in 2014 which was the same prevalence in 2013 (PMTCT programme reports). In 2014, 2.6% (5/193) of babies born to HIV-positive mothers were infected with HIV compared to 2.1% (4/191) in 2013 (PMTCT programme reports). HIV prevalence among blood donors was 0.96% of all blood screened compared with 0.3 % in 2013 (Blood Bank Programme data).

The Biological and Behavioral Surveillance Survey (BBSS) 2014 showed a sharp decrease in the HIV prevalence among female sex workers (FSWs), from 26.6 percent (BBSS, 2005) to 5.5% (BBSS, 2014). There was also a marked decrease in prevalence among MSM from 21.2 percent (BBSS, 2005) to 4.9% (BBSS, 2014) and among miners from 6.5% in 2000 to 1% (BBSS 2014). Several populations were surveyed for the first time with HIV prevalence reported as follows: Loggers 1.3%; male sex workers (MSWs) 5.1% and; transgenders 8.4% (BBSS 2014).

Data for the period 2005 – 2014 indicate that the rate of TB/HIV co-infection fluctuated between 36 % in 2005 to 22% in 2014.

Policy Response

A major achievement during 2014 was the tabling in Parliament in January 2014 of the HIV and AIDS Regulations, made under the Occupational Safety and Health Act 1997. These Regulations seek to enforce the National Workplace HIV and AIDS Policy and includes the right of persons living with HIV (PLHIV) to secure employment and be provided with the same health and other benefits accorded to other employees. The Regulations were a product of ongoing collaboration during the previous reporting period, between the Ministry of Labour, MoH, the Attorney General's Chambers, the International Labour Organization (ILO) and other key stakeholders.

During 2013, a Sexual and Reproductive Health (SRH) Policy was drafted with inputs from a broad-based technical committee chaired by the Chief Medical Officer and supported by legal personnel. The policy seeks to provide a cohesive response to address universal access to Sexual and Reproductive Health for all and to link reproductive rights and SRH to

physical and mental health, gender, adolescents and youth. During 2014, the draft submitted by the legal personnel was reviewed by the members of the committee and is currently being updated to include pertinent statistical background data in relation to youth, obtained from the Ministry of Health. Once finalized, this document will be presented to Cabinet for approval. An SRH Strategy was also drafted in alignment with the SRH Policy, Health Vision 2020 and HIVision 2020 and is currently being finalized.

A National Youth Policy was drafted as a result of extensive consultations held with key stakeholder groups. This Policy seeks to protect the rights of adolescents and youth, including those living with HIV. The draft Policy was reviewed during 2014 and additional work is to be undertaken to facilitate its finalization.

During the reporting period, the Ministry of Labour, Human Services and Social Security (MoLHS&SS) in collaboration with various stakeholder groups, including practising lawyers, developed the Domestic Violence Regulations. These Regulations, which were tabled in Parliament during February 2015, will further operationalize the Domestic Violence Act of Guyana. The Domestic Violence Act was passed in December 1996 to give legal protection to persons who suffer abuse or are at risk of suffering domestic abuse.

Programmatic Response

HIVision 2020, Guyana's National HIV Strategic Plan (2013 – 2020) is underpinned by the principles of Human Rights, Gender Equality, Inclusiveness, Accountability, Value for Money and Sustainability. It encompasses the vision of Zero New HIV Infections, Zero Discrimination and Zero AIDS-Related Deaths. The vision of HIVision 2020 is "To eliminate HIV in Guyana" and 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 and; Integration and: Strategic Information. The programmatic response of the Government of Guyana during the reporting period, has thus been grounded in these overarching principles throughout the national HIV response.

The period under review was characterized by increased coverage of HIV-related services in the areas of prevention, treatment, care and support. Special emphasis was placed on key populations at higher risk in light of the increased vulnerability of these groups with regard to the transmission of HIV. Emphasis was also placed on strengthening monitoring, evaluation and surveillance systems and the increased use of strategic information to inform programming and quality improvements.

During the reporting period, more than 5,218 health care workers and other individuals received training in a wide range of subject areas (see Annex 1) including: leadership and coordination; adolescent health; sexual and reproductive health; gender-based violence; HIV sensitization; stigma and discrimination; workplace wellness; key affected populations; prevention of mother to child transmission of HIV (PMTCT); voluntary counseling and testing (VCT); sexually transmitted infections (STIs); peer education; post exposure prophylaxis (PEP); TB; clinical management of HIV; migrant services; DNA/PCR testing;

orphans and vulnerable children (OVC) care and support; vaginal inspection with acetic acid (VIA); home-based care and; data management.

The HIV programme continued to benefit from financial resources primarily from PEPFAR (President Emergency Fund for AIDS Relief) and the Global Fund against HIV, TB and Malaria (GFATM). In 2014 the Country Coordination Mechanism (CCM) received TRP approval for its reprogramming request for the HIV Rolling Continuation Channel (RCC) application, extending the grant through December 2017. There continued to be significant technical support from technical agencies and partners including UNAIDS, Pan American Health Organization/World Health Organization (PAHO/WHO), United Nations Children Fund (UNICEF) and other United Nations (UN) agencies.

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 infants are followed through pregnancy and 18 months postpartum in order to provide the appropriate care, treatment and support. The PMTCT programme was expanded in 2014 to increase coverage through 188 PMTCT sites, with the addition of a hinterland health centre to the 187 sites that existed in 2013. The uptake of voluntary counseling and testing (VCT) by pregnant women attending these sites was 94.4% in 2014 compared with 97.2% in 2013.

During 2014, VCT continued to be provided country-wide through 62 fixed sites and several mobile units conducting outreaches particularly in the hinterland communities and key affected populations. Heightened VCT efforts have seen a steady increase in the number of persons seeking testing with a total of 54,815 tests done during 2014 which was a 10.1% increase when compared with 2013.

Special emphasis was placed on reaching key populations at higher risk during the reporting period with these populations accounting for 13.9% of the total number of persons tested during 2014. 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 2014 achieved 6% of the overall total number of persons tested during the year.

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. Special attention was paid to key populations at higher risk with efforts that included a targeted campaign. Other campaigns focused on male involvement in their health, cervical cancer, and home based care. Prevention efforts sought to maximize the use of annual commemorative days such as World AIDS Day, Zero Discrimination 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.

During 2014, a total of 2,648,976 condoms, including male and female condoms, were distributed through the national programme free of cost. This was in addition to 614,898 pieces provided through the private sector.

There was special focus on key populations at higher risk during the reporting period with the 2014 BBSS showing an HIV prevalence of 4.9% in MSM, 5.1% in MSWs, 5.5% in FSWs, 8.4% in transgenders, 1% in miners and 1.3% in loggers. A total of 2,629 MSM were reached with an appropriate package of HIV prevention services in 2014 which was a 382% increase when compared to 2013. Similarly there was a 150% increase in FSWs (3,327) reached with HIV prevention programmes, when compared with 2013. Heightened efforts to target key populations also resulted in a total of 1,895 miners and loggers being reached with HIV prevention programmes while outreach programmes continued in the prisons.

During 2014, a wide range of public and private sector organizations continued to benefit from workplace education programmes with 30 Training and Educational Awareness and HIV sensitization sessions held by the Ministry of Labour with Employers, Trade Unions and informal sectors. In addition, The Guyana Business Coalition on HIV and AIDS (GBCHA) with its membership of over 47 companies, continued to support the HIV workplace programme through HIV sensitization sessions integrated gender based violence awareness along with other aspects of health and wellness. Activities also included peer education training, health fairs, VCT, and the distribution of HIV information brochures and condoms at workplaces.

During 2014, the Blood Bank collected 10,016 units of blood (Blood Bank Reports). All units were screened for infectious markers and the proportion of units that tested positive for HIV was 0.96% compared with 0.3% in 2013.

The VIA screening programme continued at health care facilities, including all HIV treatment sites. VIA was done through onsite administration using a Single Visit Approach (SVA). During the period, 3,678 persons received VIA including 505 HIV positive clients. Of the 3,678 persons screened, 392 received a positive VIA of which 375 accepted follow up treatment.

The curriculum for the health and family life education (HFLE) pilot programme underwent a review during the reporting period. This pilot programme was expanded to all secondary schools during 2014 as a timetabled subject, thereby providing all students with life skills education.

The Youth Friendly Health Services Initiative continued 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.

A total of 5,127 STI cases were reported in 2014 representing a significant decrease (24%) from the 6,777 cases reported in 2013 (MoH Surveillance Unit). The majority of STI cases reported were among females (82%) while male cases remained under-reported. Genital discharge syndrome (GDS) remained the most frequently reported syndrome (95% of STIs in 2014) while 42% of the STI cases reported at the main sentinel site were within the 15-24

age group. There were 105 cases of HIV co-infection with other STIs. During 2014, 117 health care workers of different categories and 28 Ministry of Education officials were trained in STI Syndromic Management.

During 2014, 17 public health facilities and 2 private hospitals provided post exposure prophylaxis (PEP). There was timely provision of PEP to 69 reported cases and a total of 82 health care workers of different categories from regions 2, 5, 9 and 10 received training in how to avoid occupational exposure to HIV and also in the delivery of PEP.

Treatment

During 2014, treatment and care services were delivered through 22 treatment sites.

A total of 5,041 HIV patients (55.8% females and 44.2% males) were listed on the register in the care and treatment programme at the end of 2014 with 4,295 (85.2% of the patients) receiving antiretroviral therapy (ART). 11.6% of those on ART were on second line therapy. There were 602 new enrollments during the year, including 17 children. Survivability within the 2013-2014 national cohort was reported at 81.2% over a 12-month period while survivability for 24, 36 and 60 months was reported at 75%, 72.4% and 63% respectively. Monitoring visits to treatment sites continued and clinical mentoring sessions, chart reviews and capacity building of healthcare workers through clinical management trainings, were conducted in the ongoing efforts to improve the quality of care provided.

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 the laboratories of 5 government hospitals in Regions 2, 3, 6, 7 and 10. Three of these hospitals are regional hospitals.

Care and support

The provision of care and support to persons living with and affected by HIV continued with a total of 716 new persons enrolled into the Home Based Care (HBC) programme in 2014 (NAPS programme reports). The psychological, social and nutritional needs of persons living with HIV (PLHIV) were addressed through monthly support group (20 groups) activities and the distribution of 3,689 nutritional food hampers through the Food Bank to 937 eligible PLHIV. Public Assistance for eligible PLHIV was also provided through the Ministry of Human Services & Social Security.

Monitoring and Evaluation

Throughout the reporting period, Monitoring and Evaluation (M & E) of the national response continued with oversight provided by the MERG. During 2014 a major activity was the Biological & Behavioral Surveillance Survey (BBSS) Round 3 among key affected populations. Estimates for MSM and FSWs were developed using the BBSS data and National HIV estimates for 2014 were also developed using Spectrum and EPP. In addition, data for the 2013 Client Satisfaction Survey was analyzed, a Global Fund M&E plan was developed, finalized and approved and a National HIV Monitoring and Evaluation plan was drafted. Tools to adequately report on prevention initiatives among the key populations were revised which very importantly, included the VCT recording and reporting system among others. Throughout the period, M & E personnel received ongoing training to adequately equip them in performing their functions.

The Surveillance Unit of the MoH led the initiative of revising and updating HIV surveillance. Started in 2013, this initiative concluded in 2014 with a revised case based surveillance system developed, supported by an HIV case-based surveillance manual.

Table 1: Overview of Indicator Data

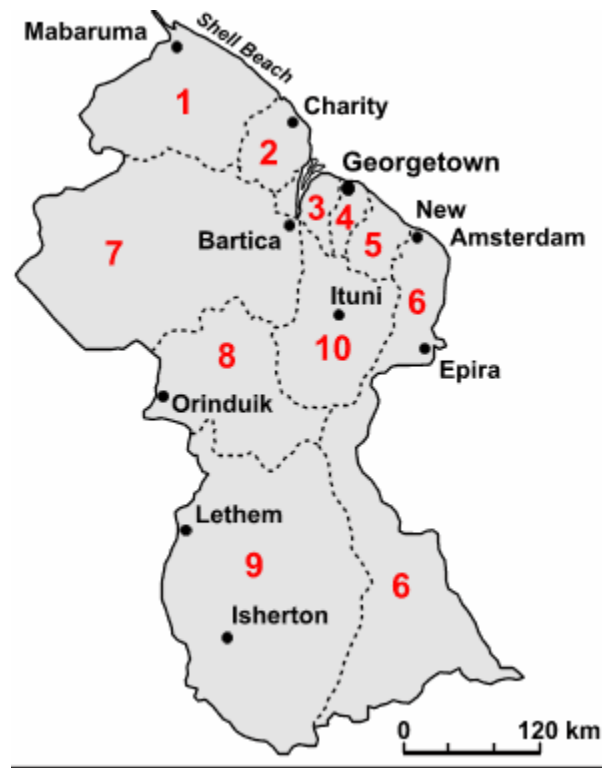
Targets	Indicator	Data origin	Period	Value	Remarks
Target 1: Reduce sexual transmission of HIV by 50 percent by 2015 General Population	1.1 Percentage of young women and men aged 15-24 who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconception about HIV 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 <i>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.</i>	DHS	2009	-	No new survey
	All Females	DHS	2009	-	
	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 <i>Note: Data not disaggregated by sex</i>	ANC Programme data	2014	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

Targets	Indicator	Data	Period	Value	Remarks
					accessed ANC services.
Sex Workers	1.7 Percentage of sex workers reached with HIV prevention programmes	BBSS	2014	48.2%	Data reflects male, female and Transgender Sex Workers
	1.8 Percentage of sex workers reporting the use of a condom with their most recent client	BBSS	2014	75.7%	
	1.9 Percentage of sex workers who have received an HIV test in the past 12 months and know their results	BBSS	2014	47.6%	
	1.10 Percentage of sex workers who are living with HIV	BBSS	2014	6.1%	
Men who have sex with men	1.11 Percentage of men who have sex with men reached with HIV prevention programmes	BBSS	2014	37.5%	Data includes Transgender
	1.12 Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	BBSS	2014	64.4%	
	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	2014	37.8%	
	1.14 Percentage of men who have sex with men who are living with HIV	BBSS	2009	4.9%	
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	-	-		

Targets	Indicator	Data	Period	Value	Remarks
	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	2014	188	Numerator is inputted and reflects data from the National Care and treatment programme and the PMTCT programme. 183 women received ARVs and 5 women single dose nevirapine. Denominator is derived from Spectrum file and will be finalized in May 2015
	3.1a Percentage of women living with HIV who are provided with antiretroviral medicines for themselves or their infants during breastfeeding period	PMTCT Programme Report & Spectrum	2014	NA	2 babies were being exclusively breastfed at admission during 2014. The denominator is derived from Spectrum file and will be finalized in May 2015
	3.2 Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth	NPHRL & PMTCT data	2014	59.5%	115 samples were processed within 2 months; 159 between 2 to 12 months and 16 samples beyond 12 months.
	3.3 Mother-to-child transmission of HIV modeled	Modeled using Spectrum	2014	Not Available	This indicator will be updated from the finalized Estimates File in May 2015. Denominator: 193 HIV positive pregnant women who delivered in 2014
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	2014	4295	4295 persons were receiving treatment at the end of 2014. Denominator will be available in May 2015 from finalized Spectrum file.
	4.2 Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	Patient Monitoring System (NAPS)	2014	81.2%	

Targets	Indicator	Data	Period	Value	Remarks
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	2014	103	Numerator reflects number of co-infected patients at TB sites who received ART (both new and retreatment cases). Denominator will be available from WHO later in 2015. Programme coverage reflects 69.6% (103/148)
Target 6: Reach a significant level of annual global expenditure (US\$22-24 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			The NCPI was not required for the 2015 GARPR report
	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				
	7.3 Current school attendance among orphans and non-orphans aged 10-14	-			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.
	7.4 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%	
			men	23.90%	

II. OVERVIEW OF THE AIDS EPIDEMIC



Guyana has a population of approximately 747,884 (2012 population census) with a landmass of 215,000 km² extending along the north-eastern coast of South America. It is the only English-speaking country in South America and is bordered by Suriname, Brazil and Venezuela. Guyana is divided into ten administrative regions and according to the 2012 census of the Guyana Bureau of Statistics (GboS), most of the population (89.1%) is concentrated in the coastal areas (Regions 3, 4, 5 and 6).

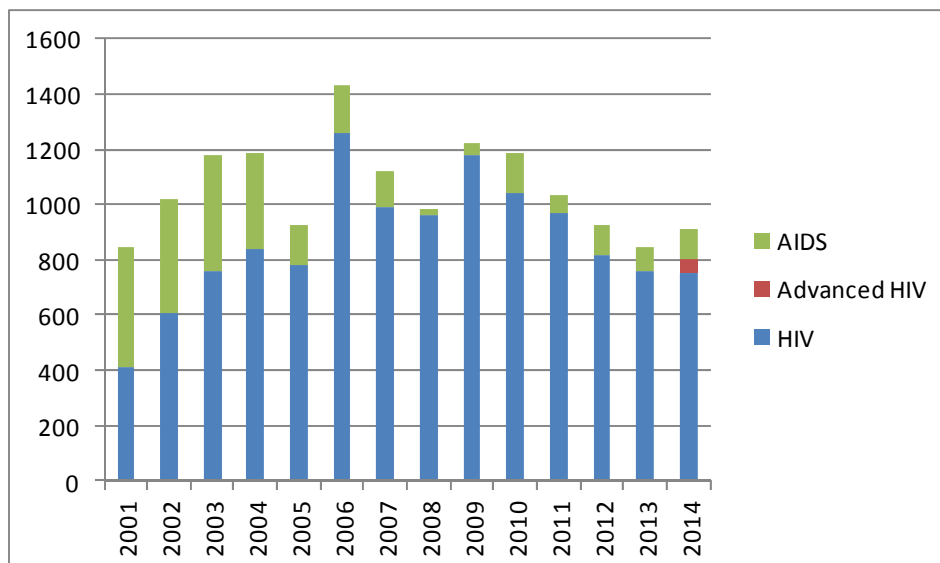
The 2012 census also showed that the ratio of men to women was 49.8% to 50.2%. The 25-54 age group comprised the highest proportion (37.2%) of the population followed by the 0-14 age group (29%). Per capita gross domestic product (GDP) was US\$8,500 in 2014 (2013 est.). Guyana is classified as a medium developing country on the Human Development Index (HDI) scale and is ranked at 121 of 187 countries in the 2014 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, 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 2014, the Surveillance system was revised to report on advanced HIV

cases (persons with CD4 = 200-350). In this regard, a total of 53 cases were reported. During 2014, 751 HIV cases were reported compared with 758 in 2013. The number of new AIDS cases increased to 105 compared with 88 cases in 2013.

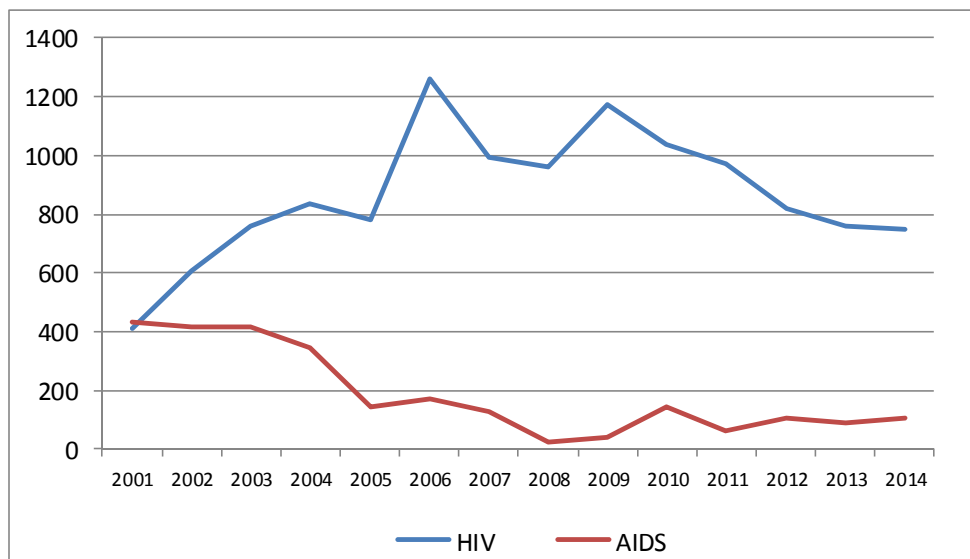
Figures 1 and 2 show the trends in the number of annual cases of HIV and AIDS reported during the period 2001 – 2014.

Figure 1: Annual Cases of HIV and AIDS, 2001-2014



Source: Ministry of Health Surveillance Unit and NAPS

Figure 2: Trends in the number of annual cases of HIV and AIDS: 2001-2014



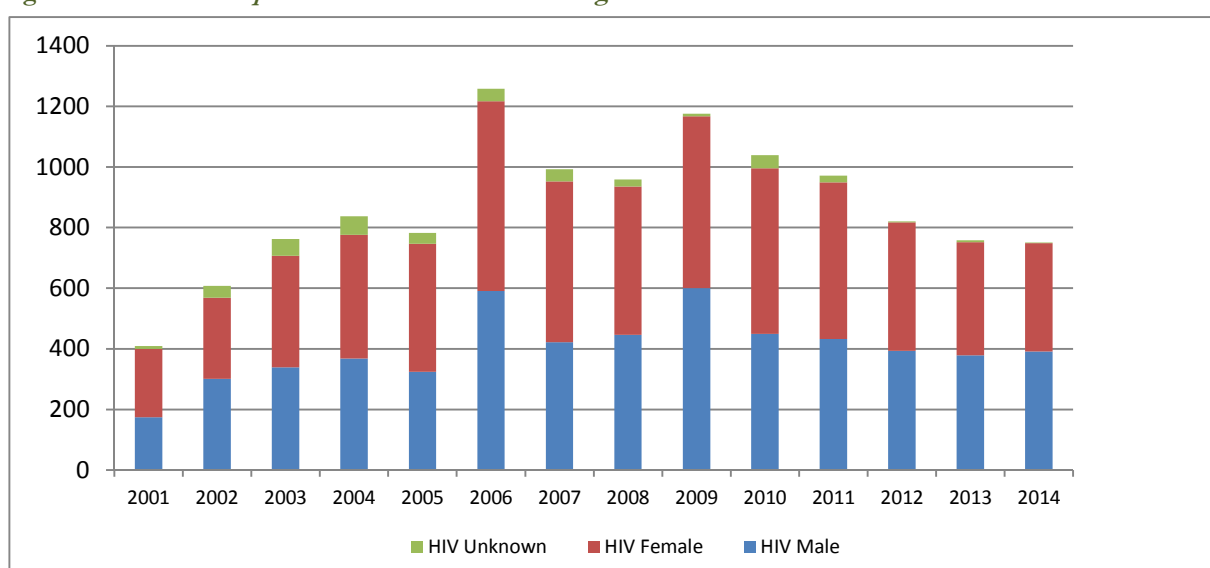
Source: Ministry of Health Surveillance Unit and NAPS

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 4 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 and this continued into 2014 with a male to female ratio of 1.09 (MoH Surveillance Unit). These trends are illustrated in Figure 3 and Table 2 below.

Figure 3: Trends in Reported Cases of HIV According to Sex 2001 – 2014



Source: Ministry of Health Surveillance Unit and NAPS

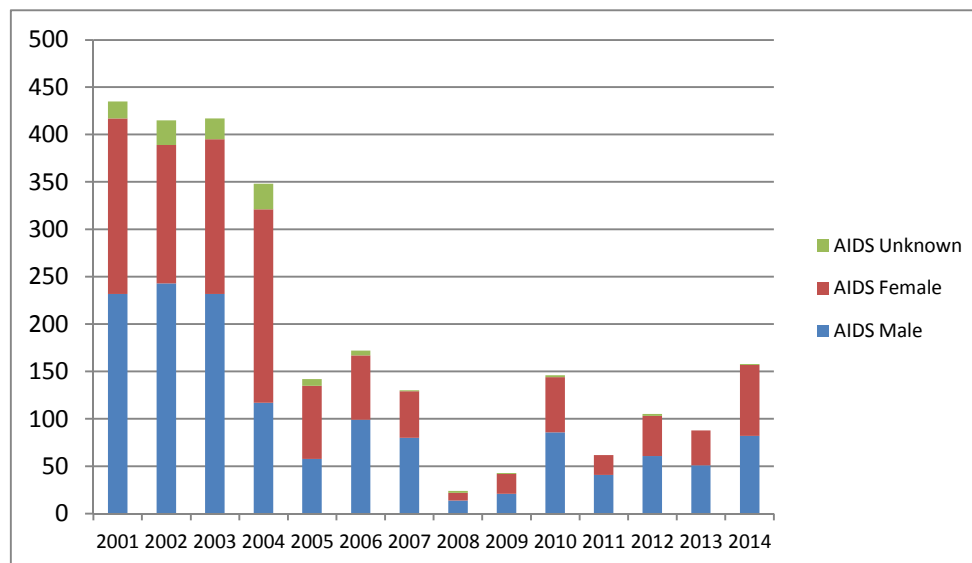
Table 2: Trends in Reported Cases of HIV and AIDS According to Sex 2002 – 2014

CLASSIFICATION		2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
HIV	Male	301	339	368	325	591	422	446	600	449	432	393	378	391
	Female	268	368	408	421	626	531	490	567	547	517	424	374	358
	Unknown	39	55	61	36	41	40	23	9	43	23	3	6	2
	Total	608	762	837	809	1,258	993	959	1176	1039	972	820	758	751
	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	1.09
AIDS	Male	243	232	117	58	99	80	14	21	86	41	61	51	61
	Female	146	163	204	77	68	49	8	21	58	21	42	37	44
	Unknown	26	22	27	7	5	1	2	1	2	0	2	0	0
	Total	415	417	348	142	172	130	24	43	146	62	105	88	105
	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	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	856

Source: Ministry of Health Surveillance Unit and NAPS

With regard to the number of AIDS cases, the male to female ratio was consistently higher during the period 2002 to 2014 with the exception of 2004 and 2005. These trends are illustrated in table 2 above and Figure 4 below.

Figure 4: Trends in Reported Cases of AIDS by Sex 2001 – 2014

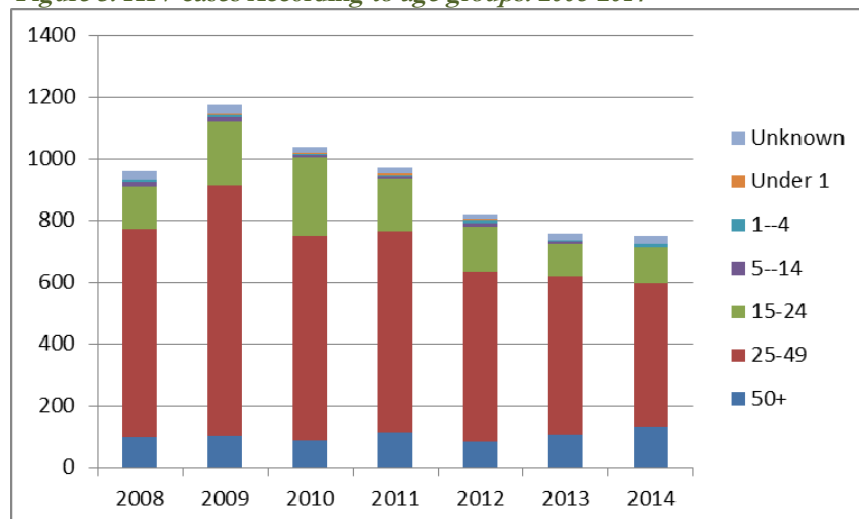


Source: Ministry of Health Surveillance Unit and NAPS

Distribution of HIV Cases According to Age Groups

The HIV epidemic continues to affect the productive sector of Guyanese society. At the end of 2014, a total of 463 cases were reported within the combined age group of 25-49 which accounted for 61.7% of all HIV cases reported during the year. In comparison, during 2013, 513 cases were reported within this age group accounting for 67.7 % of all cases. Figure 5 and table 3 show the distribution of HIV cases among the various age groups during the period 2008 – 2014.

Figure 5: HIV cases According to age groups: 2008-2014



Source: Ministry of Health Surveillance Unit and NAPS

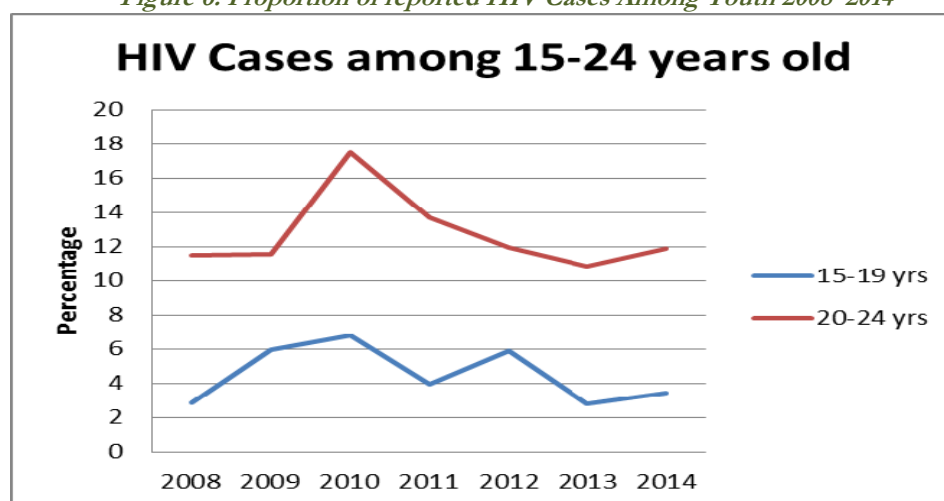
Table 3: Distribution of reported HIV Cases by Age Groups, 2010 – 2014

Age Group	2010	2011	2012	2013	*2014
Under 1	1	4	3	1	0
1-4	5	5	10	4	9
5-14	9	9	11	6	2
15-19	71	39	48	21	26
20-24	182	133	98	83	89
25-29	133	129	125	103	115
30-34	193	176	139	110	118
35-39	142	148	141	127	94
40-44	124	112	91	104	71
45-49	68	83	55	69	65
50-54	42	55	41	45	57
55+	48	61	43	62	77
Unknown	21	18	15	23	28
Total	1,039	972	820	758	751

Source: Ministry of Health Surveillance Unit and NAPS

Figure 6 below shows the HIV prevalence among the 15-19 and 20-24 age groups during the period 2008-2014. During the period this prevalence fluctuated between 2.9% and 3.5% in the former age group and 11.5% and 11.9% in the latter age group.

Figure 6: Proportion of reported HIV Cases Among Youth 2008–2014



Source: Ministry of Health Surveillance Unit and NAPS

Geographic Distribution of HIV and AIDS

Region 4, with 41.3% of the general population (2002 Population Census), continues to be disproportionately affected accounting for 72.8% in 2014 compared with 75.4% in 2013. The geographic distribution of HIV cases is illustrated in Table 4.

Table 4: Proportion of reported HIV Cases by Region 2006 – 2014

Region	*Total Population	% of population	2006	2007	2008	2009	2010	2011	2012	2013	2014
1	24,275	3.2	0.2	0.1	0.5	0.9	0.6	0.8	1.5	0.83	1.6
2	49,253	6.6	4.6	3.8	3.9	2.6	1.3	4.1	2.2	2.25	5.9
3	103,061	13.7	6.8	7.4	8.2	10.6	10.7	2.7	15.9	9.57	7.3
4	310,320	41.3	65.2	66.2	59.1	56.3	71.5	70.8	63.3	75.4	72.8
5	52,428	7.0	2.3	3.7	1.7	2.7	2.6	9.0	2.7	1.42	1.9
6	123,695	16.6	10.5	7.6	9.7	9.9	7.4	2.8	6.0	6.74	8.1
7	17,597	2.3	2.5	1.8	1.6	2.4	1.6	4.9	1.2	0.71	0.7
8	10,095	1.3	0.1	0.4	0.1	0.5	0.3	1.1	0.4	0.47	0.1
9	19,387	2.6	0.3	0.4	0.3	0.0	0.3	0.4	0.4	0.35	0.1
10	41,112	5.5	4.0	4.3	3.7	3.1	2.5	0.1	2.1	1.65	0.3
Unknown	0	0	3.7	4.2	11.1	10.8	1.3	3.3	4.5	0.59	1.2
Total	751,223	100	100	100	100	100	100	100	100	100	100

Source: Ministry of Health Surveillance Unit

*2002 Population Census

AIDS-Related Mortality

The proportion of all deaths attributable to AIDS has declined steadily from 9.5 % in 2002 to 4.8% percent in 2012 (preliminary data) as shown in table 5.

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

Year	Total Number of Deaths	No. of AIDS Related Deaths	% of AIDS Related Deaths	Rate per 1,000 population
2002	5003	475	9.5	0.6
2003	4986	399	8.0	0.5
2004	5141	356	7.1	0.5
2005	5258	360	6.9	0.5
2006	5031	298	5.9	0.4
2007	5066	289	5.7	0.4
2008	5003	237	4.7	0.3
2009	4562	192	4.2	0.2
2010	5433	194	3.6	0.2
2011	5402	230	4.3	0.3
*2012	4670	226	4.8	0.3

*2012 data is preliminary

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)	
		2014	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	
		2014	0.96	
Sex Workers	Female	1997	45.0	Special Survey
		2005	26.6	BBSS
		2008/2009	16.6	BBSS
		2014	5.5	BBSS
	Male	2014	5.1	BBSS
MSM	Male	2005	21.25	BBSS
		2008/2009	19.4	BBSS
		2014	4.9	BBSS
Transgender		2014	8.4	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)	

POPULATION	SEX	YEAR	PREVALENCE	REMARKS
		2007	35.32	
		2008	22.0	
		2009	28.0	
		2010	26.0	
		2011	23.4	
		2012	31	
		2013	25	
		2014	22	
Miners	Male	2000	6.5	Special Survey One mine study
		2003	3.9	Special Survey 22 mines study
		2014	1.0	BBSS
Loggers	Male	2014	1.3	BBSS
Security Guards	All	2008/2009	2.7	BBSS
Prisoners	All	2008/2009	5.24	BBSS

Source: National AIDS Programme Secretariat, 2014

III. NATIONAL RESPONSE TO THE AIDS EPIDEMIC

POLITICAL COMMITMENT

Following the first diagnosed case of AIDS in Guyana in 1987, the Government of Guyana was quick in responding, fully cognizant of the devastating effects of HIV.

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 focus primarily on prevention and psychosocial support.

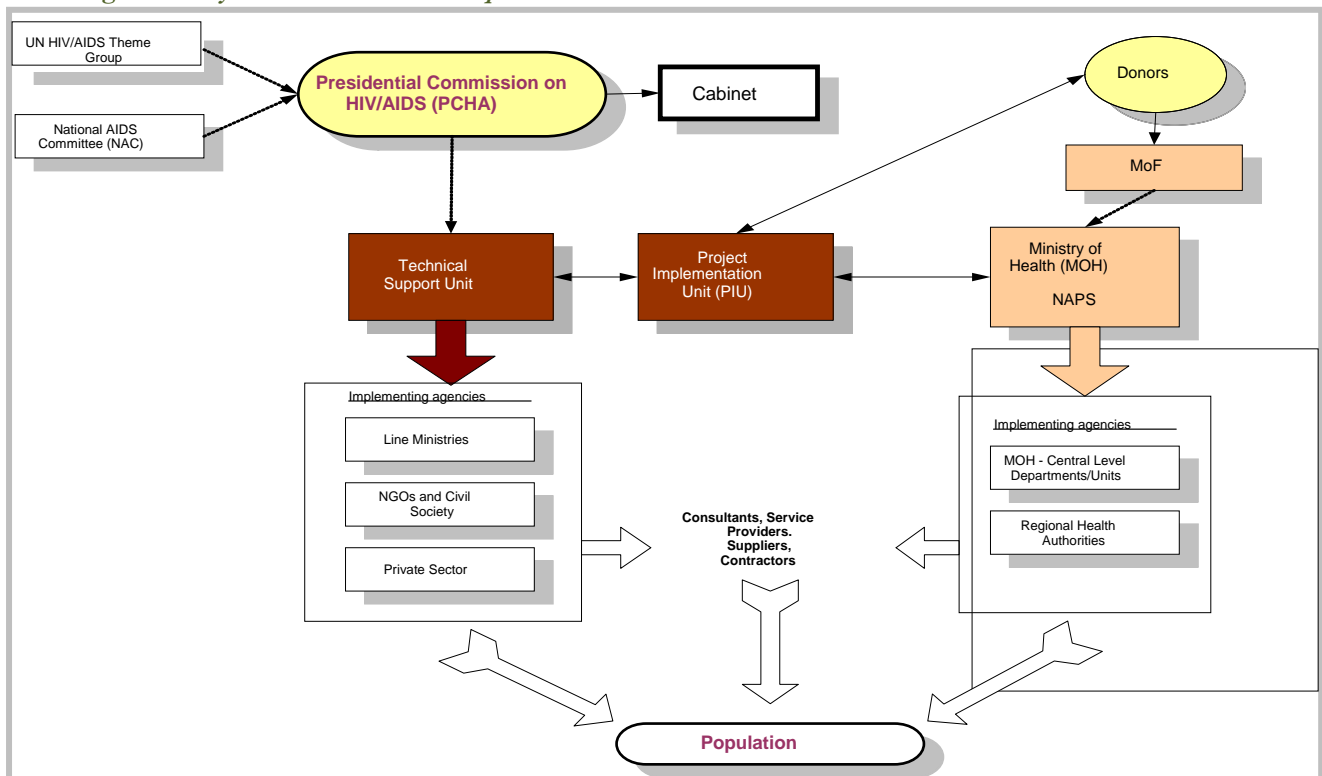
The government also developed a number of strategic plans for the health sector over the years and in 2013, HIVision 2020 and Health Vision 2020 were launched for the period 2013-2020. Health Vision 2020 was designed to be in concert with the various strategic plans for the different components of the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

In light of the reducing donor funded resources to support the national HIV response, the Government of Guyana continues to transition ownership to the Government. During 2014, there was significant transitioning of donor-funded staff to government-supported. Other areas of transitioning included the absorption of 25% of PEPFAR-supported ARVs and the commencement of transitioning of the Global Fund-supported ARVs in 2015. All laboratory supplies in support of the HIV treatment programme along with testing of CD4, Viral Load, and DNA PCR have been fully transitioned.

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 coordination of the various components of the National Strategic Plan across all sectors. The Commission is chaired by the President of Guyana and coordinates the HIV response 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 7 illustrates the Guyana multi-sectoral response mechanism for HIV and AIDS.

Figure 7: Guyana Multi-sectoral Response Mechanism for HIV and AIDS



NAPS, operating from within the MoH, is the technical unit within the Department of Communicable Diseases with responsibility for coordination, implementation and 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

The National HIV Strategic Plan 2013 – 2020 identified priority 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 was drafted and will be finalized in 2015. Significant changes were made relative to the previous National M&E plan and these included the addition of indicators on the HIV cascade, the continuum of care, and targets on the 90-90-90 projections post 2015. A detailed costed 3-year operational plan will be developed as well as an estimated cost for the overall plan.

Through coordination led by the Ministry of Finance, the NAPS provided a status update to the MDG goal 6 and all HIV related targets.

In 2013, The National Programme coordinated with the Country Coordinating Mechanism and partners in the successful submission of a phase 2 Global Fund Rolling Continuation Channel (RCC) application for HIV. In 2014, the CCM was invited to submit a reprogramming request for an extension of the HIV grant through December 2017. This was successfully submitted with the initial TRP approval. Final board approval is anticipated in early 2015. As in the case of the Phase 2 RCC application, the reprogramming considered the Epi profile of the disease and this was approved with a 50% focus on key populations at higher risk. In 2014, sub recipient agreements were signed with three major implementers providing national roll out of programmes targeting the key populations. Sub recipient agreements were signed with CSOs for direct service delivery and accounts for the significant increase in coverage of services to 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 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, the Prevention Technical Working Group, Care and Treatment Technical Working Group, and the VCT Steering Committee among others.

Additional coordination with US government partners included:

- Annual GOG/PEPFAR portfolio review successes, identify gaps and develop activities for the coming fiscal year's country operational plan
- Joint planning of the country operational plan

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 M&E among others.

The Country Coordinating Mechanism (CCM) established to oversee global fund grants, also serves 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.

Aligned to the governance recommendations of the Global Fund, the restructuring of the Guyana CCM commenced and this included a revision of its membership to include a greater representation of the key populations including MSM and FCSW. This process is expected to conclude in 2015.

Through the CCM, Guyana was invited to submit concept notes for the National Malaria and TB programmes. The concept note for TB which is due in the first half of 2015, will address a significant scale up of the TB/HIV response.

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”. The reporting period saw continued leadership and involvement of this population in the HIV response. 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 client satisfaction surveys. During 2014, the Network of Guyanese living with and affected by HIV (GPlus) received funding from the US PEPFAR programme as well as a sub sub recipient under the Global Fund HIV grant for programme implementation among its constituency. In collaboration with NAPS, GPlus provided support to the Positive Health Dignity and Prevention (PHDP) Programme through interactions with PLHIV in their support groups.

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. 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 during the reporting period. These Ministries 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 the 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, and the Ministry of Home Affairs' collaboration in the testing of prison inmates and their referral to care and treatment services. 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 civil society organisations (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 now been fully transitioned to the MCYS. 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 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.

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 (GBCHA).

Throughout the reporting period there was 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 – 2014. 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. The Supermarket Initiative which aims at promoting awareness of HIV and AIDS and general health and wellness, continued through collaboration with the 19 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. These supermarket staff were also involved in the distribution of information, education and communication (IEC) health materials and free condoms to their clientele.

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 gender based violence. The Guyana Business Coalition on HIV and

AIDS (GBCHA) through its membership of 47 companies, continued to be a key agency in supporting the HIV workplace programme in keeping with Guyana's National HIV Policy. 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 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, CSOs have been placing more emphasis on sustainability through partnerships with the business community and creative resource mobilization ventures.

During 2014, 8 NGOs funded through the PEPFAR-funded Advancing Partners and Communities (APC) project were actively involved in the delivery of HIV services within the community in collaboration with MoH/NAPS. These CSOs especially targeted key populations in providing peer education and support, distribution of condoms, lubricants and education and communication (IEC) materials, HIV Testing and Counselling (HTC) and referrals for other prevention services. These CSOs, targeted bars, brothels, mining and logging camps and adjacent communities frequented by these migrant workers. CSOs also provided GBV education and shared coping strategies with FSWs, MSM, their respective clients and partners, and the broader community.

The involvement of these CSOs in Positive Health, Dignity and Prevention (PHDP) among persons living with HIV (PLHIV) focused on reduction of high-risk behaviors for HIV transmission and reinfection, and the empowerment and development of leadership among PLHIV for modelling good HIV-prevention behaviours among their peers. In addition, the CSOs involved PLHIV in small group activities which focused on skills building, the benefits of disclosure, and gender equality.

CSOs also provided care and support services for adult PLHIV and children infected/affected by HIV across the various administrative Regions of Guyana. Community-based care to clients, case navigation to care and support across various service agencies, nutritional supports, adherence and viral load monitoring and retention in care and treatment programs were integral components of care and support. CSOs also assisted in

building linkages to skills training, child protective services and other youth-centred resources through the distribution of comprehensive service directories.

Through the active involvement of CSOs in a field survey during 2014, a cross section of perceptions about stigma and discrimination was revealed in addition to the degree of violence experienced by PLHIV, MSM, FSWs and women in general. The findings of this survey indicated that while stigma and discrimination towards PLHIV has decreased during the past decade due to increased knowledge of HIV, it is still significant in relation to MSM and FSWs. This stigma also results in violence against these groups and impedes access to HIV services.

The Guyana Responsible Parenthood Association (GRPA) whose focus is on providing sexual and reproductive health services, works in close collaboration with the MoH/NAPS in providing these services. During 2014, collaboration included joint outreaches with MoH, provision of VCT, STI and VIA services. In the latter regard, GRPA was able to benefit from VIA refresher training provided through MoH in beefing up their VIA services.

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.

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. To further boost the national prevention programme, the Prevention Coordinator's skills were strengthened through participation in a course on "Strengthening Prevention in HIV and Public Health Programmes" aimed at equipping participants with increased knowledge and skills in leading HIV prevention programmes as part of the national HIV response.

During 2014, 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.

Behavior Change Communication (BCC)

During 2014 the national programme continued to work on the development and production of Behaviour Change Communication campaigns, and existing campaigns were disseminated. These campaigns which focused on behavior change to reduce risks to HIV, addressed a variety of issues. A campaign encouraging greater health seeking behaviours among men was conducted with a focus on the importance of knowing one's HIV status, blood sugar, and cholesterol levels, etc. while promoting healthy living practices. A campaign focusing on prevention of cervical cancer and promotion of screening using VIA (Vaginal Inspection by Acetic acid) among women and girls, was also rolled out.

In prioritizing access to HIV testing and risk reduction among the key populations, a campaign focusing on HIV testing and condom use among MSM and FSWs was developed and rolled out. The design and development of the campaign had the integral involvement of this target audience. A campaign promoting home based care (HBC) targeting caregivers for the elderly and bed-ridden persons was also conducted using a documentary and brochure. These materials educated the public on how to effectively provide HBC and also included the experiences of caregivers. Table 7 provides a list of the mass media campaigns that were launched during the period 2005 – 2014.

Table 7: Mass Media Campaigns Held During the Period 2005-2014

Period	Campaign
2005-2006	<ol style="list-style-type: none"> 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	<ol style="list-style-type: none"> 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	<ol style="list-style-type: none"> 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
2014	16. Male Involvement in Their Own Health
	17. Protection Against and Screening for Cervical Cancer
	18. HIV Testing and Condom Use Among Key Populations
	19. Promotion of Home Based Care

During 2014, at the treatment site level, nursing supervisors and social workers were guided in the integration of standard operating procedures for assessing their caseload to determine which clients are at increased risk of HIV transmission. These clients were provided with Positive Health, Dignity and Prevention (PHDP) services for sexual and reproductive health care, disclosure to partner and family, assessment of partner's status, treatment adherence, substance abuse management, HIV-risk reduction and broader health maintenance. In addition, with NGO support, PHDP enrolees were involved in small group activities which highlighted harmful gender norms, promoted gender equality, and discouraged gender-based violence as cross cutting supporting activities. Achievements for PHDP shows a total of 424 PLHIV being provided with at least six service sessions based on their needs identified at intake.

Within the Guyana Defence Force, during the period 2006-2014, 5,098 members of the Force (officers, ranks and recruits) completed a standardized HIV prevention intervention which included education on HIV/STI transmission, prevention and care and correct and consistent use of male and female condoms. This included the distribution of condoms at various military bases within the country.

Information, Education and Communication

During 2014, IEC materials targeting various population groups were developed, reproduced and distributed as part of the prevention programme. These included brochures/posters/stickers on: safe sex; condom promotion; women empowerment; STIs; PMTCT and; stigma and discrimination. During 2014 several advertisements were also placed in magazines to reach various target audiences.

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 and for the first time, the globally observed Zero Discrimination Day. These national events served as a good media for providing HIV education, sensitization, and HIV services including testing, screening for STIs and referral to treatment services. There was also painting of a Youth Pledge to build HIV/AIDS awareness among youths.

World AIDS Day 2014 commemoration included: broadcasting of brief messages from senior in-country officials focusing on the WAD theme; an annual walk attended by more than 200 persons; a film festival attended by more than 1000 schoolchildren; painting of a mural on "An AIDS Free Generation"; showing of a play "Your Top My Bottom" which focused on bisexuality, unfaithfulness and HIV risk; an AIDS-awareness walk-a-thon; a rally targeting members of the community; a Red Ribbon Day and; HIV testing for key populations in an outlying area.

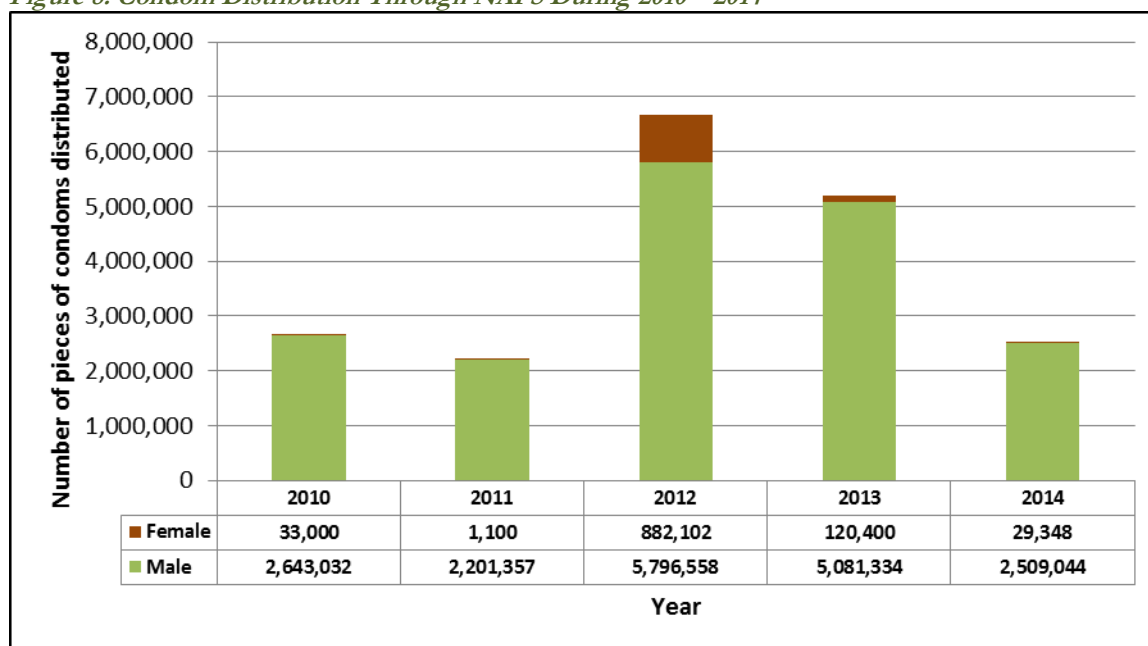
Condom Distribution

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.

During 2014, free condoms continued to be distributed to the general public, among the Armed Forces, civil society organizations, stakeholder agencies, health facilities and government ministries in the effort to reach all ten (10) Administrative Regions. The national programme was also supported by the private sector through the procurement and sale of condoms at a reduced cost. During 2014, a total of 2,648,976 pieces of condoms, were distributed through the national programme free of cost. This amount represented 81% of the condoms made available to the public, while the private sector contributed 19 % (614,898) of the total amount of condoms distributed nationally.

As seen in Figure 8 below which shows the trend in condom distribution through the national programme from 2010-2015, the number of condoms distributed during 2014 saw an approximately 50% reduction when compared to 2013. This was however due to more targeted efforts directed towards key affected populations in making condoms and lubricants available to them through the Prevention Package of Services as reported in the section of this report which addresses interventions targeting these populations.

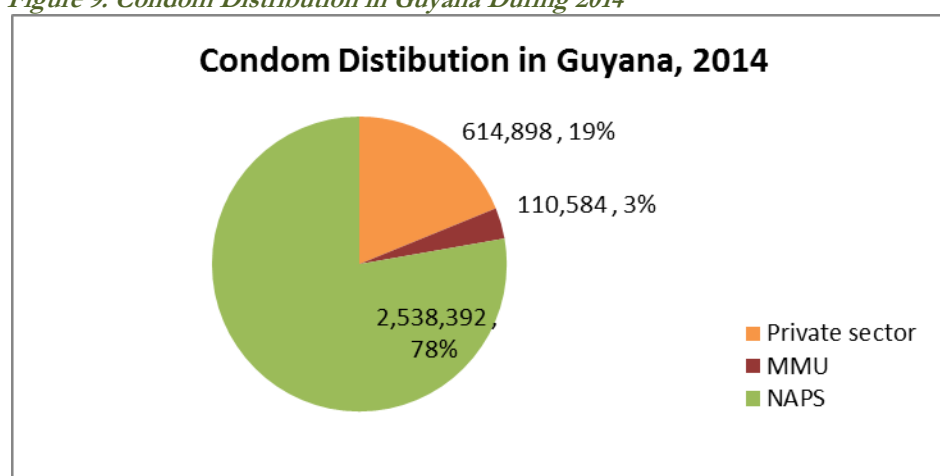
Figure 8: Condom Distribution Through NAPS During 2010 – 2014



Source: NAPS Programme Reports

Figure 9 below, shows the proportions of the contributions made by the respective partners involved in condom distribution during 2014.

Figure 9: Condom Distribution in Guyana During 2014



During 2014, 75934 packets of lubricants were distributed. This was done mainly through CSOs that provide services for MSM. Table x below shows the distribution of lubricants by Regions.

Table 8: Distribution of Lubricants by Region During 2014

Region	1 st Qtr.	2 nd Qtr.	3 rd Qtr.	4 th Qtr.	Total	%
1	0	6	0	4,200	4,206	5.5
2	60	0	0	2,400	2,460	3.2
3	0	0	0	25	25	0.0
4	144	56	37	52,179	52,416	69.0
5	0	0	0	2,400	2,400	3.2
6	0	0	0	7,250	7,250	9.5
7	0	36	0	2,600	2,636	3.5
8	5	0	0	2,700	2,705	3.6
9	0	0	0	1,800	1,800	2.4
10	36	0	0	0	36	0.0
Total	245	98	37	75,554	75,934	100

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. During 2014, meetings of this committee in addition to PMTCT feedback meetings were held with key stakeholders to review the coordination, successes and challenges of the PMTCT programme. The programme is poised to report on the elimination of mother to child transmission of HIV in alignment with the MDG goals. During 2014, a regional meeting was held in Guyana to review plans to move the Caribbean region (including Guyana) towards the Elimination of Mother-to-Child Transmission of HIV and Congenital Syphilis in the Americas. Resulting from this forum, a national evaluation committee was established to prepare Guyana's application for Elimination status.

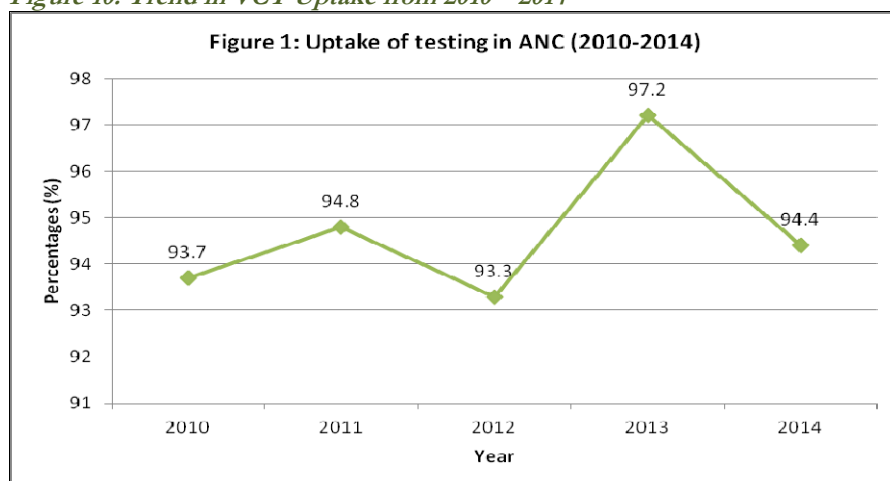
In intensifying all efforts to achieve elimination status by 2015, the PMTCT programme introduced a proactive case tracking management system which seeks to ensure that each HIV infected pregnant women is followed throughout pregnancy, delivery and the post partum period, and is provided with the appropriate 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 as per national guidelines. At the end of 2014, 150 pregnant women were enrolled and receiving support, care and treatment while 87 infants were being tracked.

During 2014, the number of primary sites providing PMTCT services, including antenatal clinics, delivery wards and private hospitals, increased to 188 compared to 187 in 2013. The Lethem Health Centre in the hinterland Region was upgraded to meet National PMTCT Guidelines and standards, with emphasis on creating a safe space for privacy and confidentiality during counselling, including pre- and post-test HIV counselling.

The proportion of pregnant women who accessed PMTCT services in 2014 was 94.4% (14,623/15,494) compared to 88.7% in 2013. HIV prevalence among women attending antenatal clinics remained at 1.9% (293/15,494) in 2014 as in 2013. 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. From 2012, the programme reported on HIV prevalence using a combination of all newly tested HIV positive and women with known HIV positive status (who were previously tested HIV positive and accessed ANC during the reporting period.)

During 2014, there was the continued thrust of provider initiated testing and counseling (PITC). Uptake of VCT services among pregnant women however was 94.4% in 2014 compared with 97.2% in 2013 due to a stock out of test kits at selected Regional sites during 2014. The reduced number of tester counselors within the programme as a result of the transitioning process from donor-funded to government, also contributed to the reduced PMTCT coverage. Figure 10 below shows the trend in VCT uptake by antenatal women during the period 2010 – 2014.

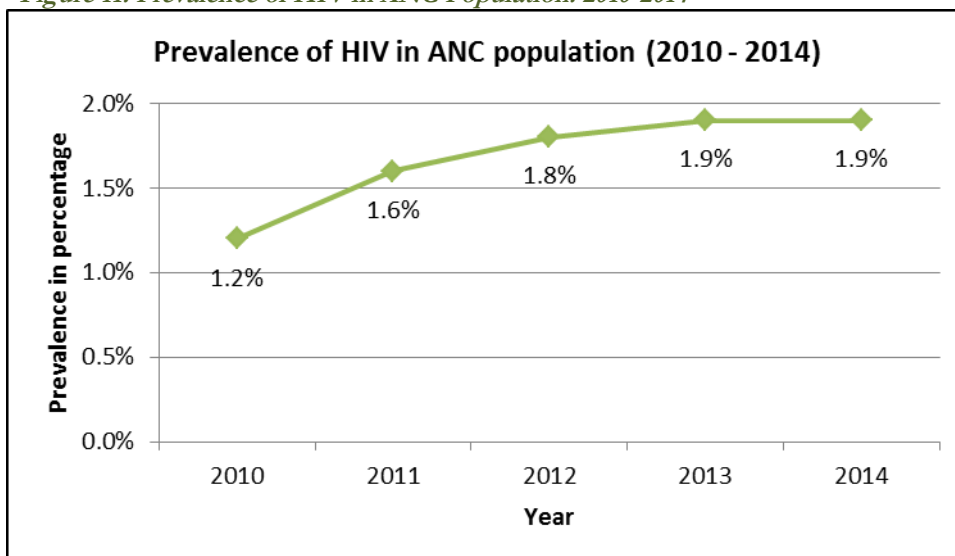
Figure 10: Trend in VCT Uptake from 2010 – 2014



Source: PMTCT Programme Reports

The prevalence of HIV among the antenatal population remained at 1.9% (293/15,494) at the end of 2014. Figure 11 below shows the prevalence of HIV in the antenatal population during the period 2010–2014.

Figure 11: Prevalence of HIV in ANC Population: 2010-2014



The proportion of HIV-positive pregnant women who received ART to prevent mother-to-child transmission was 97% (187/193) (PMTCT & ART Programme data).

Babies born to HIV positive mothers continued to be provided with early HIV diagnosis through DNA PCR testing at the Guyana National Public Health Reference Laboratory. In 2014, 2.6% (5/193) of the babies born to HIV-positive mothers were infected with HIV compared to 2.1% in 2013 (4/191). Exposed infants are currently being tracked at the care 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 – 2014.

Box 1: DNA PCR Testing

	2010	2011	2012	2013	2014
DBS specimens received	211	229	281	274	284
Samples rejected	27	16	18	23	4
Samples processed	184	213	263	251	280
Number of positive samples	11	5	3	4	5
% positive	6%	2.3%	1.7%	2.1%	1.7%
Babies tested before 2 months	87	102	75	62	115

The number of babies tested before 2 months was impacted by challenges experienced by the laboratory due to equipment down-time and a shortage of staff and supplies.

Table 9 below shows major trends in the PMTCT programme during the period 2006 – 2014.

Table 9: Major Trends in the PMTCT Programme, 2006-2014

CATEGORY	2006	2007	2008	2009	2010	2011	2012	2013	2014
No. of sites with PMTCT	92	117	143	157	165	181	183	187	188
ANC mothers tested for HIV	13,041	13,151	12,528	11,766	11,441	12,635	12,697	13,413	12,592
Uptake of VCT among pregnant women (%)	94.6	97.6	98.5	89.8	93.7	94.8	93.3	97.2	94.4
*No. of HIV positive mothers	215	176	177	180	164	233	241	279	293
Prevalence of HIV (%)	1.5	1.3	1.1	1.3	1.2	1.6	1.7	1.9	1.9
**Exposed live infants born to HIV positive mothers	126	217	227	169	161	189	177	192	190

Source: PMTCT database 2006-2014

** This figure is higher than the number of **"Exposed live infants born to HIV positive mothers" during 2014 due to the rollover of a number of pregnant women into 2015.*

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 and promotion of family planning services at all PMTCT sites. 9.2% male partners of pregnant women (1,424 of 15,494) were tested through ANC settings in 2014. Of those males, 17 (1.2%) were found to be HIV-positive. During 2013, the same proportion of male partners were tested (9.2%) of which 0.7% were HIV positive.

In the ongoing attempt to prevent Mother to Child Transmission (MTCT), the provision of infant feeding counseling and breast milk substitute (BMS) continued with exposed infants being provided with these substitutes up to the age of 18 months. During 2014, 3,769 tins of full cream milk and 7,559 tins of infant formula were distributed among health facilities country-wide.

During 2014, a National Assessment and Accreditation was conducted for Baby Friendly Hospitals in the effort to promote breastfeeding and address Infant and Young Child Feeding Practices (IYCF) for the well child and children born to HIV Positive mothers. Six out of twelve hospitals met the Global Criteria of the BFHIs and all hospitals met the criteria for Steps 6, 7, and 9 International Code of the Marketing of Breast milk Substitutes and HIV Infant Feeding. The national PMTCT programme was found to be active and functional in all the hospitals, including the provision of on-site VCT services. The majority

of pregnant women interviewed were aware of the importance of HIV testing. The survey also found that midwives were trained in how to counsel HIV positive women about their infant feeding options and they also assisted in ensuring that women accessed support services. It was recommended that the Labour and Delivery protocols should be updated to address the Mother Friendly Care Practices and that there should be a review of current National HIV Infant Feeding Guidelines based on the 2010 WHO/UNICEF/UNAIDS guidelines.

Box 2 below shows capacity development activities within the PMTCT programme during 2014.

Box 2: Capacity development within the PMTCT programme during 2014
<ol style="list-style-type: none"> 1. Drafting of Standard Operating Procedures (SOPs) for Case Tracking Managing System (CTMS) with regard to Paediatric Care of HIV Exposed Infants. 2. Capacity development of 89 primary health care staff (Regions 3,4,5,6,10) in utilizing the CTMS Tools. 3. Participation of 18 health professionals from public and private health care facilities in a trainer-of-trainers workshop on CTMS. 4. Participation of 15 health care professionals, including Regional health centre supervisors in an Integrated Paediatric Care workshop in preparation for piloting at 10 selected sites. 5. Drafting of an Integrated PMTCT Curriculum and review of this curriculum by 15 health care professionals at a workshop to determine its applicability and efficacy in integrating it into the training curriculum for pre-service nurses and Medex 6. Review of Safe Motherhood and STI training programme by a group of 33 health care workers of different categories, including training facilitators 7. Training in Dried Blood Sampling for 22 health care workers of different categories taken from hinterland Regions 7 and 8.

A research into the cause for repeat pregnancies among women (both HIV positive and negative) was also conducted, with 287 persons being interviewed including clients and health care workers. The results of this research are currently being analyzed

Challenges encountered during the year included the shortage of laboratory reagents to do DNA/PCR testing as part of Early Infant Diagnosis. Increasing male partner involvement also continued to be a challenge despite continued efforts in this area.

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. The VCT steering committee met regularly and invested significant time in considering the shift in the HIV testing algorithm from parallel testing to serial testing. This technical discussion will conclude in 2015.

During the period 2006-2013, the VCT programme expanded from 38 fixed sites and 2 mobile units to 62 fixed sites spread across the 10 regions with several mobile units targeting

the key populations and the hinterland communities. During 2014, VCT continued to be provided country-wide through these sites.

During 2014, a total of HIV 54,815 tests (24,627 among males and 30,189 among females) were done showing an increase when compared with the 2013 total of 49,674 tests. Females continued to access VCT services more than males, accounting for 55.1% of testing in 2014 which was lower than the 2013 figure of 59.6%. Among all testing in 2014, 1,034 tests (1.9%) were found to be HIV positive in comparison to 983 (2%) in 2013. Testing among Females comprised 46.6% (442/1,034) of the positives compared to 51.5% in 2013.

In relation to the general population based on the 2002 census, females account for a slightly higher proportion of the population (50.3%) with a male to female ratio of 0.98. Based on the last 5 year trends the male to female ratio for testing has been consistently lower than that of the population, however 2014 testing showed improvement compared to the previous years and significant improvement compared to 2013 (0.68 vs 0.8). Figure 12 and table 10 below shows HIV testing according to gender during the period 2010 – 2014.

Figure 12: Number of Tests done According to Gender: 2010–2014

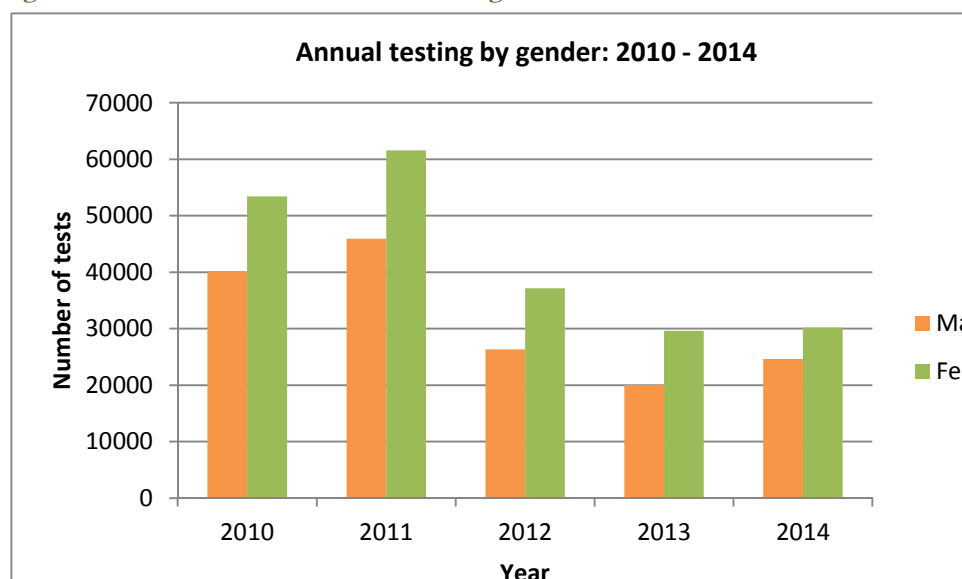


Table 10: Annual testing by Gender 2010-2014

Gender	Population > 15 years (2002 census)	2010	2011	2012	2013	2014
		Number of Tests Done				
Males	240,405	40,107	45,954	26,329	20,062	24,627
Females	243,671	53,425	61,562	37,136	29,612	30,189
Male to Female Ratio	0.98	0.75	0.75	0.71	0.68	0.8
Total Tests	484,076	93,532	107,516	63,465	49,674	54,815

Region 4 with 42% of the populations accounts for 63% of all testing in 2014, a trend which was maintained over the years. There has been a gradual decline in the proportion of testing occurring in Region 6 which has 15% of the population. Testing in this region was reported at 11.9% in 2014 compared with 19.2% on 2010. Region 3 with 14% of the population, has consistently had low levels of testing coverage accounting for 6.7% of the tests in 2014. This represents a reduction when compared to 2012 and 2013. Similarly, the combined hinterland regions (1, 7, 8, and 9) also continue to receive low levels of testing. See details in table 11 below.

Table 11: HIV Testing by Regions

Region	Populat- ion (2012 census)	Regional Proport- ion of Populat- ion	2010		2011		2012		2013		2014	
			# of tests done	Prop- ortion of testing by region	# of tests done	Prop- ortion of testing by region	# of tests done	Prop- ortion of testing by region	# of tests done	Prop- ortion of testing by region	# of tests done	Prop- ortion of testing by region
1	26,941	4	371	0.40	2318	2.2	259	0.4	521	1.0	1190	2.2
2	46,810	6	2556	2.73	3383	3.2	2662	4.2	2426	4.9	2262	4.1
3	107,416	14	4952	5.29	5705	5.3	4744	7.5	4183	8.4	3689	6.7
4	313,429	42	54794	58.57	64316	59.9	41920	66.1	32526	65.5	34569	63.1
5	49,723	7	1855	1.98	1785	1.7	821	1.3	200	0.4	573	1.0
6	109,431	15	17952	19.19	21782	20.3	8591	13.5	6000	12.1	6501	11.9
7	20,280	3	3203	3.42	1841	1.7	1517	2.4	1489	3.0	2202	4.0
8	10,190	1	1202	1.28	447	0.4	253	0.4	536	1.1	402	0.7
9	24,212	3	1379	1.47	1592	1.5	859	1.4	260	0.5	358	0.7
10	39,452	5	5288	5.65	4117	3.8	1837	2.9	1533	3.1	3070	5.6
Total	747,884	100	93552	100.00	107286	100.0	63463	100.00	49674	100.0	54815	100.0

In addition, the 25-49 year age group had the highest proportion of tests (45.9%) country-wide which was somewhat similar to the figure for 2013 (47.4%). Table 12 below shows the breakdown by age groups during the reporting period.

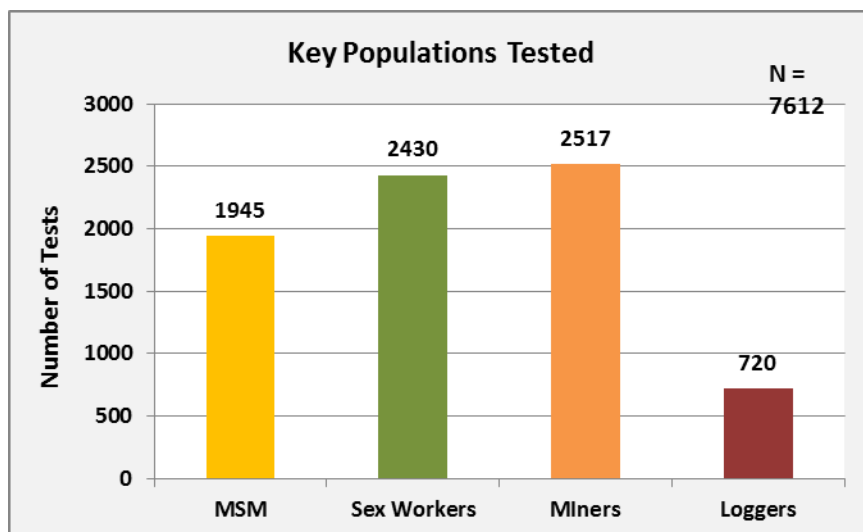
Table 12: HIV Testing by Age Groups: 2014

	<15	15 -19	20 -24	25 - 49	>49	Total Tested
Key Population	45	842	1874	4264	586	7611
General Population	967	8230	11926	20904	5177	47204
Total Tested	1012	9072	13800	25168	5763	54815
% of Test	1.85	16.55	25.18	45.91	10.51	100.00

During 2014, there was increased focus on targeting key populations at higher risk to offer VCT. In preparation for this, the VCT monitoring and reporting system was revised during the latter half of 2013 which facilitated the capturing of VCT data among these populations during 2014. Key populations focused on were mainly men who have sex with men (MSM), sex workers (male & females), miners and loggers. VCT was offered in all 10 administrative

regions through health facilities and NGOs. During 2014, key populations accounted for 13.9% (7,612/54,816) of the total number of tests done. Figure 13 below shows VCT uptake among the different categories of the key populations.

Figure 13: Number of Tests done Among Key Populations in 2014



Among the key populations tested, the miners accounted for the greatest proportion of positives among all positives at 8.9% (92/1034) while sex workers accounted for 7.9% (82/1034). This was followed by MSM accounting for 7.1% (73/1034) while loggers had the lowest proportion with 1.4% (14/1034).

In terms of the positive cases among the specific populations tested, MSM reported the highest positive rate of 3.75% (73/1945), followed 3.65% (92/2517) for miners, 3.37 (82/2430) for sex workers and 1.94% (14/720) for loggers. This programmatic data is similar to that reported in the BBSS 2014 with the exception of the miners which is significantly higher. Close monitoring of this programme will continue.

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 13.

Table 13: HIV Testing in Various Settings for the Period 2006-2014

Testing Setting	2006	2007	2008	2009	2010	2011	2012	2013	2014
VCT	25,063	48,573	63,876	85,554	93,532	106,491	63,465	49,674	54,815
PMTCT	13,041	12,004	15,702	11,776	11,441	13,490	12,697	13,413	12,592
Blood Screening	6,810	7,104	7,360	7,700	7,654	7,929	7,712	11,148	10,016
Total Tested	44,914	67,681	86,983	105,030	112,627	127,910	83,874	74,235	77,424
Total HIV Positive (Notified cases)	1,258	993	959	1,176	1,039	972	820	758	1,423
Percentage Positive	2.8	1.5	1.1	1.1	0.9	0.8	1	1	1.8

Training

During 2014, 45 members of the Guyana Defence Force were provided with VCT training in the effort to expand the availability of VCT to the Armed Forces and other members of the community. VCT Refresher Training was also provided to 104 counselor/testers within 5 Regions of Guyana. In addition, Quarterly Feedback Meetings were held with counselor/testers to monitor their progress and to address any challenges encountered.

Valentine's Day Couples Testing

The annual Valentine's Day Couples Testing, continued in 2014 in 5 of the 10 administrative regions, with the support of business partners. Under the theme "Test of Love", 3,292 persons (62% females and 38% males), including 284 couples, received VCT. This was a moderate increase compared to 2013 when 3,023 persons including 280 couples received VCT as part of this initiative. (see box 3). Of the persons tested in 2014, 1.1% (36/3,292) was found to be positive and referred for treatment.

Box 3: Persons Tested During Couples Testing 2008 – 2014				
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
2014	350	284	3,292	9

As part of the Couples Testing Initiative, incentives in the form of romantic dinners sponsored by the business community, were raffled and won by lucky couples.

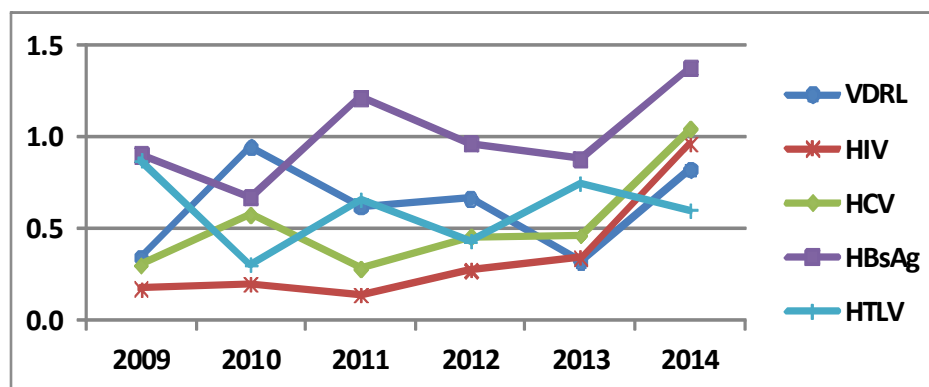
Blood Safety Programme

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 during 2014. During 2014, 10,016 units of blood were collected compared to 11,148 units in 2013.

During 2014 the proportion of persons testing positive for HIV among all blood units screened was 0.96% (96/10,016) compared with 0.3% in 2013. Hepatitis B remained the most commonly occurring infectious marker among blood units screened with a proportion of 1.37% (137/10,016) followed by Hepatitis C with a proportion of 1.04% (104/10,016).

Figure 14 below shows the proportion of infectious markers during the period 2009 – 2014.

Figure 14: Proportion of Infectious Markers 2009-2014



Source: National Blood Transfusion Unit

Post Exposure Prophylaxis (PEP)

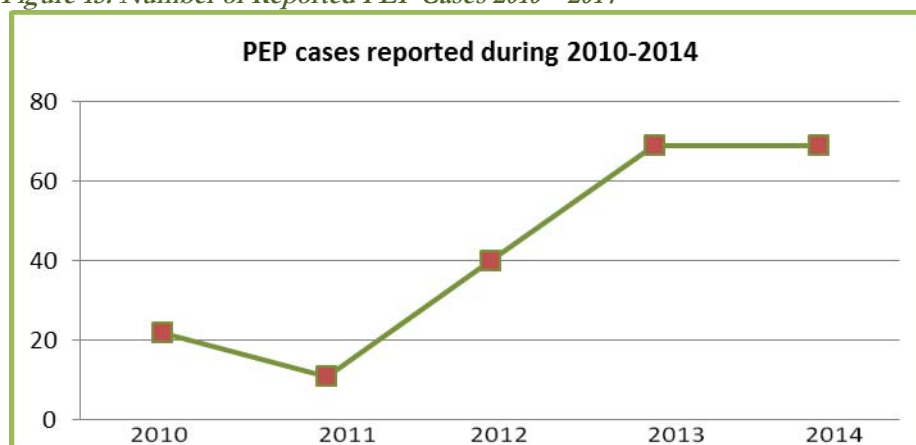
During 2014, a total of 17 public health facilities and 2 private hospitals provided PEP as in obtained in 2013. All PEP sites are equipped with a special PEP kit which includes the Standard Operating Procedures/Guidelines, ARVS, medications for emergency contraception and for treatment of other sexually transmitted infections (gonorrhea and chlamydia). The sites are supported with standard operating procedures and quick references.

In 2014, 5 government health facilities and one private hospital reported a total of 69 PEP cases. Fifty two (52) of these were due to needle stick injuries (occupational) and 17 due to sexual assault (non occupational). Persons were assessed and placed on the required prophylaxis. Box 4 shows the number of needle stick injuries versus the number of sexual assault cases by Regions.

Box 4: Needle Stick Injuries Versus Sexual Assault 2014			
Region	Need Stick Injury	Sexual Assault	Number of persons
3	11	1	12
4	37	16	53
6	2	0	2
10	2	0	2
Total	52	17	69

Figure 15 below shows the number of cases reported during the period 2010 – 2014.

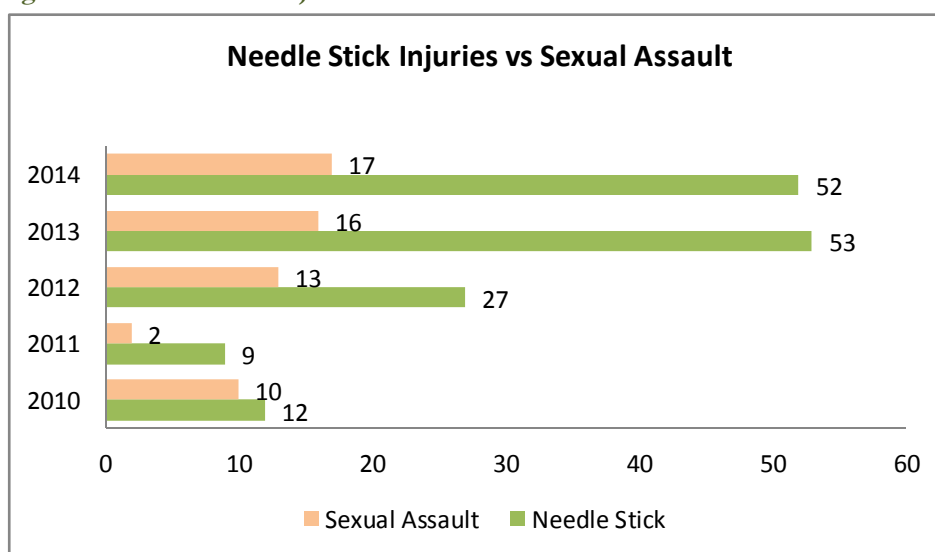
Figure 15: Number of Reported PEP Cases 2010 – 2014



An analysis of the PEP cases reported over the period 2010 – 2014 indicates that needle stick injuries (occupational) among health care workers is a commonly occurring factor in PEP cases as indicated in box 5 and Figure 16 below. Sexual assault cases (non occupational) receiving PEP have also increased over the years.

Box 5: Needle Stick Injuries Versus Sexual Assault 2010 - 2014					
	2010	2011	2012	2013	2014
Needle Stick	12	9	27	53	52
Sexual Assault	10	2	13	16	17

Figure 16: Needle Stick Injuries vs Sexual Assault in PEP Cases



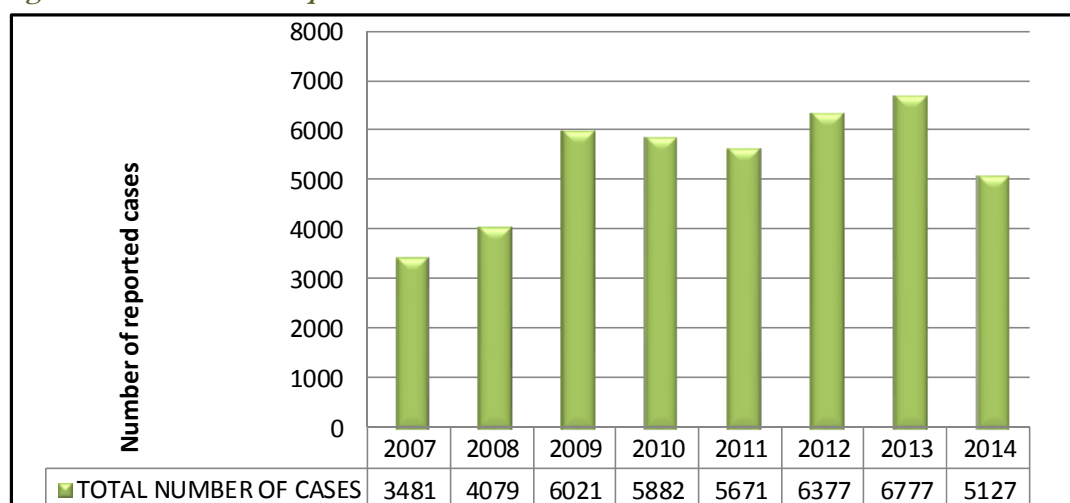
To address this situation there has been ongoing training among health care workers to avoid occupational exposure. During 2014, a total of eighty-two health care workers of different categories from regions 2, 5, 9 and 10 received training in this regard along with training in the delivery of PEP.

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 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 HIVision 2020 which was launched in 2013.

There were 5,127 STI cases reported in 2014 representing a significant decrease (24%) from the 6,777 cases reported in 2013 (MoH Surveillance Unit). The 2014 figure was a deviation from the trend seen during the period 2007 – 2013 when there was a steady rise in the number of STI cases recorded. Figure 17 below shows the number of STI cases reported during the period 2007 - 2014.

Figure 17: Number of Reported STI Cases 2007 - 2014



Surveillance Unit, MoH

Genital discharge syndrome (GDS) remains the most frequently reported syndrome during the period 2010-2014 (95% of STIs) in 2014 which is almost the same as in 2013 with its 94.7%). Overall, cases of genital ulcer disease (GUD) have been decreasing over the past five years (6.5% in 2010 steadily decreasing to 3.3% in 2014). Table 14 shows the frequency of occurrence of the various STIs during the period 2010-2014.

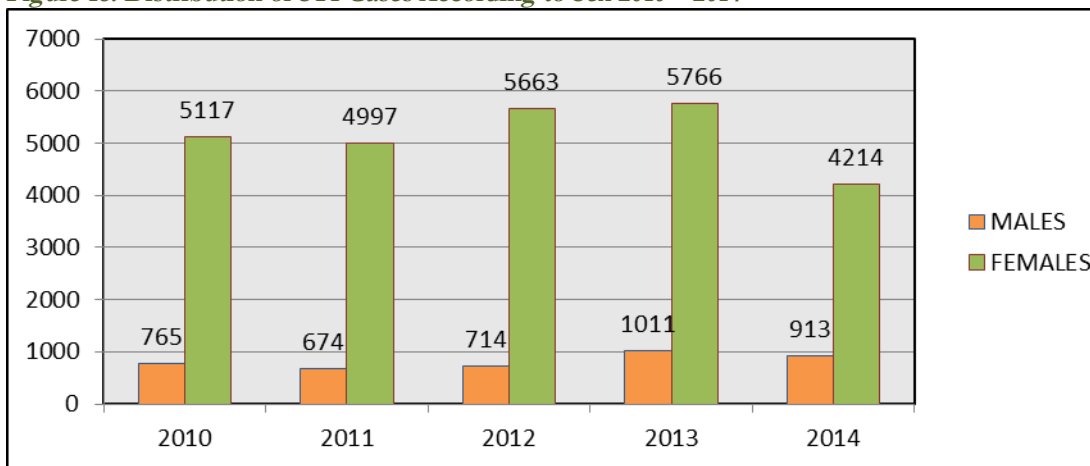
Table 14: STI by Type 2009 – 2014

STI	2010		2011		2012		2013		2014	
	No.	%	No.	%	No.	%	No.	%	No.	%
GDS	5,419	92.1	5,231	92.2	5920	92.8	6421	94.7	4863	94.9
GUD	385	6.5	344	6.1	364	5.7	260	3.8	167	3.3
Gonorrhea	19	0.3	35	0.6	23	0.4	30	0.4	30	0.6
Chlamydia	6	0.1	6	0.1	8	0.1	8	0.1	5	0.1
Syphilis	7	0.1	22	0.4	25	0.4	26	0.4	23	0.4
Trichomoniasis	30	0.5	14	0.2	22	0.3	11	0.2	16	0.3
LGV	0	0	0	0.0	0	0.0	1	0.0	0.0	0.0
Herpes Simplex	16	0.3	19	0.3	15	0.2	20	0.3	23	0.4
Total	5,882	100.0	5671	100.0	6377	99.9	6777	99.9	5127	100

Surveillance Unit, MoH

The majority of the STI cases reported continued to be among females; 82% in 2014 and 85% percent in 2013 (MoH Surveillance data), see Figure 18 below. The higher figures recorded for females might be due to the observation that females access government STI services (and also general health services) more frequently than men who are more likely to access services from private hospitals and pharmacies. As such, all STI cases among men might not have been fully captured within the public reporting system. Figure 18 below illustrates the gender distribution of STI cases for the period 2010 - 2014.

Figure 18: Distribution of STI Cases According to Sex 2010 – 2014



Surveillance Unit, MoH

As in previous years, the majority of STI cases were among persons 15 yrs of age and above, with 95% occurring among this age group in 2014. Data from the National Care and Treatment Center (NCTC) in Region 4, which is the main sentinel site for monitoring STIs, showed the highest occurrence (42%) of STIs within the 15-24 years age group. Region 4, which is the most populated region, also accounted for the highest proportion of STI cases nationally (26.5%). During 2014 there was an HIV prevalence of 12% among STI patients visiting the NCTC. This amounted to 105 cases of HIV co-infected with other STIs reported compared with 112 in 2013.

During 2014, all blood donors were screened for STIs as part of the National Blood Transfusion Protocol. The percentage of screened blood that tested positive for STIs was

5.12% (513/10,016) compared with 2.8% in 2013. Hepatitis B remained the most commonly occurring STI with a proportion of 1.37% of all blood screened followed by Hepatitis C with a proportion of 1.04%.

During 2014, 117 health care workers of different categories and 28 support personnel including Social Workers, Welfare, Child Protection, and Probation Officers were trained in STI Prevention Management and Control. Several technical documents were also revised, updated and disseminated including the STI training manual, STI and OI booklet, and posters.

Screening for cervical cancer

With clear association between cervical cancer and HIV, screening for cervical cancer has been scaled up with the expansion to 19 sites in 10 regions in 2014 compared to 17 sites in 9 regions in 2013. Visual Inspection with Acetic Acid (VIA) screening continued 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. In addition screening was done through outreaches to work places and other organisations.

In keeping with Guyana's HIV treatment guidelines which recommend VIA as a baseline screening for all HIV infected women, screening is 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.

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 2014, 3,678 persons, including 505 HIV positive patients received VIA. Of the 3,678 persons screened, 392 received a positive VIA. Of these, 310 received cryotherapy, 51 received LEEP and 14 were referred to oncology. Box 6 shows the number of persons screened and the follow up provided during the period 2012-2014.

**Box 6: VIA Services Provided
2012 - 2014**

	2012	2013	2014
Total receiving VIA	6,937	5,363	3,678
Number of HIV positive clients who received VIA	969	648	505
Total of all clients with Positive VIA	639	466	392
Percent with positive VIA findings	9.2%	8.7%	10.7%
Received cryotherapy	522	353	310
Received LEEP	26	55	51
Referred to	48	45	14

As is evident, the total number of VIA screening declined over the last 3 years with a parallel decline in the number of HIV positive clients screened. Importantly the proportions with positive VIA findings remain significant at 10.7% in 2014.

During 2014, there was a Regional training of the trainer activity in Guyana to provide training in performing the VIA procedure. Representatives from Caribbean countries included 1 from Trinidad, 2 from Suriname, 1 from Antigua, 1 from St. Lucia and 5 from Guyana. Training involved both lectures and practicals which included each participant having to conduct the procedure on a specific number of persons.

Guyanese girls, aged 11 to 13 years old continued to benefit from the administration of Human Papilloma Virus (HPV) vaccine. 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.

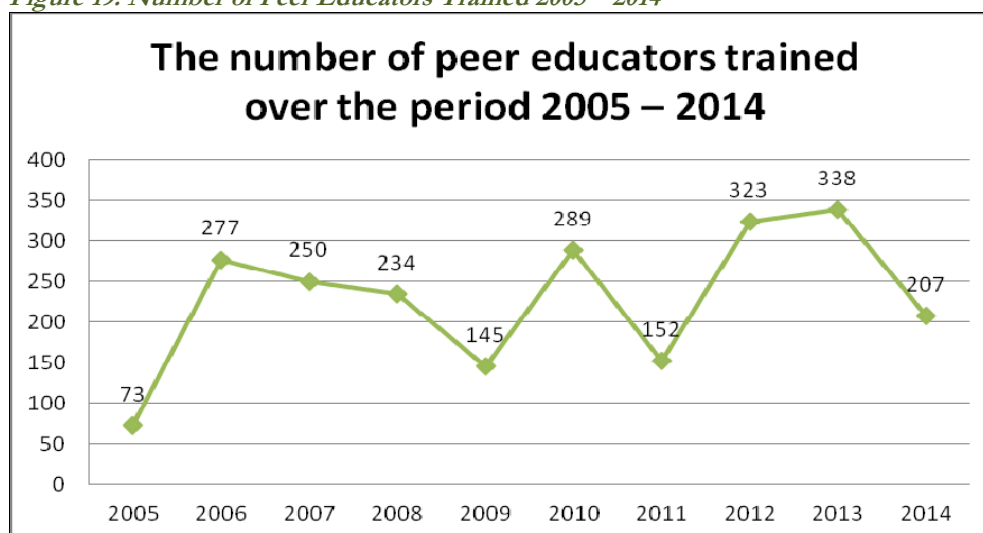
Community Mobilization

Community mobilization activities during 2014 were generally done in collaboration with Government Ministries, grassroot organizations, service organizations and civil society members such as religious leaders and other members of the community. Most of the trainings and outreaches were done in the outlying regions of Guyana where the population, are relatively underserved due to geographic barriers. Community mobilization efforts were also generally interwoven into the various components and technical areas of the national programmes (as indicated in various other parts of this report).

The community mobilization programme during 2014 included training and sensitization of in and out-of-school youth across Guyana and focused on: identifying ways in which young people can get HIV/AIDS; sensitizing young people about the ABC of HIV/AIDS prevention; emphasizing the importance of eradicating stigma and discrimination and; equipping the participants with peer education skills. A total of 207 youth (151 females and 56 males) from five (5) Regions of Guyana were trained.

Figure 19 shows the number of persons trained as peer educators during 2009 – 2014.

Figure 19: Number of Peer Educators Trained 2005 – 2014



Source: NAPS Programme Reports

Table 15 below shows the number of peer educators trained by Region.

Table 15: Number of peer educators trained by Region

REGIONS	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	Total
1	-	36	-	25	-	27	26	52	27	45	238
2	21	-	-	-	21	28	0	38	-	-	108
3	31	61	30	26	-	-	-	26	-	-	174
4	21	20	52	153	76	97	38	66	22	27	572
5	-	23	45	-	-	-	-	25	-	-	93
6	-	33	29	30	27	88	56	94	81	70	508
7	-	27	34	-	-	27	-	-	60	-	148
8	-	21	-	-	-	-	-	-	49	-	70
9	-	22	30	-	-	22	32	-	99	34	239
10	-	34	30	-	21	-	-	22	-	31	138
Total	73	277	250	234	145	289	152	323	338	207	2288

During the year, Peer Educators complemented and supported a number of activities implemented by MoH/NAPS. In addition, these Peer Educators also implemented activities independently in their respective Regions, with support from the national programme.

In the effort to update the peer education programme, during 2014 a draft “Standards & Guidelines for Peer Education in Guyana” was prepared and submitted to the Peer Education Committee comprised of representatives from MoH/NAPS, UNICEF and the national Rights of the Child Committee. Arrangements to conduct a study in all ten Regions of Guyana to determine the impact of Peer Education Trainings during the period 2007 – 2013, are also in train.

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.

During 2014, there was a significant scale-up of interventions targeting key populations as a result of increased funding allocations. This was particularly in relation to the refocusing of the Global Fund HIV Grant with its minimum of 50% grant allocation to Key Populations. The signing of the sub recipient agreements with three agencies in Guyana, resulted in the accelerated implementation of interventions targeting key population during the latter half of 2014. The combined efforts of these agencies, have for the first time ensured national coverage to all 10 geographic regions of Guyana.

During 2014, MoH/NAPS continued to coordinate the national response targeting the key affected populations (KAPs) in close collaboration with civil society organizations, NGOs, technical agencies, PEPFAR and other donors. 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, and this package continues to be delivered to KAPs. 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.

During 2014, a curriculum and teaching aids for introducing the new national guidelines and SOPs for working with KPs were developed and master trainers oriented in the use of this curriculum. Quarterly feedback meetings were held with peer educators who reach out to sex workers, MSM, miners and loggers and there were regular feedback meetings among CSOs that provide services to key populations. In addition, with NGO support, GBV education and coping strategies are provided to FSWs, MSM, their clients and partners and the broader community. During the period, a campaign focusing on HIV testing and condom use among MSM and FSWs, included the development of IEC materials with the active involvement of this target group to obtain their inputs into the design of these materials (see section on IEC)

A workshop attended by 22 members of the Lesbian, Gay, Bisexual and Transgender (LGBT) community was also held to increase LGBT activists' knowledge in human rights and advocacy, and to increase their skills in advocating for their rights in monitoring changes in the environment. With NGO support, an LGBT Mental Health Fact Sheet was drafted and finalized, and facts sheets on Human Rights, and Sexual Health were drafted and are being reviewed. The Mental Health Fact Sheet provides basic facts about LGBT persons,

their mental health challenges including double stigma, lack of family support, violence experienced, and internal homophobia. It further highlights the need for emotional support in these situations.

During 2014, training for key populations at higher risk included training for MSMs and SWs (22 from Regions 3 and 4) in Post Exposure Prophylaxis, basics of HIV and positive health and dignity. A two-day training on the MARPS Guidelines and Standards for Non-Governmental Organizations was also held for twenty five (25) MSM and SW peer educators taken from NGOs from 7 Regions. Training was also provided to Monitoring and Evaluation Officers and Prevention Officers (total of 11 from 10 organizations) in the use of monitoring and reporting tools used to capture information relating to SWs, MSM, and Miners and Loggers.

Work continued in sensitising the proprietors of venues (bars, clubs and other places) on HIV prevention. Venues were equipped with brochure holders and IEC materials and condoms were made readily available.

In addressing increased access to clinical services (STI screening and treatment, VIA, VCT and HIV care and treatment), an initiative was introduced in November 2014 and piloted up to December 2014 at the National Care and Treatment Center (NCTC) whereby the hours of service provision were extended beyond the regular working hours (total of 50 extra hours provided). These extended hours specifically targeted key populations through a referral system established with NGOs, with direct accompaniment of clients to the NCTC where possible. An evaluation of this pilot indicated that 7 clients visited and accessed STI screening and treatment. Among these, no one was identified as a member of the key populations.

A major activity during 2014, was the conclusion and dissemination of the findings of the Biological and Behavioural Surveillance Survey (BBSS) which focused specifically on key populations. This was conducted in the effort to obtain data that would guide the design of interventions targeting these populations. The results of the BBSS were shared with key stakeholders during the latter half of 2014 and these are currently being fine-tuned for final dissemination.

Guyana Biological Behavioural Surveillance Survey 2014

Background

During 2014, a Biological Behavioural Surveillance Survey (BBSS) was conducted in Guyana to better understand the dynamics of HIV transmission and in addition, to gauge the level of knowledge of HIV and attitudes and behaviours among key populations. MSM, CSWs, miners, and loggers were specifically targeted. The survey was accomplished through a collaborative effort involving MoH/NAPS, its donor partners, various other MoH departments, and with critical support provided by the Guyana Forestry Commission (GFC), Guyana Geology and Mines Commission (GGMC), and the Guyana Bureau of Statistics (GBoS).

Methodology and sample selection

The PLACE methodology which was used for the survey involved identifying public places (such as hotels, bars, and events) where the target groups met new sexual partners and which were potential intervention venues where individuals most likely to transmit HIV could be accessed. Venues and events were identified by informants within selected communities, then mapped accordingly. The survey sample was selected through a combination of random sampling in addition to the selection of priority locations which were felt to be high risk areas. The locations (venues) were identified by Community Informants and mapped using a GPS device. A comprehensive de-duplicated list of venues was developed and verified. At each venue selected, a knowledgeable person was interviewed followed by interviews of the patrons and workers regarding their sexual behaviours and exposure to HIV prevention measures. Respondents were also offered testing for HIV, syphilis, hepatitis B and haemoglobin. Malaria testing was conducted in the hinterland locations.

During the study, interviews were conducted with 3804 individuals from 153 sites in 9 out of 10 administrative regions. These included: 2,248 males; 1,435 females; 2 trans males and; 119 trans females. In terms of key and other vulnerable populations, the study sampled: 530 sex workers (both male and female); 545 MSM (including transgender) and; 1417 miners and loggers

Survey questions focused on: socio-demographic characteristics; mobility and employment of the target populations; knowledge and use of health services and; sexual partnerships and condom use. All ethical study procedures were adhered to and confidentiality maintained throughout the study, including the omission of names or other explicit identifiers in the questionnaires given the sensitive nature of many of the questions administered.

Findings

HIV prevalence was found to be highest among transgenders with an overall prevalence of 8.4%. Transgenders involved in sex work had an even higher prevalence at 10.4% while those not involved in sex work were found to have a prevalence of 4.8%. FSWs had the second highest prevalence at 5.5% followed by MSWs at 5.13%. MSM were next with a prevalence of 4.9% while loggers had a prevalence of 1.3% and miners had the lowest prevalence at 1%.

The general findings of the survey were as follows:

Use of health services: Respondents felt that health services were more widely available in the Coastal Regions and approximately 50% of those in the Coastal Regions knew of HIV/AIDS treatment services in their area. In comparison, 1 in 10 of the respondents in the Hinterland Regions reported knowing of the availability of these services within their regions and less than half felt that the available general health services met their needs. Study participants were more likely to have visited a public health facility within the past year compared to any other type of health facility.

HIV knowledge and attitudes: Populations from smaller and more rural villages from randomly selected areas within the Coastal Regions had a lower knowledge of HIV prevention measures and had common misconceptions about HIV. Knowledge of condoms as prevention was high throughout Guyana however, only 3 out of 4 persons knew that abstinence can prevent HIV transmission. Approximately 1 in 10 persons in the larger towns and cities experienced stigma and discrimination regularly because of their HIV-positive status, being LGBT, or being a minority.

Sexual partnerships and behaviour: 30% of men, 20% of women and 50% of transwomen reported at least one new sexual partner within the four weeks preceding the survey. Vaginal sex was the most common form of sex with oral and anal sex reported in much smaller proportions. Approximately 1 in 5 men in the larger towns and cities and HIV priority areas reported having sex with men within the past year compared with 1% of men within the Hinterland Regions. Commercial sex (receiving cash or gold for sex) within the past 12 months was reported by 12% of men and 15% of women in the larger towns and cities. Approximately 1 in 5 men in the Hinterlands paid for sex within the past three months.

HIV prevention: Condom use as prevention was common with nearly half the respondents having used a condom within the last six months and approximately 1 in 4 reported having used a condom every time they had sex in the past six months. 33% of the survey sites were seen by the interviewers to have condoms for distribution and one quarter of the site informants said that there was HIV testing onsite within the past year. Knowledge of where to access VCT was 80% in the Coastal Regions compared to 68% in the Hinterlands. Despite this, similar rates for having ever been tested were found among these populations. HIV information was widely available to respondents with 95% of Coastal respondents having received some form of information within the past year compared to 86% in the Hinterlands.

Sexually transmitted infections: More than 1 in 10 respondents reported at least one symptom of an STI during the time of the interview. Of those who sought treatment, most did so within their respective regions however but 2 out of 5 persons in the Hinterlands sought treatment in another region or country.

HIV prevalence: HIV prevalence was found to be highest in the larger towns/cities (2.4%) and the HIV priority areas (1.9%). The highest HIV prevalence rates were found among transgender respondents with rates as high as 30% in the priority areas. Higher prevalence rates were also found in the larger towns and priority areas among MSWs, FSWs and MSM in comparison to the randomly-selected sample areas and the Hinterlands.

Limitations of the study

Limitations to the survey included: the reluctance of some members of the key populations to report behaviours that are seen as stigmatizing or illegal, thus avoiding participation in the survey; some persons who knew themselves to be HIV positive might have avoided being interviewed because they did not want to be tested again and; members of the target populations who did not visit the survey sites would have been missed during the survey.

Men who have sex with men

The results of the 2014 BBSS indicated that HIV prevalence among MSM had decreased from 21.2% in 2005 to 4.9% in 2014. HIV prevalence among male sex workers was found to be 5.1% in 2014 and condom use was low when with clients (52.4%). HIV prevalence in both these groups was still high when compared with that found in the general population.

Other findings of the survey among MSM indicated: approximately 66% knew of the three methods of prevention; misconceptions existed regarding HIV transmission; 84% did not feel stigmatized; approximately 33% had an HIV test during the previous 12 months; the majority of MSM obtained their HIV/AIDS information from the media, friends and family; approximately 21% were victims of physical violence from their partners or were raped and; a large proportion acknowledged having a low or no HIV risk perception.

Due to the significant scale up of interventions aimed at MSM during 2014, there was a 382% increase in MSM reached (2,629) with HIV prevention programmes, when compared with 2013 (see Box 7). With NGO support, interventions focusing on (MSM) during 2014 were mainly through the “Path for Life” initiative which aims to prevent the spread of HIV/AIDS among MSMs and the rest of the population.

Peer education was used as the primary mechanism through which MSM were reached and fifteen (15) new MSM peer educators were trained. In addition to direct service delivery through community mobilization and outreach sessions at bars, brothels, night spots and street corners where MSM congregate, significant efforts were made at targeting the proprietors of these venues who were sensitized on HIV, STIs and stigma reduction. These proprietors also became involved in the distribution of IEC materials and condoms on behalf of MoH. The main objectives of these interventions were to advocate for behavior change and to educate on risky behavior and its association with HIV and STIs. To complement these behavior change activities, the local radio series drama *Merundoi*, also included educational messages for MSM.

**Box 7: MSM
population reached
2009 - 2014**

Year	MSM
2009	1,375
2010	1,354
2011	763
2012	722
2013	597
2014	2,629

HIV testing for MSM remained a priority for the programme in 2014 with 1,945 MSM being tested, even though challenges were encountered in getting this population to seek VCT services.

In the effort to build their capacity to earn, computer training was provided to 6 MSM (and also SWs). In 2014 the first national forum on Prevention for MSM was hosted with thirty seven (37) MSM from seven (7) Regions in attendance. Topics included: Update the HIV Epidemic; the UNAIDS Gap Report; 90-90-90 Targets; Myths about MSM and Transgenders; Healthy Living; Substance Abuse and; New Strategies for Reaching MSM. Group discussions on barriers to testing, myths about MSMs and strategies to dispel these myths were also held. A major outcome of the conference was the consensus to use the

feedback from these discussions to develop a workplan to address the challenges encountered by MSM.

During 2014, a Mini Consultation with White-Collar MSM was also held with 18 members of the white-collar community (media personnel, senior public servants, business professionals, lawyers, etc.) to discuss and document strategies to reach white-collar MSM, their peers and partners with holistic HIV services. The sample of attendees was selected based on the considerable influence and social reach that they have within society. During this consultation, effective strategies for meeting and engaging the rest of this MSM sub-population were devised.

Female sex workers

The BBSS 2014 showed a sharp decrease in the HIV prevalence among female sex workers (FSWs), from 26.6 percent in 2005 (BBSS 2005) to 5.5% in 2014, even though this was still relatively high when compared with the prevalence within the general population. Other findings of the survey among FSWs revealed: comprehensive knowledge of HIV had decreased; condom use decreased when with clients; alcohol used decreased; STI reported symptoms decreased and; engagement in anal sex had increased.

Due to the significant scale up of interventions aimed at FSWs during 2014, there was a 150% increase in FSWs (3,327) reached with HIV prevention programmes, when compared with 2013 (see Box 8).

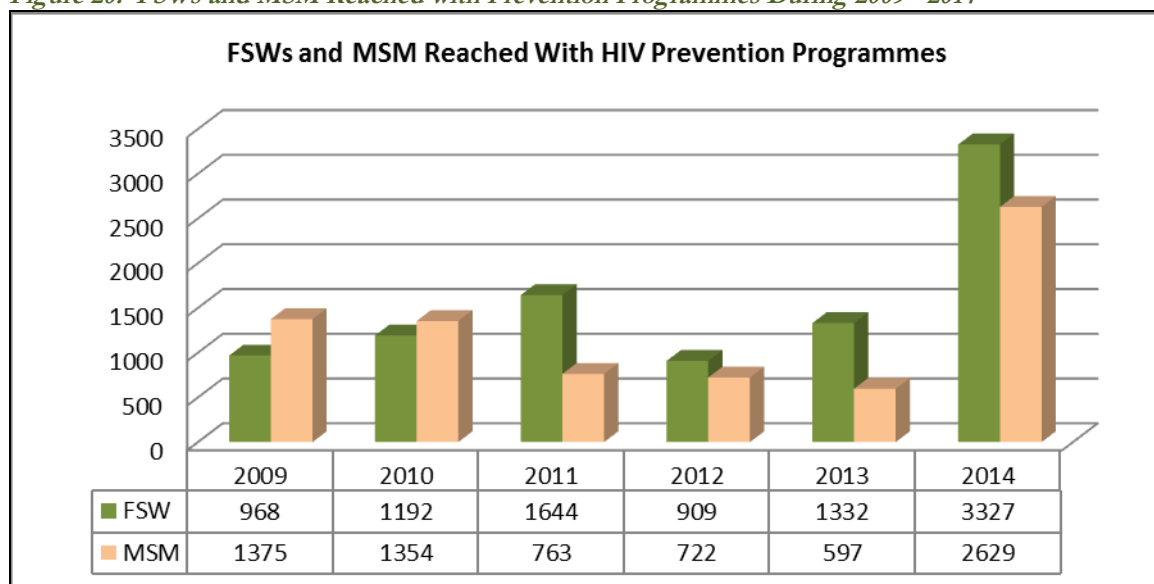
During 2014, interventions focused on female sex workers (FSWs) through the “Keep the Light On” initiative which aims to prevent the spread of HIV/AIDS among FSWs and the rest of the population. Peer education was used as the primary mechanism for reaching FSWs and activities also included community mobilization and outreach sessions at bars, brothels, night spots and street corners where FSWs congregate. The proprietors of these establishments were also sensitized with regard to HIV, STIs and stigma reduction and were engaged in the distribution of IEC materials and condoms on MoH behalf. The main focus was to advocate for behavior change and educate on the risky behavior and its association with HIV and STIs. The local radio series drama, Merundoi also targeted CSWs in providing educational messages.

**Box 8: FSW
population reached
2009 - 2014**

Year	FSW
2009	968
2010	1,192
2011	1,644
2012	909
2013	1,332
2014	3,327

HIV testing for SWs remained a priority for the programme in 2014 with 2,430 FSWs being tested. The building of capacity to encourage behavior change among Sex Workers also continued to be a priority in 2014 with skills building activities such as craft production (5 sex workers) and computer training being provided (6 MSM and SWs). In order to sensitive sex workers about their rights to representation in matters involving the police, court and in instances of violence, a workshop on Human Rights, HIV and Sex Work was conducted with nineteen (19) CSWs in attendance.

Figure 20: FSWs and MSM Reached with Prevention Programmes During 2009 - 2014



The promotion of correct and consistent condom use remains a key component of the prevention package designed for the key affected populations at higher risk. During 2014, a total of 697,905 male condoms, 22,266 female condoms and 76,294 lubricant packets were distributed among these populations.

Figure 21: Regional Distribution of Condoms/Lubricants Among Key Populations

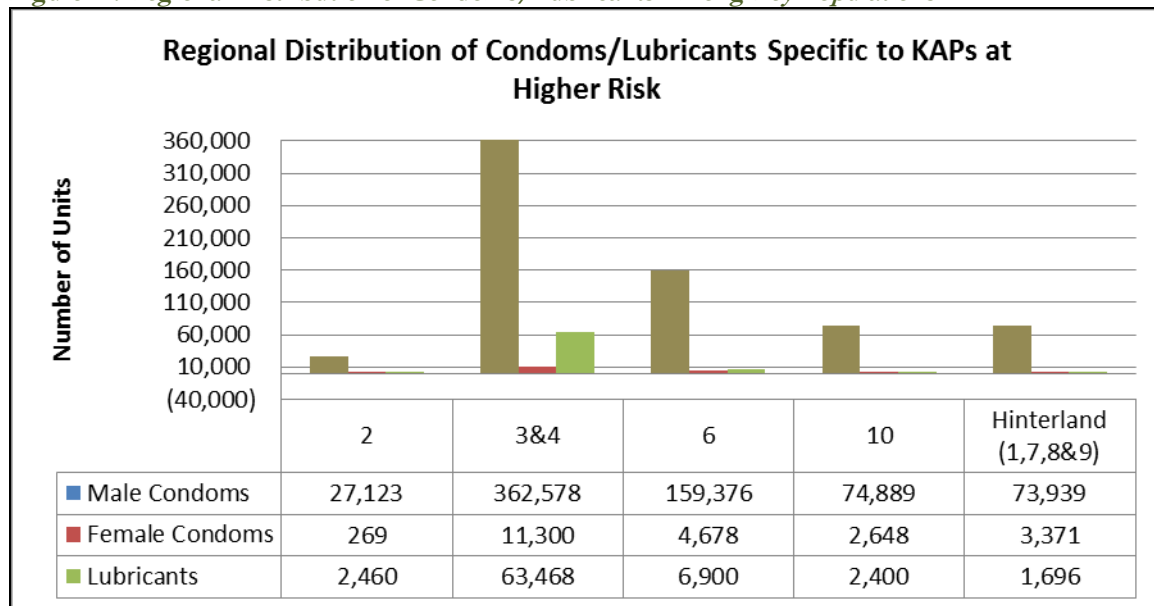


Table 16 below presents a list of the organizations that provided services to key affected populations during 2014.

Table 16: Organizations that Provided Services to Key Affected Populations during 2014

Organization	Regions	Target Populations
Cicatelli Associates Incorporated	2,3,4,5,6,10	FSWs, MSM
International Organization for Migration	1,7,8,9	Miners & Loggers
Guyana Business Coalition	3,4,6,10	FSWs, MSM, Miners & Loggers
Youth Challenge Guyana	1,7,8,9	FSWs, Miners & Loggers
G+ Network	3,4	PLHIV, FSWs, MSM
Artistes in Direct Support	3,4	FSWs, MSM, Transgenders
Hope For All	1,2	FSWs, MSM, Miners & Loggers
SASOD	4,6	MSM
Guyana Sex Work Coalition	3,4,6,10	SWs
Guyana Trans United	3,4	Transgenders, MSM
Hope Foundation	7	FSWs, MSM, Miners & Loggers
FACT	Upper 6	FSWs, MSM
United Bricklayers	5, Lower 6	FSWs, MSM
Linden Care Foundation	10	FSWs, MSM, Miners & Loggers
Merundoi	3,4,5	General Population

Interventions among the transgender groups

During the 2014 BBSS, HIV prevalence among the transgender population was found to be 8.4%. Other findings revealed that: 35.9% had a low perception of HIV infection; the average age of sexual debut was 15 years; 23.3% were not stigmatized; 3.7% use illicit drugs; 76.8% solicit commercial partners and; 41.2% were tested within the previous 12 months.

HIVision 2020 recognises the transgender groups as a key population and identifies them for strategic intervention. The Trans Guyana United group formed during the previous reporting period, continued to conduct HIV sensitization and prevention activities during 2014. During the reporting period, 4 transgendered persons were reached with the prevention package of services including peer education, risk reduction counseling, promotion, demonstration and distribution of condoms and water-based lubricants.

United Bricklayers Reaches Key Populations through Peer Networks and Social Media

Reaching MSM, transgenders and sex workers with HIV prevention education and early care is difficult because of the high levels of stigma and discrimination they experience. Fear of moral judgements and abuse make them reluctant to seek help when the price of help is disclosure of sexual behaviours that the society considers immoral and illegal. There is however, a growing body of evidence that suggests that outreach through social media is a promising strategy for reaching key populations, particularly when it is rooted in peer networks. This type of approach can offer anonymity (which engenders truthfulness/trust); endorsement of key populations-friendly services and; user-led two-way communication.

United Bricklayers (UBL), an NGO actively involved in HIV prevention among MSM, transgenders and CSWs in Regions 5 and 6 Guyana, ventured into the use of social media as one of its approaches for reaching transgenders and MSM in January 2014. In initiating this venture, UBL NGO worked with an already established social network of transgenders and

MSM via Facebook to host weekly two-hour chats which integrate HIV prevention information into the discussions of everyday topics important to MSM and transgenders.

Through the use of social media, UBL has been able to provide greater assurance of privacy to MSM and transgenders and to respond to the broad health concerns of these groups – beyond their individual sexual risk behaviour. Topics discussed include gender enhancing hormones, sources of lubricants, VCT, relationships, and suicide. Opinion leaders inform peer groups on how to stay HIV-free and where to find services that are LGBT-friendly.

A small, even though early measure of success for UBL, is that the group chat receives repeat visitors who in turn refer others to join (eleven such referrals made at the time of writing). UBL also invited chat members to join their support group which 3 of the 10 chat members have since done while 2 others have indicated their intention to join. UBL's venture with the social media is still relatively new, however these preliminary results with the 10 chat members are encouraging. Their experience suggests that online platforms can be promising avenues for engaging key populations in learning more about HIV prevention, care and treatment.

Interventions Targeting Miners and Loggers



The 2014 BBSS revealed an HIV prevalence among miners of 1%. Whilst the methodology of this survey is not comparable, this BBSS is seen as a more representative survey than the HIV Seroprevalence survey conducted among miners in 2004 which revealed an HIV prevalence of 6.5%

Loggers showed a prevalence of 1.3% (BBSS 2014). Other findings during the survey among miners and loggers revealed:

secondary education was high among this group; miners showed greater knowledge of HIV than loggers; miners consumed alcohol more frequently than loggers; circumcision was practiced by both miners and loggers; marijuana use was higher among miners than loggers; health facilities, family members and the media were the main sources of HIV information for miners and loggers.

During 2014, services to miners and loggers continued to be provided by health care facilities and the CSOs primarily through outreaches in the hinterland regions where mining and logging activities dominate. The Ministry of Health through its Global Fund HIV Grant signed a sub recipient agreement with the International Organisation for Migration to work with miners and loggers in regions 1,7,8 and 9. During 2014 a total of 1,895 miners and

loggers were reached with HIV prevention programmes while a total of 3,129 miners and loggers were tested for HIV.

Training for miners and loggers was conducted in mining camps in 4 Regions through outreaches and miners and loggers also attended a two-day workshop covering a broad range of topics including: HIV and STI Education; Stigma and Discrimination and; Risk Reduction.

Project to Improve Access to HIV Services for Mobile and Migrant Populations

During 2014, the Government of Guyana with support from PANCAP/GIZ continued implementing a Migrant Population Project to enhance the accessibility and the quality of HIV prevention, care and treatment services for migrant and mobile populations. This project was being implemented in 7 pilot countries within the Caribbean, including Guyana. The Migrant Population Project consists of four components: policy guidelines & legal framework; health financing mechanism; empowerment of organizations supporting migrants and; improvement & adaptation of HIV services to targeted populations. The broad-based Technical Working Group (TWG) established for this project continued to meet during 2014. The TWG comprised focal persons from: NAPS; Ministry of Amerindian Affairs; National Malaria Programme; National Tuberculosis Programme; Ministry of Health; PAHO-WHO; Guyana Bureau of Statistics; Guyana Geology & Mines Commission; Guyana Forestry Commission; and Institute of Migration; Guyana Red Cross; and Youth Challenge Guyana.

Among the activities identified for the Migrant 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. During 2013, an assessment of “The Legal and Policy Framework Influencing Access to HIV Services by Migrants in Guyana” was conducted. In addressing sustainability of the HIV response with specific focus on access to services to the migrants and mobile populations, Innovative Health Financing Mechanisms were explored and options recommended. These two reviews are currently under consideration by the Ministry of Health.

As part of the Empowerment of Organizations Supporting Migrants, a training of trainers manual on “*Stigma, Discrimination, Cultural Sensitivity and Human Rights Related to Health and Migration*” was developed in 2013 and finalized in 2014 for the pilot countries under this project. Validation training using this manual was conducted in Guyana during January 2014 with trainers from these countries. Participants included immigration officers, the Police, health care workers and personnel from NGOs that interact with migrants. Subsequent to this validation training, with the use of the manual, four (4) sensitization training workshops (60 persons trained) and one training of trainers workshop (14 persons trained) were conducted in Guyana through a collaborative effort with the funding partner, NAPS and an NGO.

With regard to Improving and Adapting HIV Services to Targeted Populations, the Bartica Hospital, representing a gateway to the mining and logging communities, was selected in

2014 as a pilot site. In July 2014 a baseline survey was conducted to assess the accessibility to health services (including HIV services) for these populations. An action plan was then developed based on recommendations made by members of mobile/migrant population and the hospital staff. The focus of the action plan was to address the needs of both the hospital staff and patients in the attempt to provide migrant-friendly services - in particular to the relatively large proportion of Brazilians who comprise the migrant population. As part of the action plan, training was conducted for the hospital staff in Customer Service Excellence (32 persons trained), Basic Portuguese (34 persons trained), and HIV-related topics (34 persons trained). Wallcharts targeting patients were also developed in English and Portuguese for posting up in the hospital waiting areas.

Under this project, the BBSS 2014 was also supported for miners and loggers (see findings in section above).

Interventions Targeting Prisoners

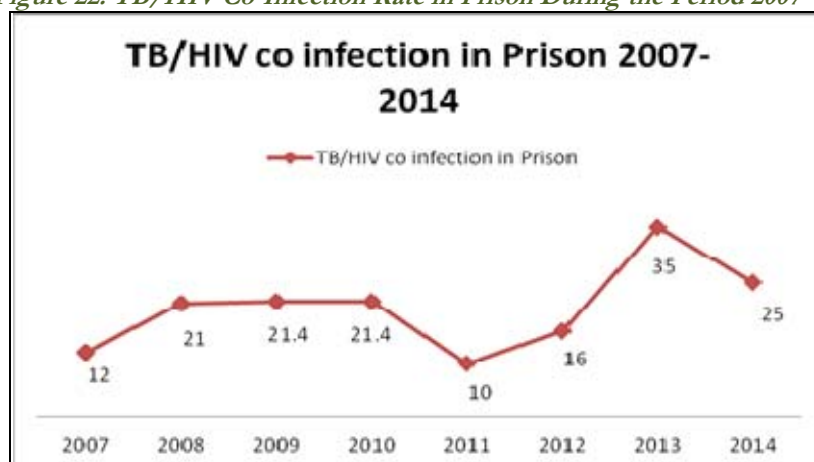
HIVision 2020, National HIV Strategic Plan (2013 – 2020), identifies prisoners among the key populations at higher risk and aims to provide strengthened HIV prevention, care and treatment services for this population in the effort to ensure equitable access to health services. HIV prevalence among prisoners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

During 2013, a permanent VCT site was established within the Camp Street Prison, the largest prison in the country. VCT was provided to 502 inmates of this prison through a VCT visiting team. In addition, a team comprising a physician, social worker and a multipurpose technician/phlebotomist made monthly visits to this prison to provide treatment, care and support for HIV positive inmates. Inmates from two other prisons outside of the city were also brought to this prison for treatment. Through this system, 33 prisoners were provided with HIV care and treatment. Prisoners from other parts of the country were escorted to the treatment sites nearest to their prison to obtain treatment.

As part of the package of services provided to prisoners, TB and TB/HIV co-infected patients are routinely monitored by the TB/DOHS prison supervisor who oversees all TB control activities in correctional facilities country-wide. Inmates are screened for TB upon entry into prison and screening is also conducted periodically. During 2014, three TB Collaborative Meetings for Prisons were held with key stakeholders from MoH and representatives from the correctional facilities.

During 2014, 51% of 2,023 prisoners were screened for TB and 12 were diagnosed with TB disease. Of these 3 (25%) were found to be co-infected with HIV. Figure 22 shows TB/HIV co-infection among prisoners.

Figure 22: TB/HIV Co-Infection Rate in Prison During the Period 2007 – 2014



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 demonstrated that knowledge of HIV was reported at over 95% (BBSS 2005, BBSS 2009) among youth. Further findings however indicated that this knowledge does not necessarily translate into behaviour modification as evidenced by the decrease in age of sexual debut from 15 to 14 (BBSS 2005, BBSS 2009).

Data from the National Care and Treatment Center (NCTC) in Region 4, which is the main sentinel site for monitoring STIs, showed the highest occurrence (42%) of STIs during 2014 to be among the 15-24 years age group. 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 and other stakeholders continued to target the youth population.

A draft Sexual and Reproductive Health Policy and Strategy developed during the reporting period and which is currently being finalized, provide overall guidance for the provision of a basic package of SRH services to youth among other age groups. These services include: adolescent sexual and reproductive health; family planning; pregnancy-related services; HIV prevention and diagnosis and treatment of STIs; prevention and early diagnosis of breast and cervical cancers; and care for survivors of gender-based violence. The strategy also addresses the integration of HIV prevention, management and care into SRH services.

During 2014, the Adolescent Health Unit of MoH continued to engage adolescents in activities to educate them on sexual and reproductive health, healthy lifestyles and in increasing access to essential services through the promotion and implementation of adolescent friendly services.

As part of the Youth Friendly Services Initiative, the 6 pilot health centres previously established along with 1 District Hospital provided adolescent-friendly antenatal services to 151 pregnant adolescents. In addition to the routine antenatal services, these adolescents were educated 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.

In focusing on Health, Literacy, Attitude and Behaviour, the Adolescent Unit during 2014: provided sports equipment to 3 dormitory schools within the hinterland with the aim of encouraging sports as a form of healthy living as part of the initiative introduced during 2013; participated actively along with a wide cross-section of stakeholders in Water and Sanitation and Hygiene (WASH) the review of the Health and Family Life Curriculum implemented in schools, to introduce changes in the content and teaching methods employed; collaborated with the Ministry of Education in training teachers in Region 4 to address Drug Use Among the in-School Population and; provided active support to the 18 School Health Clubs established in Regions 3,4 and 10 in addition to training 24 teachers from these Regions.

During 2014, in the effort to educate parents, teachers and other stakeholders on how to respond to the health needs of adolescents, training activities included: focus group discussions with teachers in 4 hinterland areas to discuss the topic of teenage pregnancy; 4 trainings in Adolescent Health in Region 1 and one training in Region 9 with the participation of Community Support Officers, Teachers and School Welfare Officers and; training of 68 health care professionals and 32 peer educators from Regions 4 ,5, 6 and 10 in Adolescent Sexual and Reproductive Health.

The Ministry of Education's Health and Family Life education (HFLE) programme that was piloted during the 2010-2011 reporting period, continued during 2014 with its implementation in all secondary schools across the country. The programme was implemented as a time-tabled subject 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. An extensive review of the HFLE programme was undertaken in 2014 by a wide cross-section of stakeholders to examine the progress achieved by the programme and to plan the way forward.

In support of the HFLE module on sexual and reproductive health, the YES programme (Youth Educators Safe-Guarding our Work Force) also continued during 2014. 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 were conducted weekly by young adults in schools in Regions 3, 4, 6 and Georgetown, targeting 1,168 students in providing HIV/AIDS education.

The Ministry of Education continued to train and sensitize head teachers, teachers and sector management staff on issues related to HIV&AIDS. HFLE teacher training was conducted for 37 primary school HFLE teachers from across the regions and 310 pre-service teachers. Teaching materials were provided during these training sessions. In addition, 2146 pieces of HIV resource materials were made available to teachers within the MoE system to be used in classroom discussions and for parent-child HIV education.

The Guyana Responsible Parenthood Association (GRPA) whose focus is on providing sexual and reproductive health services, during 2014 provided family planning services for 1190 persons of child-bearing age, performed STI screening for 692 persons and provided STI counseling for 801 persons.

During 2014, three Capacity Building Workshops were held in the areas of Sexual & Reproductive Health, Gender Based /Sexual Violence and Advocacy Skills and Techniques to enable youth organisations to integrate SRH and GBV/Sexual Violence into their programmes. In addition, 28 persons between the ages of 15 - 24 participated in a Youth Advocacy Workshop on family planning, contraceptive modalities and the need for Comprehensive Sexuality Education. Twenty eight representatives from Faith Based Organizations were also engaged in a discussion on the importance of family planning and their role in promoting this within their communities. Through collaboration with partner agencies and NGOs, the national programme, reached approximately 3,000 persons within the 15-49 age group in 14 communities in Regions 2,3,4,5 and 6, with family planning information and services. Of these, approximately 1,500 were persons among the 14-35 age group. Twenty Community Facilitators and sixty nine health care workers from the targeted communities benefited from Capacity Building training to deliver the family planning information and SRH services.

Prevention of Gender Based Violence

Within recent years, 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 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 MoLHS&SS 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.

The Men's Affairs Bureau that also forms part of the MoLHS&SS 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.

During 2014, 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. During the reporting period, 140 Nursing students were trained in the new Sexual and Domestic Violence Protocol for health care providers. Life skills training using the HFLE training modules on violence prevention, was also provided to 228 students during football competitions and 31 students through essay writing and a poetry competitions. GBV sensitization sessions were held with 99 fathers using the tools developed by the Ministry of Human Services for addressing GBV. In addition, 4 Public Service Announcements in the form of television advertisements, were developed and aired.

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. The Guyana Responsible Parenthood Association, one such entity, provided gender based violence screening and counseling for approximately 3,500 persons during 2014. Help & Shelter, another 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. Help and Shelter's mission is to work towards the elimination of violence in all its forms. During 2014, Help and Shelter provided services to 8000 persons – mostly women who were in abusive relationships. The organisation also ensures that the public is adequately educated and sensitised on the issues of abuse and domestic violence.

Other key Initiatives Implemented Under the National Prevention Programme

Workplace Programme

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. These Regulations seek 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 thrust of the workplace programme within recent years has been to propel enterprises towards sustaining their own programmes through the implementation of comprehensive health and wellness programmes which include addressing issues such as HIV, promotion of human rights and social security, and gender based-violence including male norms and behaviors.

A wide range of public and private sector organizations continue to benefit from workplace education programmes implemented by the Ministry of Labor. This Ministry continued to

be proactive at its weekly Training and Educational Awareness programmes for Employers, Trade Unions and Informal sectors in heightening and sensitizing key stakeholders on HIV/AIDS in the workplace. A total of thirty (30) sessions were held at the Ministry of Labour and other locations with the participation of over three hundred persons. These sessions allowed for discussions on negative behaviour, behavior change, and the knowledge and skills required to address these. Training on HIV/AIDS was also tailored to assist persons in understanding the dynamics involved in implementing an HIV in the workplace programme.

The Guyana Business Coalition on HIV and AIDS (GBCHA) which has a membership of over 47 companies, continued to be a key agency in supporting the HIV workplace programme in keeping with Guyana's National HIV Policy. Prevention programmes were planned and implemented by both the Secretariat staff and peer educators within companies to highlight issues related to HIV and gender based violence. These activities included awareness sessions, trainings for peer educators, peer educator support group meetings, health fairs, HIV testing and counselling, and the distribution of condoms and HIV information brochures distribution. GBCHA also partnered with Help & Shelter and the Ministry of Human Services & Social Security to raise awareness among workplaces on violence. During 2014, the Coalition made significant strides in responding to general health and wellness workplace programmes for member organizations and partnership with the Ministry of Health is being expanded to increase understanding on the issues of diabetes, heart disease and other diseases affecting Guyanese.

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 19 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 are also provided for free distribution to the public. Staff of the supermarkets also wear T-shirts with HIV messages as a strategy to create greater HIV awareness among customers. During 2014, an awareness session on Modes of HIV Transmission and Stigma and Discrimination was conducted for the popular opinion leaders of three of the participating supermarkets.

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. 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 as was evidenced during the previous tabling in Parliament of the HIV and AIDS Regulations that sought to enforce the National Workplace HIV and AIDS Policy.

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. Over the years, mass media efforts appear to have had some impact 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. There are ongoing efforts within the health sector to incorporate stigma and discrimination modules in all pre-service training curricula for health care personnel. In addition, 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. During 2014, a number of members of the Guyana Defence Force were trained as trainers to address stigma and discrimination.

During 2014, the findings from a rapid assessment on HIV stigma, discrimination and GBV against PLHIV, MSM, FSWs and women in general were shared with a wide cross-section of stakeholders. Resulting from this forum, a number of recommendations were offered for reducing stigma, discrimination and GBV under two thematic areas — New Structural Directions and New Programmatic Directions.

During 2014 forty seven (47) health care workers of different categories from Regions 2 and 3 received training in stigma and discrimination which focused on: positive health and dignity; understanding stigma and discrimination; real life experiences; attitudes to MSMs and Sex Workers; personal values and behavior toward PLHIVs and; the needs of health care workers. In addition to this training, a one-day activity on Stigma and Discrimination and its effects on marginalized populations seeking health care, was also held for health care workers of different categories at the Regional Hospital in Region 3.

During 2014, Stigma and Discrimination Awareness sessions were conducted with health care workers and CSWs at three hospitals in the hinterland area of Region 1. These were done in collaboration with a donor and NGO partner and the main objective was to support the institutional strengthening of primary health care providers to improve access to services in underserved communities, including among adolescents and marginalized groups. The participants for these sessions were staff of different categories of these hospitals. Topics included HIV/AIDS related Stigma, Discrimination and Confidentiality. Upon conclusion of these sessions, each hospital was presented two plaques: “Stigma and Discrimination Policy” and; “Code of Ethics”. A suggestion box was also presented to each hospital. During each of these hinterland trips, outreaches were also conducted within the surrounding communities and interactions were held with CSWs, miners, shopkeepers, youths, and the Police to provide education on HIV/AIDS and to offer VCT.



Wall Plaques and suggestion box being presented to Doctor in Charge of the Matthew's Ridge Hospital, Region 1

An interactive session involving role play and focusing on Stigma and Discrimination, was also held for members of key populations groups. At both of these sessions, persons recounted their personal experiences with stigma and discrimination.

Justice for All Programme

In response to the compelling epidemiological evidence that key populations continue to be vulnerable to HIV, PANCAP in collaboration with UNAIDS, mounted a programme of activities, which is continuing, under the theme, Justice for All (JFA). The aim of the programme is to promote activities consistent with the United Nations Universal Declaration of Human Rights to which all countries are committed. More specifically, it is intended to achieve one of the goals of the United Nations High Level Meeting Political Declaration (2011) to eliminate stigma and discrimination against people living with HIV by 2015, and to uphold the human rights and dignity of all. Phase 1 of the programme involved a series of National Consultations in Grenada, Guyana, Jamaica, St. Kitts and Nevis and Suriname, and a Caribbean Consultation on Justice for All and Human Rights Agenda involving Parliamentarians, Faith-based leaders, Youth, Private Sector and Civil Society Leaders. Outcomes of the Caribbean Consultation was a PANCAP Justice for All Roadmap 2014-2018 and a PANCAP Declaration: Getting to Zero Discrimination through Justice for All.

During 2014, CARICOM Heads of Government reviewed the PANCAP Declaration of "Getting to Zero Discrimination Through Justice For All" and agreed to defer full consideration pending consultations at the national level. At the 2014 Special Council for Human and Social Development (COHSOD), PANCAP provided an update on the Justice for All initiative which also highlighted important considerations for continuing discussions, especially in light of the upcoming transition from the MDGs to the SDGs. It was agreed that PANCAP should continue the consultations on the JFA proposals at the national and regional levels to clarify issues, especially those related to eliminating discriminatory laws. It was also agreed that the JFA discussions should take into consideration the developments arising out of the 20th International AID Conference, in particular the UNAIDS 90-90-90 goals and that the elements of the JFA Declaration be revised accordingly. In keeping with this decision, PANCAP will begin a second wave of national consultations in Belize and Trinidad and Tobago in January 2015.

While retaining its original elements, the JFA initiative now focuses on: What will it take to end AIDS by 2030?; what role can stakeholders – parliamentarians, faith leaders, civil society, private sector, youth and media – play to achieve the goal of ending the AIDS epidemic? and; What would a road map look like with immediate, medium and long term actions to end AIDS?; Five major elements of a proposed JFA roadmap are now included: 1. paying attention to family life and those in need; 2. accelerating affordable treatment as an important ingredient of 90-90-90; 3. eliminating gender inequality including violence against women and girls; 4. promoting sexual and reproductive health and rights. Including education at all levels; and 5. addressing legislative and other reforms to eliminate AIDS related stigma and discrimination.

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. included components on HIV prevention and reduction of stigma and discrimination.

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.

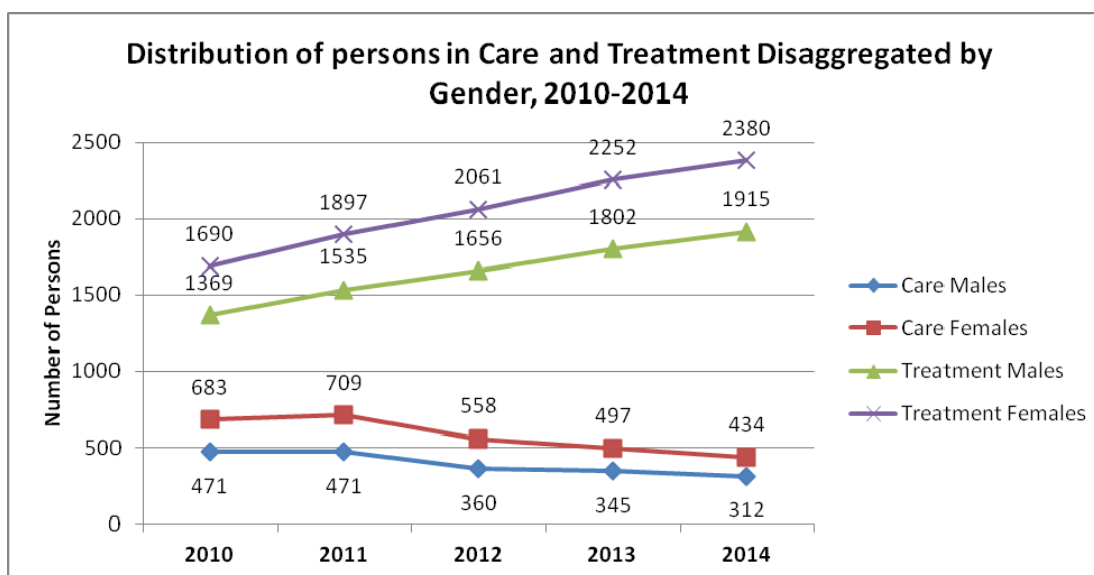
The HIV Treatment and Care Programme

During 2014, HIV treatment and care continued to be provided at 22 treatment sites across the 10 Regions of Guyana. Efforts also continued to integrate the HIV treatment programme within the general health services.

As at end of December 2014, the total number of persons enrolled in the national care and treatment programme stood at 5,041 persons (55.8% females and 44.2% males) compared to 4,896 (51.1% females and 48.9% males) in 2013. Of the persons enrolled, 3.5% (174/5,041) were children compared to 3.2 % in 2013. Figure 23 below shows the trend in enrollment by gender during the period 2010 – 2014.

During 2014, there were 605 new enrollments, including 17 children. The National Care and Treatment Centre (largest treatment site) enrolled 26.3% of these persons, 49.9% were distributed among 16 other government treatment sites, and the remaining 23.8% were distributed among the two private hospital treatment sites.

Figure 23: Persons in Care and Treatment Disaggregated by Gender, 2010-2014

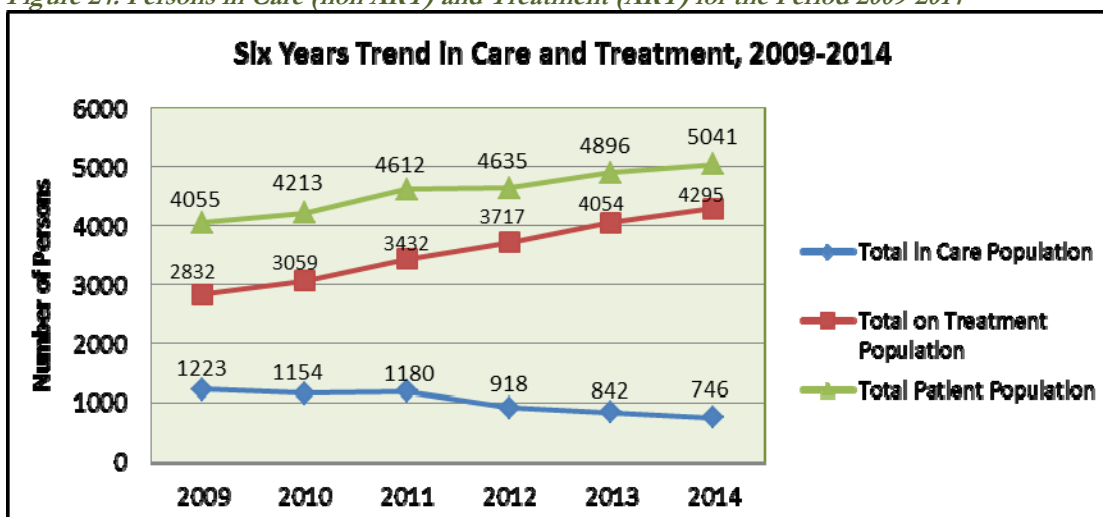


Source: NAPS Programme Reports

In 2014, the number of persons receiving antiretroviral therapy was 4,295 (85.2% of HIV patients) compared to 4,054 (82.8% of HIV patients) in 2013. 174 (4%) of the recipients of ART in 2014 were children. Of the persons on ART in 2014, 88.4% were on first line therapy compared to 89.6 % in 2013. 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 11.6% (497/4,295) in 2014, with only a slight drop (8.9%) in 2011. Of the 497 patients receiving second line therapy in 2014, adults account for 470 while children account for the remaining 27.

Figure 24 below shows the trend in care (non ART) and treatment (ART) for the period 2009 – 2014.

Figure 24: Persons in Care (non ART) and Treatment (ART) for the Period 2009-2014



Source: NAPS Care and Treatment Report 2014

Table 17 below shows the number of persons on ART during the period 2003 (ART commenced in Guyana from 2002) to 2014.

Table 17: Persons on ART for the Period 2003-2014

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
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	4,295
Increase over previous year	NA	374	505	609	354	508	359	227	373	285	337	241
Percentage (%) increase over previous year	NA	304	101	60.7	21.9	25.8	14.5	8.0	12.2	8.3	9.1	5.9
Number of persons on 2nd line ARVs	NA	NA	NA	58	69	169	262	296	305	375	441	497

Source: NAPS Care and Treatment Reports

National Cohort – Survival and Retention on ART

The 2013-2014 national cohort report revealed 536 persons were initiated on ART with 81.2% (435/536) 12 months survivability and retention on ART. This represents a slight increase from the 79.7% reported for the 2012-2013 cohort. Of the remaining 18.8%, mortality accounted for 5%, those who stopped treatment accounted for 6% and 7.8% were lost to follow-up. Box 9 shows the survivability and retention on ART by gender and age group for the national cohorts during the period 2010 - 2014.

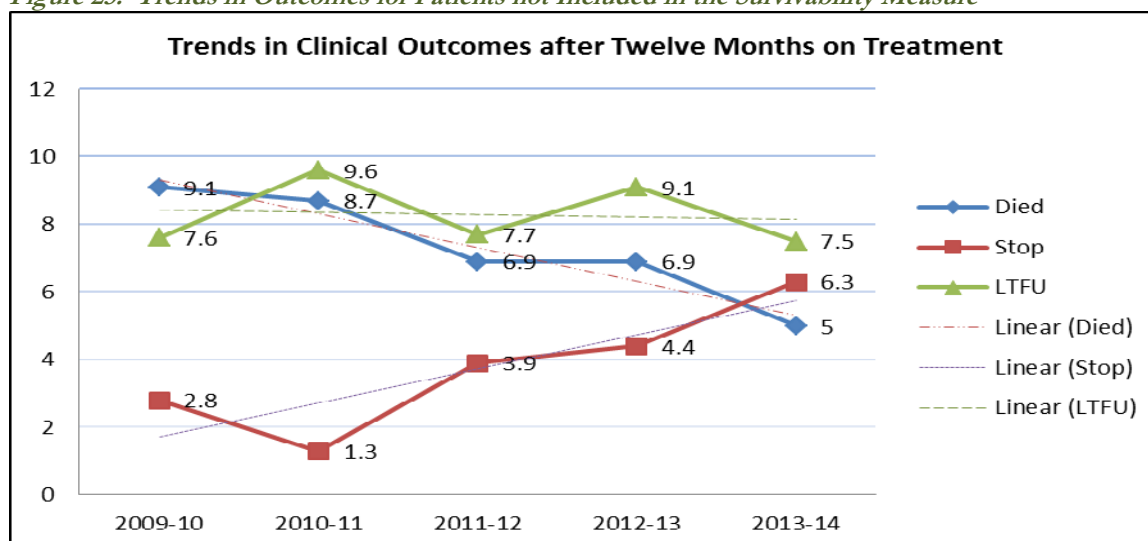
Box 9: Twelve month Survivability among the National Cohort (%)

Indicators	2009-2010	2010-2011	2011-2012	2012-2013	2013-2014
Total	80.7	80.4	81.5	79.7	81.2
Adult Male	77.3	76.9	80.8	78.8	82.8
Adult Female	83.4	83.8	80.7	81.4	79.1
Children-Male	90.0	80.0	92.9	66.7	100
Children-Female	78.6	85.7	94.1	57.1	86.7

With regard to survivability among adults, for the first time it is noted that the 12 months survivability and retention in care is greater among the male cohort when compared to their female counterparts. Whilst this is optimistic development, it would be important to monitor this so as to establish any trends. An examination of the programme attributes this increase to the intensified focus of the treatment programme on improving treatment outcomes among the male population, through the increased capacity building of social workers and other clinical practitioners.

There was a marked increase in survivability in both male and female children when compared with the 2012-2013 cohort. Of the 22 children in the 2013-2014 cohort, there was 100% survivability and retention on ART among male children, compared with 66.7% in the previous cohort. Similarly survivability among female children increased to 86.7% in the 2013-2014 cohort compared to 57.1% in the previous cohort.

Figure 25: Trends in Outcomes for Patients not Included in the Survivability Measure

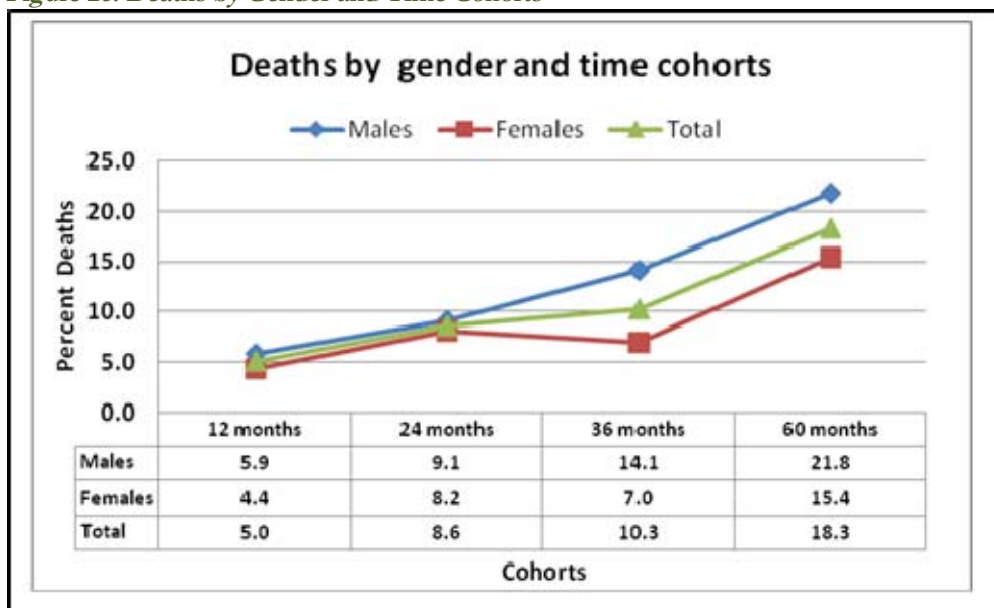


Source: NAPS Care and Treatment Report 2014

In fact, treatment interruption (Stop) has more than doubled since the 2009-2010 cohort with an increase to 6.8% when compared to 2.8% in the 2009-10 cohort. Loss to follow up (LTFU) has fluctuated over the last five cohorts while the percentage of patients who died decreased gradually during successive cohorts achieving a low of 5% for the 2013-2014 cohort. In the effort to improve treatment adherence, pre-initiation and adherence counselling is provided to patients on an ongoing basis by members of the multidisciplinary care and treatment team at the various treatment sites country-wide. In addition, the team follows up on defaulters, does contact tracing, and provides psychosocial support, including referral for support services.

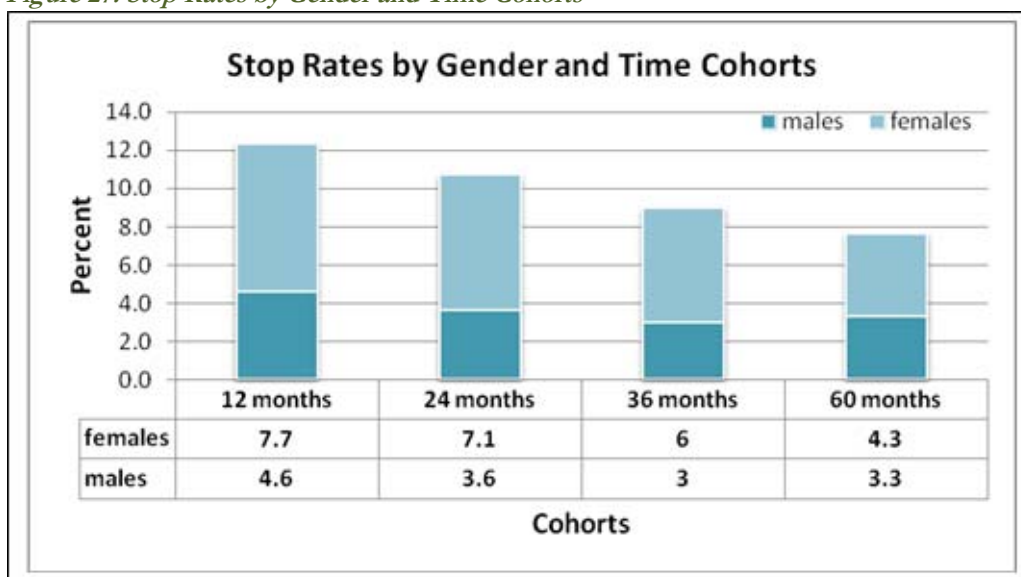
Survivability for 24, 36 and 60 months is reported at 75%, 72.4% and 63% respectively. A closer examination of the other treatment outcomes indicates that with the exception of the most recent 12 months cohort (2013-2014), there are less deaths among women compared to men, see Figure 26 below.

Figure 26: Deaths by Gender and Time Cohorts



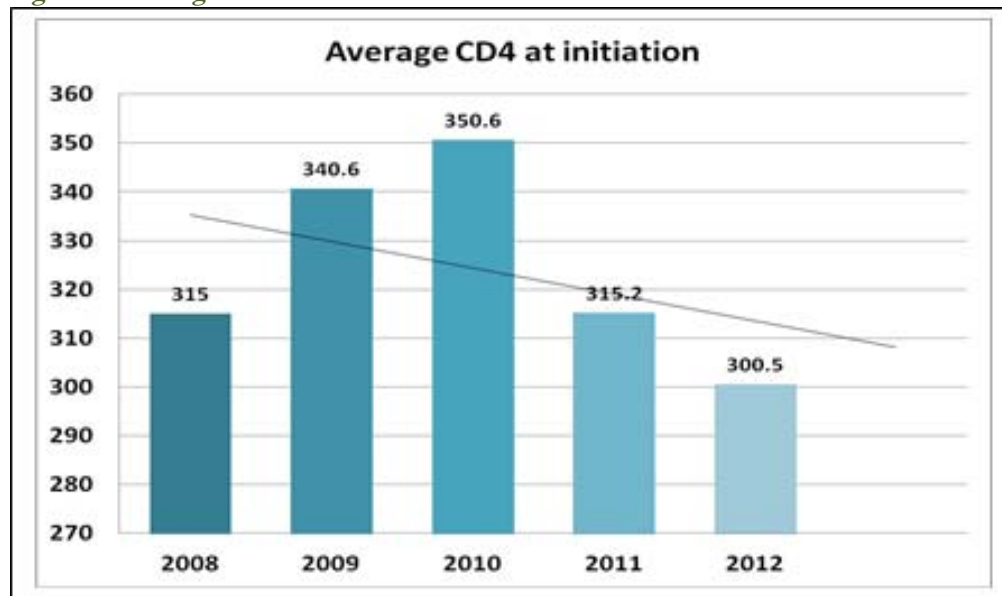
On the contrary, all cohorts examined indicate that stopped rates among females are significantly higher than that among males, see Figure 27 below. The reasons for this have to be explored and modifications considered to ensure improves. The possibility that these stopped rates are associated with women using ARVs for prophylaxis and discontinuing post pregnancy has to be explored as Option B+ has to be optimised in- country.

Figure 27: Stop Rates by Gender and Time Cohorts



Whilst relatively good treatment outcomes are noted, clinical monitoring indicates that significant additional work is required to further strengthen the programme. A rapid assessment indicates that there is a trend in the average CD4 at initiation reporting at about 300 cells at the end of 2012 as seen in figure 28 below.

Figure 28: Average CD4 at Initiation



Based on the HIV treatment guidelines, each HIV positive person should be receiving at least 2 CD4 tests per year. With a treatment programme accounting for 5041 patients, then the estimated minimum CD4 testing to be done equals 10,082. In 2014, a total of 8,360 CD4 tests were done, addressing 83% of the needs and presenting a deficit of 17%. Of all persons receiving a baseline CD4 for 2014, 37.5% (197/526) had CD4 less than 200 cells, presenting with AIDS.

The national treatment guidelines recommend that each person on treatment receive at least 2 viral load tests per year, thus translating to the need in 2014 for 8,360 tests to be done for the 4,295 patients on ARVs. In actuality, a total of 3482 tests were done in 2014 representing 41.6 % of the estimated needs and presenting a deficit of 58.4%. Further analysis indicated that among all persons receiving a viral load test during 2014, there is 70.15% (940/1340) viral suppression of <1000 copies. Further viral suppression is reported at 78.7% (381/484) for patients after 12 months of ARVs.

Both CD4 and Viral load testing were affected by the high staff attrition from the National Public Health Reference Laboratory as well as sick-outs and equipment malfunctioning/nonfunctioning.

During the year, senior personnel from the national programme continued to make monitoring visits to the various treatment sites in order to provide oversight, obtain feedback and conduct training. Chart reviews were conducted at 12 treatment sites by senior HIV clinicians. The results of these reviews were shared with the site staff and

recommendations made for improvement in the delivery of patient care. As part of an ongoing clinical mentorship program, the national programme continued to mentor additional physicians and medex from the outlying regions, including the hinterland regions, to increase the pool of medical personnel providing HIV care and treatment. This programme comprised both on-site mentoring and attachments at the National Care and Treatment Centre (largest treatment site) along with formal training in the use of the Patient Monitoring System, etc. Through this programme, 8 medex and 4 physicians received training during the year through a 2 weeks attachment at the National Care and Treatment Center.

During 2014, the clinical management of HIV was further strengthened through a number of training programmes: Clinical Management of HIV/TB (35 HCWs); Quantimed Training for Medication Consumption Projections (17 HCWs); Completion of Patient forms (20 social workers/counselors); profiling the HIV Care Continuum (19 staff); continuum of care 90-90-90 targets (60 HCWs/civil society members); patient monitoring system (16 social workers/data entry clerks).

Profiling the HIV Continuum of Care in Guyana

Since its first discovered case of HIV in 1987, Guyana has made significant strides in combatting HIV through its multisectoral response. Based on the UNAIDS 2013 estimation exercise, Guyana's adult HIV prevalence is 1.4%. This represents a steady reduction from the 2.4% prevalence found in 2004. The proportion of deaths attributable to AIDS has also declined steadily from 9.5% in 2002 to 4.8% in 2012 (preliminary data from MoH Statistics Unit). An integral part of the national response to HIV is surveillance to obtain more robust data on the state of the epidemic to accurately inform program planning and decision making. The National Alliance of State & Territorial AIDS Directors (NASTAD) through PEPFAR support, provided technical assistance in the use of the HIV Continuum of Care Framework as a tool to identify existing needs and measure progress towards increased access to and retention in treatment and care. Through a collaborative effort with MoH/Surveillance Unit/NAPS, a workshop on "Profiling the HIV Care Continuum" was designed and implemented in recognition of the need for a more robust method for demonstrating the movement of patients through the HIV Continuum of Care – from the entry point of testing to the point of enrollment into care and treatment, and finally to retention in care and treatment and viral suppression.

Nineteen participants representative of the various government health care units involved in the collection and use of HIV-related data, attended the workshop. These included the staff of MoH, NAPS/MoH, the National Blood Transfusion Center and NPHRL. The objectives of the workshop were to:

1. Foster cross-programmatic understanding of existing HIV data in Guyana.
2. Expand and develop knowledge and skills required for triangulation of existing data.
3. Build the capacity of participants to develop an HIV Continuum of Care so as to better profile the HIV epidemic in Guyana.

During the workshop, a series of exercises related to data triangulation were conducted, including a SWOT analysis of the current HIV data triangulation practices. Participants also brainstormed on the plausibility of linking HIV/AIDS data in Guyana given the numerous personal unique identifiers (PUIDs) used in the different programs. They also identified data sources available for key measures of the HIV epidemic and response (e.g. prevalence, impact, etc.) and developed key definitions required for the construction of the HIV Care Continuum in Guyana. Emphasis was placed on the need to maintain cross-programmatic communication and collaboration in drafting the HIV Care Continuum. In developing an action plan for profiling the HIV Care Continuum, it was proposed that its construction be piloted at one high-volume site and that the collection of data commence to draft a national HIV Care Continuum.

Since the conclusion of the workshop, participants have demonstrated ownership in the execution of the action plan developed. MoH has begun planning for the HIV Care Continuum pilot as well as the convening of a Technical Working Group (TWG) to discuss the possibility of moving to a name-based HIV case surveillance system and the establishment of a uniform PUID across all other HIV programs. With a clear understanding of the elements of the continuum of care, a 90-90-90 meeting was convened and a roadmap developed to address the gaps in reaching 90% of persons knowing their HIV status, 90% linkage into care and 90% viral suppression. An annual follow up meeting will be conducted to gauge progress against this roadmap.

The initiation of the process for profiling the HIV Continuum of Care has resulted in the building of capacity to collect, link, triangulate, and use HIV program data across the various entities involved in the national HIV programme. It will also support a better understanding of the Continuum of Care in Guyana which will in turn help to drive the public health response.

Management of TB-HIV Co-infection

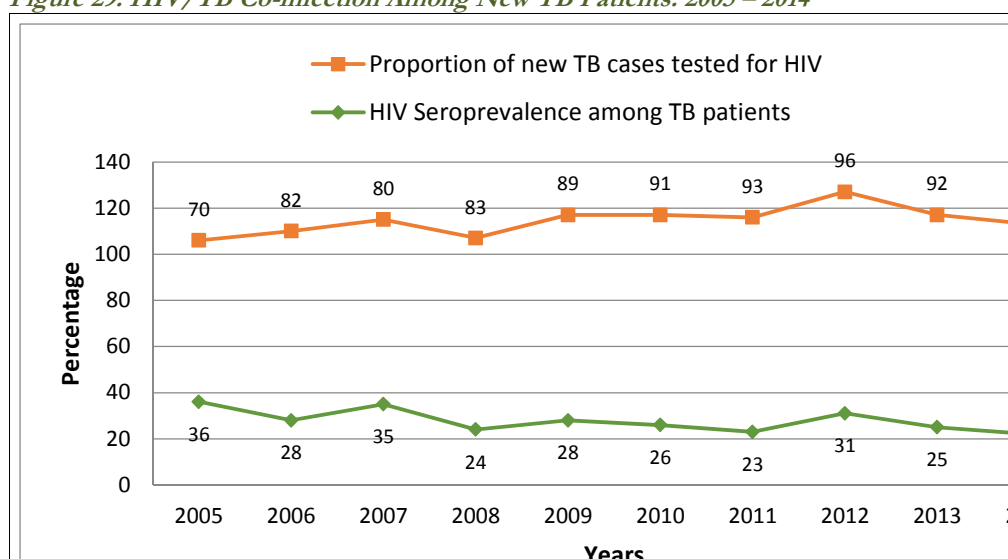
During the reporting period, the TB/HIV committee continued to hold meetings and provide oversight for the TB HIV response as aligned with the WHO 12 Point Policy. This committee comprises representatives from NAPS, the National Tuberculosis Programme (NTP), clinicians from HIV and TB programmes, and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

During 2014, 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, reaching more than 90% of the patients during the reporting period. As aligned to the guidelines, HIV counseling and testing was routinely provided to TB patients and TB screening was provided to HIV-infected patients.

During 2014, a total of 449 (91%) of the new TB cases (494) were tested for HIV and 109 (22%) of the new TB cases were found to be HIV positive. 73 (66%) of the TB/HIV cases were placed on ART and 98 (90%) were placed on Cotrimoxazole.. The TB/HIV co-infection rate of 22% found during 2014 represents a reduction when compared to 25%

occurring in 2013. Data for the period 2005 – 2014 indicate that the rate of co-infection fluctuated between 36 % to 22% during that period as shown in Figure 29 below.

Figure 29: HIV/TB Co-infection Among New TB Patients: 2005 – 2014



Source: NTP Programme records

Enabler support in the form of hot meals, nutritious drinks and food vouchers (food voucher provided through the NAPS Food Bank) continued to be provided to TB/HIV patients during 2014. During the period 4,121 units of nutritious drinks, 160 hot meals and 309 food vouchers were provided to these patients.

The integration of tuberculin skin testing (TST) into the package of services provided at health care facilities during 2014 was further strengthened with a total of 44 healthcare workers (Regions 3, 4, 6, 10) being trained in the administration of TST. This also enhanced the referral process between HIV treatment sites and TB treatment sites. Other training activities included: the training of 17 physicians in TB/HIV Management and Infection Control and; TB/HIV Peer Education training provided to 34 representatives of the private and public sector in Regions 2, 4, and 9.

Additional activities undertaken during the period included: regular outreaches in the prisons to screen for HIV and TB (see section on prisoners); revision and dissemination of the DOT/HAART manual; monthly HIV/TB support group meetings for clients; completion of the protocol for a retrospective study to assess the determinants of high mortality among TB and TB/HIV patients; and infection control assessments conducted in collaboration with the MoH Standards and Technical Services Department at 5 facilities providing DOTS and ART services (Regions 2, 3, 6, and 10).

Monitoring Quality Treatment and Care

The national programme continued to monitor quality care during the reporting period through a series of quality programmes.

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.

With partner support, the development of an electronic medical records and a Health Management Information System (HMIS) for the HIV programme is being addressed. Initial discussions surrounded a modular system with the introduction of an Electronic Medical Record system (EMR) and the addition of subsequent modules. An assessment of the existing system is slated for the first half of 2015 with the overall objectives of understanding the current system and providing viable alternatives to this system.

Supportive Supervision

During 2014, supportive supervision for the clinical teams continued with monitoring visits made to 12 treatment sites. This process was led by experienced HIV clinicians who conducted mentoring and training through a didactic on-site mechanism whereby patients were seen jointly, and cases were consulted and discussed. In addition, chart reviews were conducted, the results shared with the site staff and recommendations made for improvement in the delivery of patient care.

Client Satisfaction Survey

Since the release of the results of the previous client satisfaction during the last reporting period which showed a relatively high percentage of satisfaction (93.4%) in the provision of services to HIV patients attending HIV and TB clinics, another survey was conducted during the 2014 period. 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 in the ongoing effort to provide optimum care to PLHIV. This survey was conducted at all HIV and TB sites, including private facilities but excluding the hinterland regions. The results of this survey are currently being compiled and will be disseminated in the second quarter of 2015.

HIV Drug Resistance Survey

An HIVDR survey conducted at the National Care and Treatment Center, Guyana's largest and most representative HIV treatment site concluded its data collection in September 2013. This survey is guided by a National HIV Drug Resistance Working group with technical assistance as required from PAHO/WHO. Much of 2014 was expended on attempting to solve the many problems encountered with the database supporting this survey. As no solution to the database problems was achieved, an alternative approach was agreed with PAHO in conducting the data analysis. The report will be completed in 2015.

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 testing for the national programme in 2010. During the reporting period, CD4

testing was also provided by 5 other government laboratories located within Regional hospitals: New Amsterdam (Region in 6); Linden (Region 10); West Demerara (Region 3); Bartica (Region 7) and; Suddie (Region 2). Additionally TB identification and drug safety testing is conducted. TB diagnosis received a special boost during 2014 with the introduction of GeneXpert Technology which enables a much more rapid detection of TB and drug-resistant TB.

GeneXpert Technology Introduced in Guyana to Enable Rapid Diagnosis of TB

Through the Global Fund Grant to the Ministry of Health, a Gene Xpert MTB/RIF equipment was procured to support the TB/HIV programme. This machine enables the rapid diagnosis of TB which presents a challenge for Guyana which has an incidence rate of 109 cases per 100,000 populations (WHO 2013). HIV/TB co-infection rates have also fluctuated between 36% and 22% during 2005 to 2014. The rapid diagnosis of TB will enable timely management of co-infected patients in addition to accelerating the implementation of MDR-TB control measures.



During 2014, through ASM personnel support, four technicians from the National Public Health Reference Laboratory (NPHRL) in Guyana received comprehensive training in using the GeneXpert MTB/RIF machine. Training comprised lectures and practicals using the Global Laboratory Initiative of the StopTB department/WHO GeneXpert training package. Training included:

- Xpert MTB/RIF verification tests
- Development of Xpert MTB/RIF testing algorithm
- Assessment of competence among the trainees to do the Xpert MTB/RIF assay

In addition, an Xpert awareness stakeholders meeting was held to sensitize the relevant parties with regard to the introduction of the new technology to rapidly diagnose TB.

This implementation, validation, and training in the GeneXpert technology will have a positive impact on the future of TB diagnostics in Guyana—the technicians were eager to apply the new technique and support is strong from both the laboratory network and the MoH. The introduction of this technology will be further expanded during the coming year with the provision of 2 additional Gene-Xpert machines.

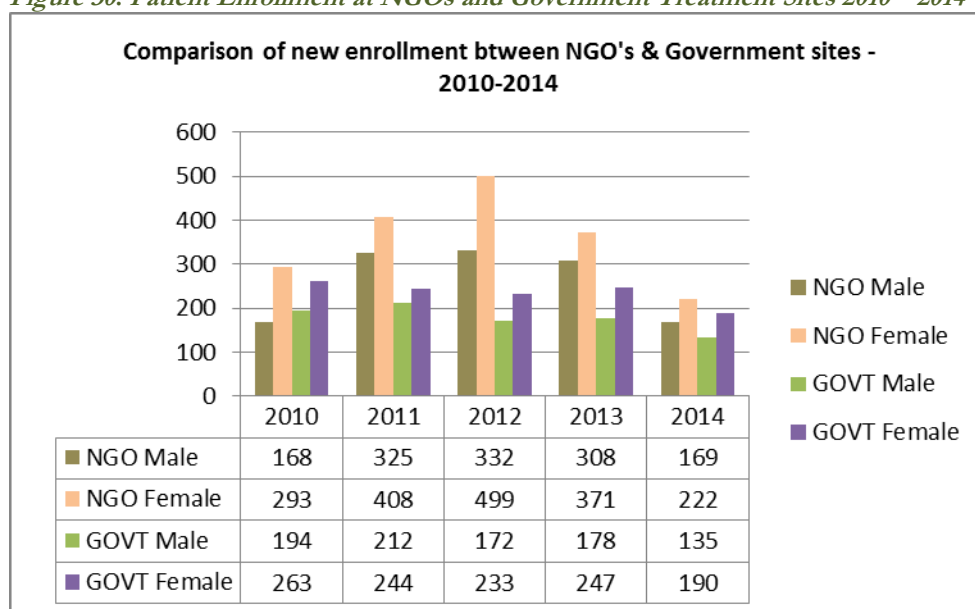
Home Based Care

The aim of the home-based care programme is to enable PLHIV to receive quality care and services in their homes, most often provided by family members. During 2014, health care personnel from treatment Sites and NGOs, continued to work with caregivers to improve their skills and capacity to provide such care to PLHIV.

During 2014, 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 716 new persons were enrolled into the HBC programme in 2014 (325 at government treatment sites and 391 at NGOs). In comparison, in 2013, 1104 new persons were enrolled into the HBC programme (425 at government treatment sites and 679 at NGOs). One key factor attributed to this reduction, is the improved quality of life of persons living with HIV. 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 30 below.

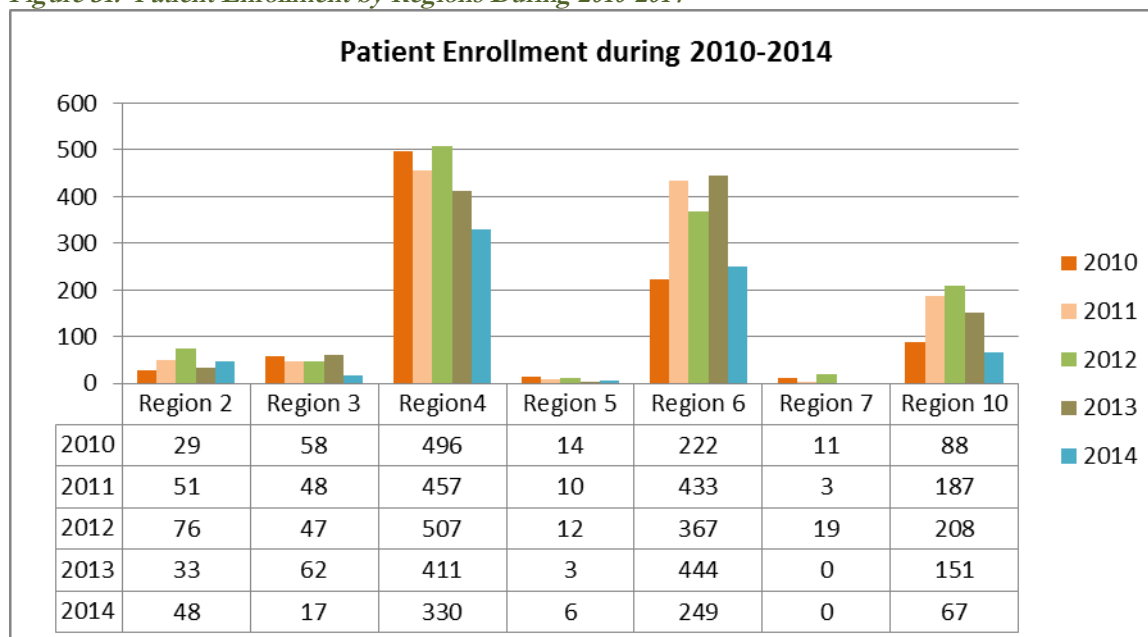
Figure 30: Patient Enrollment at NGOs and Government Treatment Sites 2010 – 2014



Source: NAPS Programme Report

Region 4 had the largest number of persons enrolling for HBC in 2014 (330) followed by Region 6 with 249. This pattern has generally been maintained over the period 2010 - 2014 as shown in Figure 31 below due to the number of treatment sites and NGOs operating in these regions.

Figure 31: Patient Enrollment by Regions During 2010-2014



During 2014, 29 caregivers were provided with HBC refresher training aimed at assessing their knowledge, attitude and practice of basic nursing techniques to meet the needs of the patient. During the year, HBC nurses held regular meetings to discuss issues pertaining to their clients' wellbeing in areas such as clinic appointments, disclosure, attendance to support group meetings, nutrition, and other social issues.

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 2014. This committee continued to guide both the Ministry of Health's OVC response in addition to providing guidance for its constituent member organizations. The OVC policy 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). A One Stop Advocacy Centre for Children's Rights introduced in 2013 is currently working towards facilitating 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.

During 2014, a number of non governmental entities also provided a range of programmes and services to 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, provided children with temporary shelter, face-to-face and hotline counselling services, free court support services, and referral services. During 2014, Help & Shelter commenced a new Child Protection Project aimed at: drafting inter-agency protocols for child protection; establishing multi-sector community teams for child protection; building parents' capacity to provide safe family environments for children; monitoring of child abuse and; development of community action plans to demand intervention and protection for children who are the victims of abuse. Through this programme, 6 sensitization sessions on parenting, early childhood development, child abuse, were conducted during 2014 within two rural communities for 106 persons, including parents and teachers.

During 2014, seven NGOs provided care and support services for children infected/affected by HIV, in Regions 1, 2, 4,5,6,7 and 10. Community-based care to clients, case navigation to care and support across various service agencies, nutritional supports, adherence and viral load monitoring and retention in care and treatment programs were integral components of care and support. In addition, there were also linkages to child protective services, youth-centred services and other social services through the distribution of comprehensive service directories. NGOs also offered psychosocial counselling and after-school homework assistance to OVC and were able to incorporate HIV prevention education into the package of services being offered to OVC.

During the reporting period, a Children's Day march to commemorate the 25th anniversary of the UN Child Rights Commission, saw hundreds of children marching through the streets of Georgetown to raise awareness of the importance of prevention child abuse, empowering children and ensuring their safety and care. The march concluded with celebrations and a public panel discussion in which children, their families, child protection officials and community members talked about why child rights, care and protection matter to them.

Psychosocial Support to Persons Living with HIV

Several initiatives continued during the current reporting period and these included Public Assistance through the Ministry of Labour, Human Services and Social Security (MoLHS&SS), psychosocial support through support groups at HIV treatment sites, and nutritional support through the Food Bank.

Public Assistance

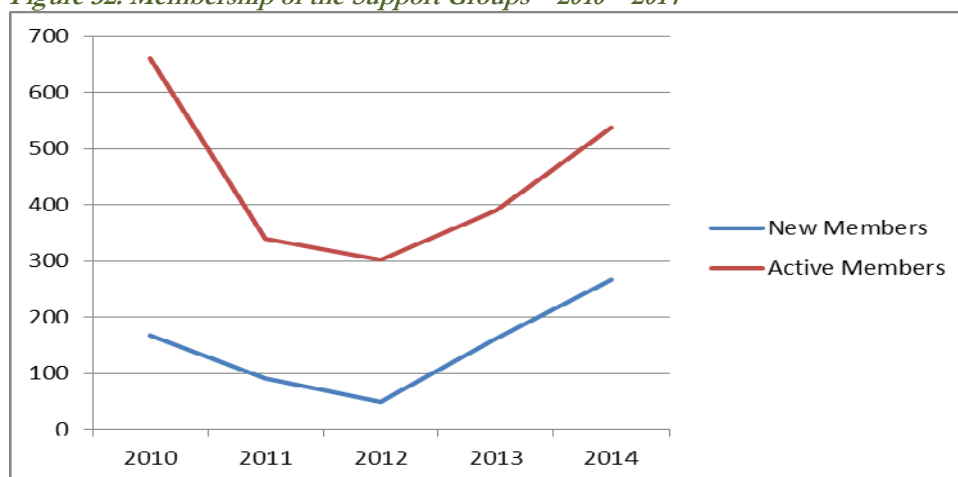
During 2014, PLHIV who were eligible, along with their family members were provided with public assistance through the (MoLHS&SS). Eligibility was determined by both a means test and the CD4 level of PLHIV which was used as a measure of their physical capacity to earn an adequate living. After receiving public assistance for a period of six months, each PLHIV's situation was evaluated to determine the need for continued assistance and support provided as appropriate.

PLHIV Support Groups

During the period, the HIV/AIDS support group programme which commenced in 2004, continued at 14 HIV treatment sites country-wide and 6 NGO sites. The aim of the programme is to provide support services to PLHIV and their affected families in the effort to improve quality of life and reduce morbidity and mortality.

The 20 support groups (including NGO support groups) reported on during 2014 had a total membership of 538 (30% males, 70% females). Of special note was that the adolescent support group membership at the largest treatment site increased by 36% (from 22 to 30). Figure 32 below shows overall support group membership over the period 2010 – 2014.

Figure 32: Membership of the Support Groups – 2010 – 2014



Source: NAPS Programme Reports

The support groups continued to provide a forum for PLHIV to meet monthly to discuss health issues, common challenges and personal experiences. During meetings, topical issues were also discussed. These included: adherence; nutrition; positive health; mental health; stigma and discrimination; domestic violence; disclosure; condom use; STIs; prevention with positives; substance abuse and: personal hygiene.

The groups were also engaged in recreational activities, skills building and income generation activities. 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 group members in the areas of craft production, and with NGO support in hydroponics and 'kitchen gardening'. With the skills gained, a number of PLHIV were able to embark on income generation activities. In addition, a support group that was previously provided with grass-cutting machinery to facilitate its venture into the provision of sanitation services, continued to generate employment for a number of its group members. Assistance was also provided in finding employment for group members within various business establishments. Other income generation activities embarked upon by support groups included take-out lunches, cake sales, etc. In-house efforts among group members to support one another included the contribution toward food baskets for members and penny banking to raise seed money for small-scale business activities.

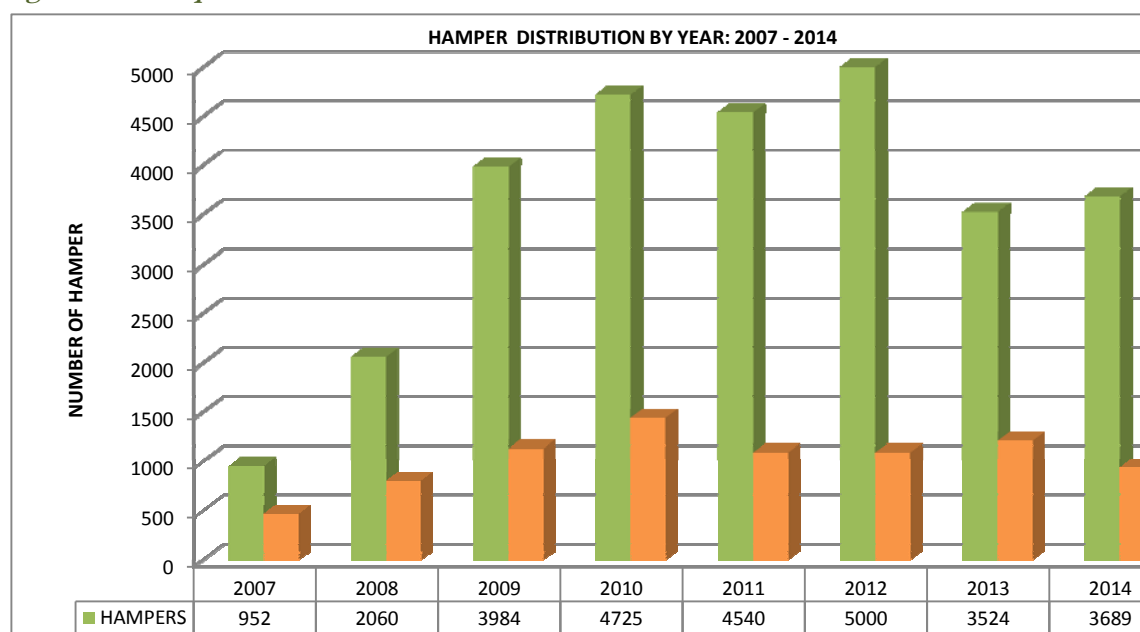
As of 2014, in the effort to promote sustainability and build leadership skills, the leadership of each group was transitioned to the President of the group, with guidance provided by NAPS personnel through oversight and feedback meetings. Leadership by a peer was also instituted in the attempt to attract more group members whose comfort level appeared to increase with such leadership. In the ongoing move towards sustainability, refreshments for support group meetings were also provided by group members instead of the national programme.

Nutritional Support for Persons Living with HIV/AIDS

The MoH/NAPS Food Bank was established in September 2006 with the aim of providing nutritional support to PLHIV in order to have improved treatment outcomes and thus improve the quality of life of PLHIV. The Food Bank continued to provide nutritional support for HIV and HIV/TB co-infected patients during 2014, with 937 patients receiving a total of 3,689 hampers compared to 1,202 patients who received 3524 hampers in 2013. While the number of patients receiving hampers decreased in 2014, the average number of hampers received per patient increased to 4 (3,689/937) compared to 3 (3,524/1,202) per patient in 2013. The reduction in number of patients was partially due to strict adherence to the eligibility criteria which was revised within the past year to allow for preference to be given to PLHIV whose economic, social and medical circumstances were comparatively more severe than others. A patient's eligibility for nutritional support is also reviewed every six months and a decision made as to whether to continue providing support

The years 2007-2014 showed a steady increase in patients that accessed the Food Bank, with fluctuations during the period 2011 – 2014. A total of 937 patients (HIV and HIV/TB co-infected) benefitted from 3689 food hampers from the Food Bank during the year 2014. The trend in distribution between 2007 and 2014 is illustrated in Figure 33. This shows that a total of 28,474 food hampers were distributed to eligible HIV/TB co-infected patients, during the period 2007 – 2014.

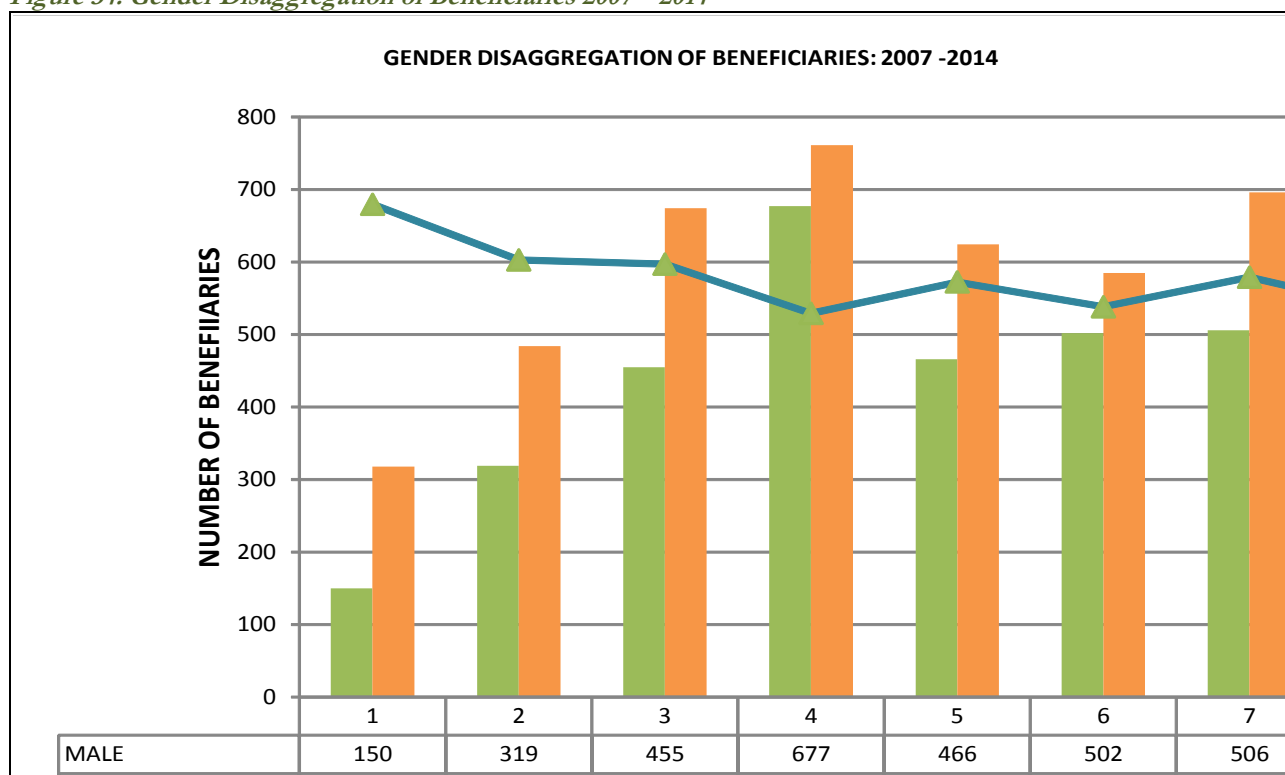
Figure 33: Hamper Distribution: 2007 – 2014



During 2014, while patients from all ten of Guyana’s administrative regions had access to the Food Bank, Region 4 which has the largest number of treatment sites accounted for 84% (3,112/3,689) of the hampers distributed. The vast majority of beneficiaries to the Food Bank were unemployed (72.92%) while beneficiaries within the age group 30-49 years, accounted for 57% (534/937) of all beneficiaries in 2014. A similar situation obtained in 2013 when this same age range accounted for 55% of the beneficiaries. The proportion of children 0-14 years old accessing the Food Bank in 2014 decreased to the lowest ever ($58/937 = 6.19\%$) since the commencement of the Food Bank. The increasing success of Guyana’s PMTCT programme is felt to have had some impact on the decreasing number of children seeking nutritional support. During 2014, 34%% (320/937) of the beneficiaries were single parents compared to 22% (264/1202) in 2013.

During the period 2007 – 2014, females continued to be the major beneficiaries of the programme as illustrated in Figure 34 below. During 2014, 499 (53%) females benefitted from the Food Bank while 438 (47%) males benefitted.

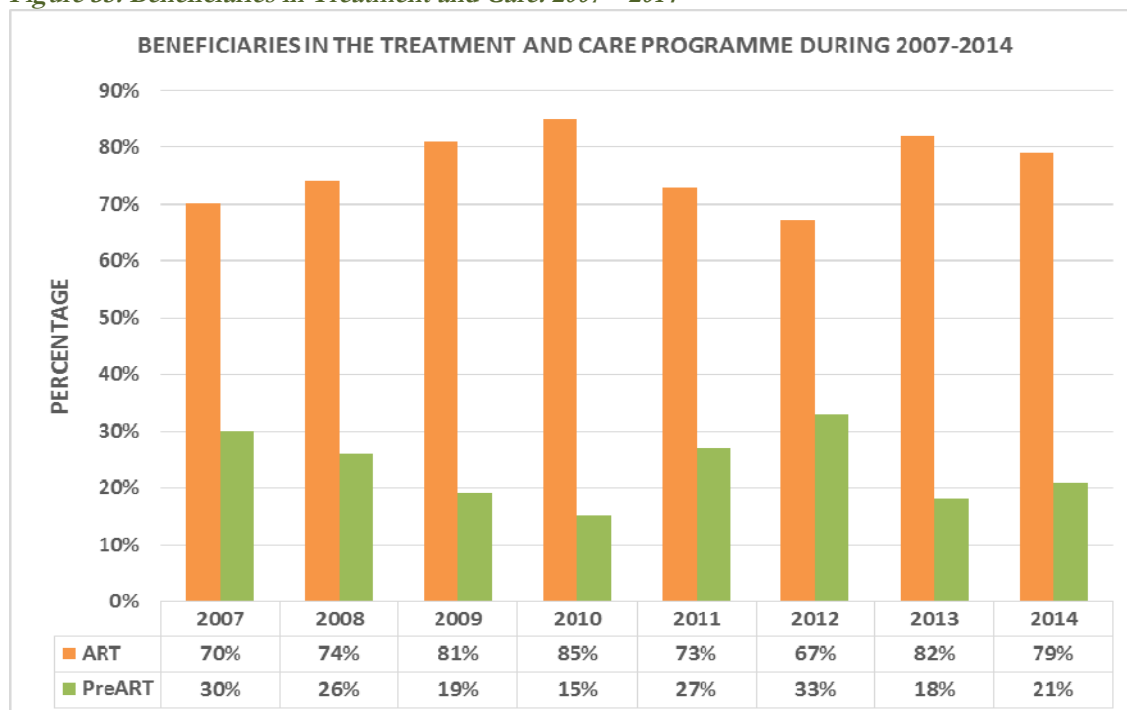
Figure 34: Gender Disaggregation of Beneficiaries 2007 – 2014



Source: NAPS Programme Reports

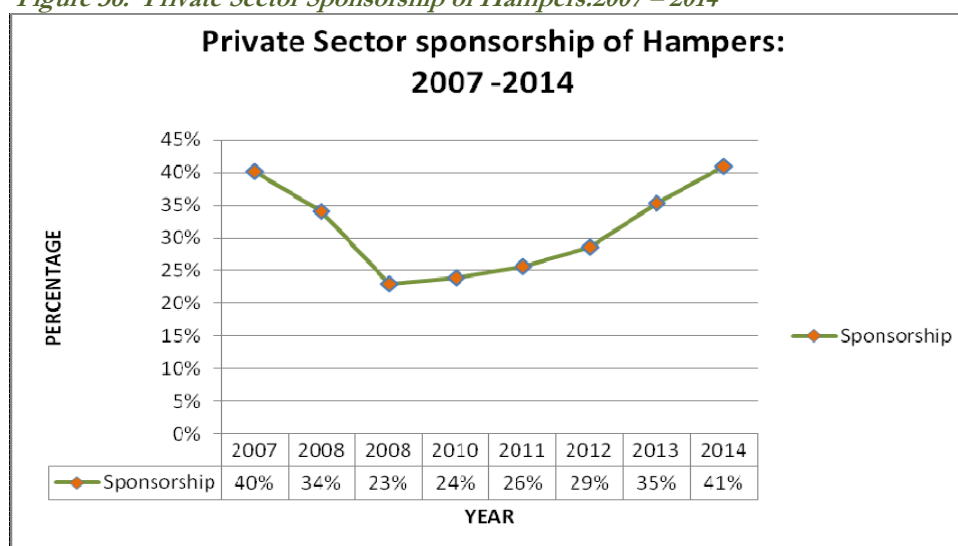
During 2014, 79% (743/937) of the patients that benefitted from the Food Bank were on treatment while 21% (194/937) were in pre-ART or care. The proportions were somewhat similar in 2013 with 82% on treatment and 18% in care. During 2014, 8% (74/937) of the beneficiaries were HIV/TB co-infected compared with 19% in 2013. Figure 35 shows the proportion of patients in pre-ART and in treatment who benefitted from the Food Bank during the period 2007-2014.

Figure 35: Beneficiaries in Treatment and Care: 2007 – 2014



There was a steady increase in private sector sponsorship of the food bank during the period 2009 – 2014. While the number of private sector agencies reduced from 32 in 2013 to 30 in 2014, the year 2014 witnessed the highest ever private sector contribution towards the food bank of 40.98% compared to 35.36 % in 2013. See Figure 36 below which illustrates the private sector sponsorship.

Figure 36: Private Sector Sponsorship of Hampers: 2007 – 2014



IV. BEST PRACTICES

1. HIV CITIES Project: Engaging Local Government as Critical Allies in Addressing Discrimination Against Key Populations

During 2013-2014, UNDP in a historic collaborative effort with MoH/NAPS and the leadership of two major municipalities in Guyana – Linden and New Amsterdam - implemented a project that sought to address discrimination against key populations within these townships. This project was initiated against a backdrop of existing stigma and discrimination which hindered access to HIV services. Of particular concern was the discrimination displayed against LGBT persons and commercial sex workers within these communities, and the lack of recourse for these groups when lodging complaints in cases of violence encountered within the community. This was especially given the existing laws that prohibited same sex relationships and commercial sex work. The HIV CITIES Project which had a strong focus on Human Rights and Gender and Sexual Diversity, was aimed at strengthening the governance of AIDS responses by government, municipalities, civil society and community groups. In particular, this project focused on addressing HIV programming for marginalized and vulnerable populations. Approximately one year after the commencement of this project, members of these marginalized populations are now able to sit around the table to have discussions with key institutional stakeholders who have become their allies in championing their cause within the Linden and New Amsterdam communities.

This is what we as leaders of municipalities should do, work on issues like HIV that affects our citizens. I am pleased that we can invite all stakeholders especially persons from the vulnerable population to meetings where we sit and discuss strategies to address this issue in our town. We all need to address this issue and many times we get caught up in all other kinds of activities which are also important and have not recognized that HIV is a critically important platform to be addressed by us as leaders within our municipality"

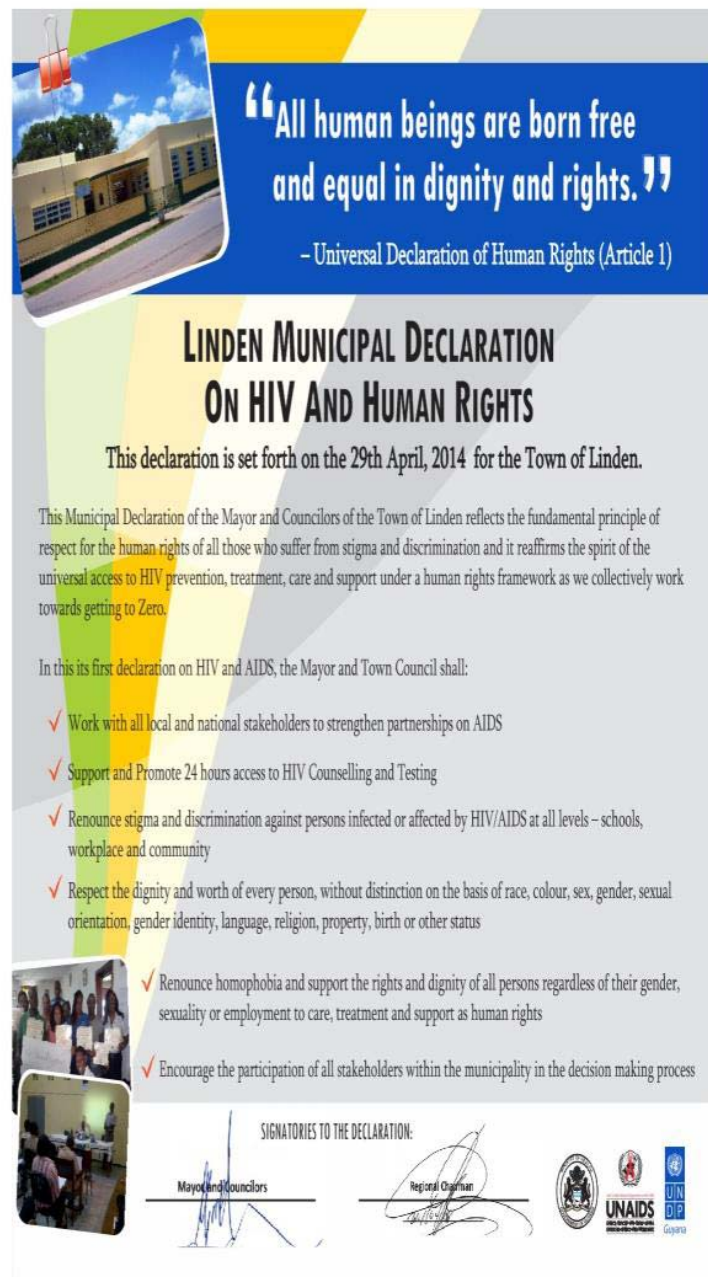
Statement by Councilor, January 2014

In initiating the project, consultations were held with the leadership of the two municipalities and other key stakeholders within Linden (population approximately 20,000) and New Amsterdam (population approximately 35,000) to identify the populations most vulnerable to HIV, to assess their access to HIV services, and to identify the gaps in the provision of these services. The municipal leaders soon recognized that in pursuing their substantive roles as service providers in creating a clean and healthy environment for their citizenry, they had a critical role to play. Together with the other key stakeholders, they also recognized that stigma and discrimination negatively

impacted access to HIV services for vulnerable members of their communities and that this access was integral for the economic development of their townships. It became evident, that a broad-based multi-sectoral approach involving municipal leaders and civil society organizations, was required in addressing this important issue.

As a follow up step, there was a ground-breaking signing of the Municipal Declarations by leaders of the Linden and New Amsterdam municipalities at a symbolic ceremony attended by representatives of MoH/NAPS, other government Ministries, donor agencies, NGOs involved in HIV, the Police Force and other key stakeholders from the New Amsterdam and Linden townships. This powerful six-point declaration which was locally inspired and designed by the Mayors of the two townships and their stakeholder groups, embodied

Article 1 of the Universal Declaration of Human Rights which states that “All human beings are born free and equal in dignity and rights”. The Declaration also secured the Municipalities’ commitment to “the fundamental principle of respect for the human rights of all those who suffer from stigma and discrimination and reaffirms the spirit of the universal access to HIV prevention, treatment, care and support under a human rights frame as we collectively work towards getting to Zero”. As a reminder of this commitment, a framed copy of the signed Declaration was posted up in the town halls of Linden and New Amsterdam.



A major activity implemented during this project was a series of workshops for various sectors of society, to create an awareness of the issues affecting diverse groups, to address

these issues and, to orient participants to human rights concepts which negate discrimination in all forms. This training was seen to be crucial in light of the homophobia that existed within the two townships in which it was recognized that discrimination occurs at multiple levels – by families, religious bodies, and even institutions whose mandates were to provide care for members of the society. During the first wave of training, 40 members of each municipality, including members of key populations, were trained. These initial sessions brought to light the fractured relations between the citizenry and the Police Force and served to obtain the commitment of the Force in providing non discriminatory services to the LGBT community when their assistance is being sought. A follow-up training of trainers workshop included 27 participants from various sectors including the LGBT community, NGOs, municipalities, Police, health services and other government Ministries. Training focused on human rights and facilitation techniques which was later followed by field practicum in delivering training at the Police College and the Nursing School. With members of the LGBT community equipped as trainers, they were able to conduct sessions that spoke to their realities whilst the Police officers and nurses trained, were able to serve as advocates beyond the training. The third wave of training was provided to 650 persons including health care professionals, Police and other security personnel. While religious views on homosexuality remained a challenge during these training sessions, participants recognized the right of key populations to equal treatment.

I have never interacted with ...withwell gay people before, so this is a new experience.

A Human Rights Training Manual was also prepared as part of this project and in observance of the International Day Against Homophobia and Transphobia on 17 May 2014, a Media Encounter on Human Rights and Homophobia was hosted to publicly address discrimination against key populations. Another accomplishment of this project was the setting up of a 24-hour VCT site within the New Amsterdam Municipal Complex through collaborative efforts between Local Government, NGOs, and the business community.

A major success of this project was the willingness of all stakeholders to commit to pursuing change - both at a personal and an organizational level. Discrimination by the Police against the LGBT community and sex workers has decreased somewhat and these groups are now able to obtain redress through the Police Complaints Desk. In addition, key alliances were formed between institutional stakeholders and marginalized groups in addressing their challenges and these marginalized groups have now become part of a system in which their opinions are valued and which increases their confidence level. Moreover, the media who participated in the trainings, are now sensitized to the issues facing key populations and are now better equipped to advocate on their behalf.

Imagine we are meeting regularly in the Council Chamber, sitting around the Council table and talking...planning with police officers, nurses, Councilors and other important people. This is a real breakthrough. It shows that the municipality, the town council respects us and for me, as an MSM, that is important.

Statement by Participant, March 2014

Moving forward in this ongoing project, the level of ownership demonstrated by the municipalities and stakeholder communities within the Linden and New Amsterdam townships throughout the HIV CITIES Project, highly favours its sustainability!

2. The Private Sector as a Major Partner in Providing Nutritional Support for PLHIV

In September 2006, the Ministry of Health/National AIDS Programme Secretariat established a Food Bank as part of the National HIV/AIDS response, to provide nutritional support to persons living with HIV (PLHIV). This initiative was aimed at achieving improved treatment outcomes and enhancing the quality of life of PLHIV. Through this initiative, PLHIV enrolled at care and treatment sites in the different Regions of Guyana, and who satisfied the criteria for eligibility, were able to obtain a nutritious food hamper through a referral system. Over the period 2007-2014, a total of 28,474 food hampers were distributed with the average number of hampers received per patient in a given year rising from 2 in 2007 to 4 in 2014. Eighty five percent of the Food Bank beneficiaries surveyed in 2013 (2013 Client Satisfaction Survey), reported being either satisfied or very satisfied with the contents of the hamper. Throughout the period, the private sector has continued to be a major partner in this venture, commencing with 12 companies coming on board in 2007 and rising to 30 companies in 2014. During 2014, the private sector contributed 40.98% of the overall costs of the Food Bank.

Eligibility for the receipt of a food hamper is determined through a clinical evaluation along with an assessment of the patient's socioeconomic conditions – status of employment, whether single parent, family size, and number of dependents. Patients are re-assessed every six months to determine their continuing eligibility. Over the years, a slightly higher proportion of females have accessed the Food Bank compared to males. The Food Bank continued to benefit unemployed PLHIV who comprised approximately two thirds of the beneficiaries while single parents made up approximately one third. In addition to 85% of the beneficiaries expressing their satisfaction with the contents of the hamper in the 2013 survey, more than half felt that the hamper contributed to an improvement in their health and of special significance, was that the same proportion had changed their diets to a healthier one since receiving the hampers (2013 Client Satisfaction Survey). Based on both observation and the feedback received from patients, it was evident that the socioeconomic support provided through the Food Bank was complementing their medical care and treatment.

A major success of the Food Bank initiative was the engagement of the private sector in making contributions to the Food Bank. In engaging their support, the impact of HIV on members of the working population was placed at the forefront of the discussion. The 30 companies currently providing support to the Food Bank span a variety of business interests ranging from food-related establishments to clothing stores, exporting agencies, etc. Over the years, there was a steady increase in private sector contributions with the 40.98% contributed in 2014 being the highest ever. Quarterly feedback sessions between the National AIDS Programme Secretariat and private sector contributors, serve to keep the contributors abreast with the national response to HIV and in particular, to highlight the important role played by their contributions.

The involvement of the private sector in the Food Bank initiative is an outstanding example of a Public Private Partnership in which the business community can play its role as good corporate citizens. This is especially crucial at a time when donor support is being

reprioritized thus highlighting the need to explore innovative ways of sustaining the national HIV response.

3. The Guyana Defence Force Actively Promotes HIV Prevention Among its Military Officers and Ranks

The Guyana Defence Force (GDF) HIV/AIDS Prevention Programme commenced in March 01, 2006 focusing on prevention activities as part of the PEPFAR-supported initiatives. The goals are to promote HIV/AIDS prevention measures, reduce the incidence of HIV/AIDS and facilitate access to care, treatment and support for PLHIV within the military. The GDF's HIV programme constitutes part of the national HIV response and is a collaborative effort with MoH/NAPS through which it obtains technical and material support for its prevention, care, treatment and support services. Within the military hierarchy of the GDF, there is strong buy-in and open lines of communication regarding the GDF HIV/AIDS Prevention Programme in full recognition of the need to maintain a healthy defence force. As such, it was mandated that HIV education and behaviour change communication be an integral part of all military training sessions. The strong commitment demonstrated by the GDF hierarchy will also ensure the sustainability of the army's HIV prevention programme well after PEPFAR's support is concluded.

On average 660 new recruits pass through the GDF each year, even though the Force has approximately 2,500 members at any given time. As part of the compulsory programme of prevention education for every new recruit and existing officer, 5,098 army officers and ranks received the GDF's standardized package of intervention during the period 2006-2014. This package includes information on gender-based violence, STIs/HIV, modes of transmission, stigma and discrimination, and prevention measures including partner reduction and consistent and correct use of male and female condoms. In addition, VCT and IEC materials focusing on prevention measures and specially adapted for the military are provided. Prevention and risk reduction activities are conducted at all military bases and locations throughout the country through peer education, educational outreaches and sensitization activities, including the distribution and display of specially adapted posters at all military locations.



Peer educator in action during an HIV Prevention awareness session

As part of the army's HIV prevention programme, there is heavy emphasis on the consistent and correct use of condoms through condom demonstrations and the availability of free condoms at all military locations. During 2014, 32 army officers and ranks received VCT training to add to its existing cadre of trained counsellor/testers. During the period 2006 – 2014, a total of 180 members of the GDF were trained and certified as Voluntary Counselor Testers. VCT services are provided at 4 stand-alone sites at the main bases and military locations across the regions, given the mobile nature of military work. In addition, VCT is provided during medical outreaches. Over the years, the MoH has been able to tap into the pool of GDF Counselor Testers during collaborative activities such as the National Week of Testing, when a large number of these testing personnel are required.

Box 10 below shows VCT conducted within the military since the commencement of its HIV/AIDS programme. As indicated, established targets were surpassed by over 200% during certain periods. Any army officer or rank found to be HIV positive was referred to a care and treatment site of his/her choice within the national system.

Box 10: VCT Among the Military: 2006-2014			
Year	Target	Persons tested	Percentage of target
2006-2007	400	223	56
2007-2008	200	673	337
2008-2009	700	1266	181
2009-2010	1200	1031	86
2010-2011	1200	550	*46
2011-2012	500	1209	242
2012-2013	800	673	84
2013-2014	700	2102	300

**Competing military operations impacted the numbers tested*

In addition to targeting the military, the GDF's HIV/AIDS prevention activities also includes outreaches, often in collaboration with the MoH/NAPS e.g. in observing World AIDS Day. A major activity of the GDF is its annual health fair which is open to the public and which has a heavy focus on HIV and wellness programmes targeting family members and the general public. The health fair is a major collaborative effort between the GDF and its various partners involved in HIV/general health care in setting up booths, performing medical tests, and disseminating information on healthy living. The GDF health fair over the years, has seen the participation of an average of 59 partner organizations on each occasion including NGOS, hospitals, pharmacies, laboratories, suppliers of medical equipment, gyms and 2,800 members of the public in attendance including health care workers, school children and families.

An HIV and STI Seroprevalence and Behavioural Epidemiology Risk Survey (SABERS) conducted within the military in 2011, revealed that there was a low HIV prevalence of 0.2% with approximately 86.2% of the military ever having taken an HIV test. HIV Knowledge was found to be relatively high with an average of 81.7% and male condom use was reported at 93.3%. The recent introduction of the Military Electronic Health Information Network will further facilitate improvements within the GDF medical facilities in reporting, patient registration, data quality and operational management of infectious diseases, chronic diseases in leading to further research within the GDF's health programmes. This network is the first of its kind within the South American continent and will further enhance the GDF's HIV programme through tracking of prevention services, VCT, and care services.

The sustainability of the GDF's HIV prevention programme beyond PEPFAR is assured through the commitment of the military's hierarchy towards maintaining a healthy army coupled with the ongoing training of trainers within the military to create a pool of resource personnel capable of imparting the standard package of HIV prevention services to army officers and ranks. This is especially evidenced through the ongoing training of Counselor Testers in developing a culturally sensitive and sustainable programme. The ongoing training of GDF laboratory personnel to expand and strengthen their capabilities, in addition to the continuous scaling up of laboratory systems and facilities to support HIV/AIDS related activities, also augurs well for sustainability.

4. BBSS 2014 Completed through Strong Multisectoral Collaboration

During the period 2013-2014, MoH/NAPS in collaboration with key partners, conducted a Biological and Behavioural Surveillance Survey (BBSS) among key populations at greater risk of HIV. The purpose of this BBSS was to understand the dynamics of and garner information on HIV transmission, level of knowledge, attitudes, and behaviours among these groups to better inform HIV prevention programming. Key populations selected were CSWs, MSM, miners and loggers. This was the first attempt by the country to include miners and loggers in a study of this magnitude.

A remarkable feature of this BBSS was the level of multisectoral multi-partner collaboration involved which was key to the successful completion of this survey. The tremendous effort involved in designing the survey, interviewing 3804 individuals within 9 out of 10 regions, and analyzing this data, would not have been achieved without this demonstration of support from among donor agencies, government agencies, NGOs and community members. Most of all, the willingness of the survey population to participate in the study, despite the sensitive nature of many of the questions administered, was crucial to accomplishing the goals of the study.

During the survey, leadership and direction were provided by MoH/NAPS throughout the process of planning, securing funding, determining the technical content, implementation, and dissemination of information. MEASURE Evaluation through PEPFAR and USAID funding provided technical assistance in designing and roll out of the study based on the Priorities for Local AIDS Control Efforts (PLACE) methodology, a tested methodology for reaching high risk populations. Despite the challenges and limited infrastructure within the far-flung regions of Guyana, MEASURE Evaluation was able to assist MoH/NAPS in creating an appropriate sampling design to reach miners and loggers in the places where they

socialize within these hinterland areas. Data was also collected in the coastal regions, capturing disease burden and high-risk activities in the bigger towns and cities. Completed questionnaires and test results were transferred to NAPS/MoH for data entry and securely transferred to the University of North Carolina where MEASURE Evaluation completed the data analysis.

Additional funding and collaboration during the BBSS were provided by the PANCAP/GIZ through the Migrant Project, the Global Fund, UNAIDS, PAHO, and MoH, all of whom participated in the designing, planning and implementation of the survey. Several departments within the Ministry of Health performed critical roles. These included the National Public Health Reference Lab, Department of Standards & Technical Services, and Vector Control Services. The Guyana Forestry Commission and the Guyana Geology and Mines Commission were central to identifying the locations and facilitating an understanding of the workings of the “landings” in the hinterland regions where the miners and loggers congregate and socialize on a regular basis. The Guyana Bureau of Statistics provided vital oversight and management of the implementation of the study within the hinterland regions.

In designing the study, obtaining external buy-in to the process at the community level was essential and was brought about through sensitization visits to the Regional Democratic Offices and communities within the hinterland regions. The study protocol was also discussed with logging and mining company representatives such as the Guyana Gold and Diamond Miners’ Association. Several successful consultations with camp leaders, miners and loggers were conducted. Civil society members and members of the key populations were also actively involved in the technical working groups for the BBSS in addition to serving as key members of the mobilizing and interviewing teams. Data collection tools were translated into Portuguese and interviewing teams in the hinterlands comprised a Portuguese speaker in the effort to reach Brazilian miners/loggers. During the data collection phase, the participation of key community informants, civil society groups and NGOs, was invaluable in contributing their knowledge, expertise, and staff to ensure that the survey team reached the right people and asked the right questions.

The dissemination of the findings of the BBSS was conducted by the MoH with support from USAID. The final report of the survey will be printed by CDC and disseminated in 2015. It is planned that relevant secondary data analysis would be supported by MEASURE through USAID and that CDC will support further qualitative assessments based on the BBSS findings.

The BBSS 2014 is an excellent demonstration of how collaboration across sectors can allow each sector to provide the essential components required for completing the machinery to be used in achieving a seemingly monumental task. The coordination of activities and the manner in which the various entities complemented each other in the chain of activities leading to the completion of BBSS 2014, is worthy of replication in undertaking other major activities.

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 **2012-2013** identified the following challenges as being critical in needing to be addressed in moving forward post 2015. These included:

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 known 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:** 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 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.

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 table 18 below.

Table 18: Remedial Actions in Response to Challenges

Challenges	Remedial Actions
1. Access to the hinterland communities	<p>In 2014, the Ministry of Health as the principal recipient to the Global Fund signed a major sub recipient agreement with the International Organisation for Migration. This will ensure that there is a significant scale up of prevention, care and support services to the miners and loggers and adjacent communities. The work started in 2013 in transitioning the HIV treatment programme from a mobile unit centrally led, to a more sustainable approach of local ownership. This was consolidated in 2014 with the establishment of fixed treatment sites within these hinterland communities. The functioning of these sites was strengthened through training of the health care workers, clinical mentoring, and oversight.</p> <p>The BBSS concluded in 2014 provided key data on miners and</p>

Challenges	Remedial Actions
	loggers and adjacent populations in the hinterland regions. Importantly whilst the BBSS measured knowledge, attitudes and practices; access to services was also explored in a significant way. Further qualitative assessments will be conducted and this information would be used to further strengthen the delivery of services to the hinterland communities.
2. Repeated pregnancies among the HIV positive pregnant women	High rates of repeated pregnancies among the HIV positive women continued in 2014. The PMTCT programme in collaboration with partner agencies concluded a research to understand the factors associated with the repeated pregnancies. The data analysis is being conducted and a final report will be presented in 2014 and will be used to guide any changes in programming.
3. Retention of patients on ARVs	2014 presented its significant challenges to the HIV treatment programme; the programme operated without a treatment coordinator and significant staff attrition was noted with the transitioning of HIV treatment staff from donors to government. Despite this, compared to 2013 a small increase in 12 months survivability is noted with improvement in loss to follow up and death rates. Interestingly, for the first time, survivability among males was significantly improved and is reported as being greater than that of females. One of the factors attributed to this phenomenon is an increased strengthening of the social work component of clinical management in addressing issues affecting the male population.
4. Laboratory support for the ART programme:	This factor, acknowledged as a challenge in 2012-2013, continued as a greater challenge in 2014. The NPHRL experienced greater attrition of technical staff as a result of transitioning of staff from donor to Government. This has resulted in interruption in CD4, Viral Load and DNA PCR testing in addition to routine hematology and biochemistry. The situation is currently deemed a priority in the Ministry of Health and is being addressed accordingly.
5. Data collection system	The Global Fund and CDC were engaged in 2014 and commitment made towards the development of a Health Management Information Systems and an Electronic Medical Record System. An initial assessment of the current situation with recommendations on the way forward including viable alternatives, will be conducted early 2015 with support from CDC.

Despite the progress referred to above, many of the challenges reported during the 2012-2013 period remain since long term solutions are required. In addition to these, new challenges were identified during this reporting period. Cross cutting these challenges is the issue of staff attrition. The following key challenges are noted:

1. **Human resource transitioning:** The Ministry of Health has commenced the transitioning of several aspects of donor funded support to the Government of Guyana's budget. The transitioning of training, procurement of medical supplies, consumables and ARVs and other programmatic functions, has been a relatively smooth process. The staff transitioning however has been challenging and has resulted in interruptions in service delivery. This has been most evident in the PMTCT programme with a reduction in coverage for HIV testing among that population, the HIV treatment programme with a shifting of the workload from the site level to a more centrally driven one as in the case of data entry and laboratory support. The latter resulted in interruptions of viral load, CD4, DNA PCR and other testing which had the potential to result in suboptimal care. Whilst approval has been given for a phased three years transition plan for Human Resources, the Ministry of Health has prioritized the optimization of this plan.
2. **Reaching the key populations:** Despite the significant progress made during this reporting period, reaching the key populations remains a challenge. Issues identified in this regard include a reluctance of individuals to identify themselves as FSW or MSM and lack of disclosure of sexual orientation or sexual identity, fuelled by stigma and discrimination. Other issues were high cost and difficult terrain associated with reaching remote areas in addition to safety issues. The BBSS of 2014 provided significant information on these populations and the planned additional follow up with qualitative assessments, will further consolidate the understanding of these issues identified.
3. **Linkage into care:** Programmatic data suggest that there is a gap between persons testing positive for HIV and early linkage into care and treatment. Further to this, a rapid assessment of the HIV treatment data indicate that 37.5% (197/596) of persons entering the treatment program within the last year had a CD4<200 cell. Efforts are being made to address this issue at several levels: at HIV testing sites through training of counselor testers to adequately discuss CD4 testing and the impact of early treatment and through the expansion of the case navigator programme and: at the general population level with increased campaigns on early testing and linkage to care and through addressing issues of stigma and discrimination and disclosure. The client referral system will undergo a review to ensure that it is sufficiently robust to capture the required information to monitor linkage into care.
4. **Inequity in treatment and care:** An increase is noted in the 12 months survivability with a parallel reduction in loss to follow up and deaths. An examination of the treatment data with regard to these outcomes indicate that several treatment sites are underperforming in almost every measure. It is therefore critical that an assessment be conducted to establish the factors associated with this underperformance and that appropriate follow up actions and supportive mechanisms be introduced to ensure that there is uniformity in the quality of care being provided to all patients.
5. **Opportunistic infections and chronic diseases comorbidities, cervical cancer screening:** As the HIV treatment programme matures, there is increased focus on quality of care not only for the management of HIV and opportunistic infections but also for other chronic diseases and co morbidities. There is clear evidence that women living with HIV are at an increased risk for cervical cancer compared to their counterparts. The Ministry of Health has approved a policy decision on the use of VIA

and Single Visit (SVA) approach to screening for cervical cancer and treatment for atypical cervical lesions. This guidance was incorporated within the HIV treatment guidelines recommending annual screening for the population. As indicated, the total number of VIA screen declined over the last 3 years with a parallel decline in the number of HIV positive clients screened. Importantly the proportions with positive VIA findings remain significant at 10.7% in 2014. This programme continues to be challenged by limited human resources.

6. **The TB/HIV co epidemic:** There continues to be progress in addressing the TB/HIV co-epidemic with the maintenance of high levels of HIV testing among the TB population and increased ART coverage among the population. The high rates of co-infection and the relatively low (despite significant increase in 2014) ART coverage continues to engage the TB and HIV programmes. Linked to this is the reported high mortality and low treatment success related to this co-morbidity. Efforts have commenced in considering the WHO recommendation for IPT prophylaxis for HIV patients for whom active TB is ruled out. Additionally, there will be intensified clinical mentoring and collaboration between the TB and HIV staff.
7. **Laboratory Support:** Interruption in testing support for treatment continued to a greater extent in 2014 compared to 2013. This is evident as the data shows a reduced number of Viral load, CD4, DNA PCR and other testing. Two critical factors were associated with this; the continued attrition of technical staff of the NPHRL linked to the transitioning process and stock out of reagents and supplies. These were further compounded by the fact that there were occasions when the equipment was not functional for a variety of technical issues. Evidently, this has resulted in the provision of some level of sub optimal care being delivered to the population of PLHIV. The Ministry has prioritized all issues relating to the NPHRL and these are being addressed accordingly.

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): PEPFAR/USAID Partner - Advancing Partners and Communities (APC); United States Government (USG) partners include United States Agency for International Development (USAID), MEASURE, MEASURE Evaluation, US Centers for Disease Control (CDC), Peace Corps, 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 für Internationale Zusammenarbeit (GIZ)

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

1. Continued acknowledgement and appreciation that the HIV response is a country led process and thus support for the HIVision 2020 and alignment with national policy and strategic guidances.
2. Support the Ministry of Health on resource mobilization for the response.
3. Continuing support in working towards a mutually agreeable, phased transition plan from donors to Government.
4. Collaboration on initiatives in charting the way forward on sustainability of the HIV response.
5. Ensuring that there is health systems strengthening - a key component for sustainability of the HIV response
6. Provide technical assistance in coordination, policy development, prevention, care treatment and support, strategic information and all other coordination and technical areas aligned to the HIVision 2020.
7. Update the national response on new international and regional evidence, policies, guidelines and standards.
8. Conduct joint planning, monitoring and evaluation with the Ministry of Health.
9. Prioritize and support the National response in areas where there are gaps, including but not limited to policy development, research, surveillance.
10. Provide technical guidance through the sub-programmes technical working groups.

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 2014 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 (MERG) which aims at streamlining monitoring and evaluation efforts among the various partners. The MERG met throughout the year to plan M&E related work and to disseminate information.

The following were key areas of progress during 2014:

- **Biological & Behavioral Surveillance Survey (BBSS) Round 3:** A major achievement during 2014 was the completion of the BBSS through supportive collaboration with MEASURE Evaluation and partner agencies.



MAP showing Sites visited during the BBSS 2014

Data collection and data entry for the BBSS which commenced in 2013, was concluded in July 2014. A preliminary analysis of the data was done by MEASURE Evaluation, followed by the collection of supplemental data to validate the preliminary results after which the data analysis was completed.

In November 2014, a Stakeholder Dissemination meeting was held to share the findings of the BBSS and to receive feedback. The wide cross-section of stakeholders in attendance included representatives from the Ministry of Health/NAPS, civil society organizations, the Guyana Forestry Commission, technical partners and funders, and the media. The findings were presented according to the populations surveyed: Miners & Loggers; Female Sex Workers; Men who have Sex with Men and; Transgenders. Estimates for Key Populations (namely MSM and FSWs) were also developed using the BBSS data, and presented during the Dissemination meeting. The final report of the BBSS is currently being prepared and this will be made available in 2015.

Development of 2014 HIV Estimates: Using Spectrum the M & E Unit developed HIV estimates for 2014 (see table 19 below).

Table 19: HIV Estimates: Guyana 2014

Indicator	Estimate
HIV Adults + Children	7700
New HIV infections	<1000
Annual AIDS Deaths	<200
Prevalence Adult (%)	1.4
Incidence (15-49) (%)	0.11
HIV Adults (15+)	7500
HIV Adult Female (15+)	4000
New HIV infections - Adults (15+)	<1000
Annual AIDS deaths - Adults (15+)	<200
Prevalence Young Male (15-24)	0.6
Prevalence Young Female (15-24)	0.9
HIV Children (0-14)	<200
New Infections (0-14)	<100

Table 20 below shows ART coverage estimates for 2014. As indicated, using the national criteria for ART eligibility (CD4 ≤ 350), Guyana achieved 79% coverage among adults living with HIV and more than 95% coverage among children.

Table 20: Key Coverage Indicators: Guyana 2014

Indicator	Estimate
People receiving ART as a percentage of total HIV population (%)	Adults 52
	Children >95
ART Coverage - National HIV Eligibility Criteria (%)	Adults 79
	Children >95
Number of people eligible for ART - National HIV Eligibility Criteria	Adults 4900
	Children <200
Mothers receiving PMTCT (% Coverage)	>95
Mothers needing PMTCT	<200

- **Client Satisfaction Survey (CSS) 2013:** Data entry and cleaning of the CSS 2013 dataset was completed in 2014. The data was inputted into Excel and imported into SPSS for analysis. Data analysis commenced and a number of tables were prepared for the National Report. The CSS data will be analyzed further to generate two reports: (1) a national report on all data collected and (2) a TB report on data collected at all TB sites. These reports are scheduled for completion and dissemination by June 2015.
- **Preparation of HIV M & E Plan:** With the launching of the HIVision 2020, work commenced in 2014 in preparing a national HIV M&E Plan to accompany the Strategic Plan. A draft M&E Plan was completed by the M&E Unit and reviewed by MEASURE

Evaluation. The MERG also provided feedback on the draft plan which will be finalized during the first Quarter of 2015.

- **Revision of Monitoring Tools:** The monitoring tools for conducting outreaches to key populations were updated in 2014 with partner support. The staff from CSOs and USG sub-recipients were then trained in the rollout of these tools through further partner collaboration and the tools are to be further updated based on the feedback received from the users.
- **Capacity Building:** During the year, the skills of the M&E staff were further upgraded through participation in the following training:
 - Methodology for Surveillance on HIVDR in the Caribbean
 - Profiling the HIV Continuum of Care
 - Applied Public Health Leadership and Management Training
 - Leadership for Data Demand & Use
- **Completion of Key Reports:** During 2014, the M & E Unit was actively involved in coordinating the data collection and submitting this data online to UNAIDS during the preparation of the 2014 Global AIDS Response Progress Report and the Score card on Gender Equality in the National HIV Response. The Unit was also involved in the collection, collation and presentation of data for the Global Fund Semester seventeen (17) and eighteen (18) reports.

ANNEXES

ANNEX 1: Training Activities Conducted During the Reporting Period

Region	Topic	Number of Persons Trained	Target Audience	Training Category
Leadership and Coordination				
Tanzania	PEPFAR Impact Evaluation Workshop	1	HBC Coordinator	Leadership and Coordination
Jamaica	Strengthening Prevention in HIV and Public Health Programmes	1	NAPS Prevention Coordinator	
2, 3 4, 5, 6, 7, 10	Training on the MARPS Guidelines and Standards for Non-Governmental Organizations	25	MSM and SW Peer Educators from NGOs	
Prevention				
3, 4, 6	HIV YES Programme	1168	5 primary and 1 secondary school students	Adolescent Health
	HIV/STI education	61	Secondary school students	
	Sensitization HIV&AIDS		Teachers and education sector management staff	
	Career/Knowledge Fair (to sensitize youths regarding career choices)	79	In and out-of-school youths	
1, 9	Adolescent Health (4 sessions)		Community Support Officers, Teachers and School Welfare Officers	
1, 4, 6, 9, 10	HIV Sensitisation using Ready Body Manual	207	Youths	
4	Drug Use Among in-School Population		Teachers	
	Health and Family Life Education using HFLE Modules		Students of all secondary schools	
	Adolescent Health	24	Teachers	
	Peer Coaching in Expressive Arts Therapy and Parent Education	15	School welfare officers	
	Capacity Building to Deliver Family Planning Information and SRH Services	89	Community facilitators and health care workers	Sexual and Reproductive Health

Region	Topic	Number of Persons Trained	Target Audience	Training Category
	Youth Advocacy on Family Planning, Contraceptive Modalities and Comprehensive Sexuality Education	28	Youths of 15-24 age group	
Hinterland Regions	Focus Group Discussions on Teenage Pregnancy		Teachers	
	Family Planning and the Role of Religious Leaders in Promoting Family Planning Within Communities	28	FBO representatives	
4, 5, 6, 10	Adolescent Sexual and Reproductive Health	100	68 HCWs 32 peer educators	
	Sexual Reproductive Health and HIV/AIDS	310	Pre-service teachers	
	Training in Sexual and Domestic Violence Protocol for health care providers	140	Nursing students	Gender Based Violence
	GBV Sensitization Using Tools Developed for Addressing GBV	99	Fathers	
	Capacity Building for Integration of SRH and GBV/Sexual Violence into Youth Programmes		Youths	
4	Public Education on Gender Based Violence and HIV	49	Members of the public	
	Life skills Training using HFLE Training Modules on Violence Prevention	259	Secondary Students	
4	Stigma and Discrimination, HIV Transmission		Popular opinion leaders of 3 supermarkets	HIV sensitization and stigma and discrimination
1,2,3	Stigma and Discrimination	69	HCWs of different categories	
3, 4	PEP, Basics of HIV, Positive Health and Dignity	22	MSM/SW	
	Sensitization on HIV/AIDS in the Workplace (30 sessions)	300	Employees of various agencies	Workplace wellness
7 Regions	Prevention for MSM: 90-90-90 Targets, Myths about MSM and Transgenders, Healthy Living, Strategies for Reaching MSM	37	MSM	Key Affected Populations
3, 4, 6, 10	LGBT: Advocacy and Human Rights	22	LGBT members	
6	Human Rights, HIV and Sex Work	19	SWs	
4	HIV and STI Education, Stigma and Discrimination, Risk Reduction		Miners and loggers in mining camps	

Region	Topic	Number of Persons Trained	Target Audience	Training Category
2, 3	Stigma and Discrimination Against Key Populations, Positive Health and Dignity	47	HCWs	
6, 10	Key Affected Populations and Human Rights	40	Residents of New Amsterdam and Linden municipalities including key affected populations	
6, 10	Training of trainers workshop on Key Affected Populations, Human Rights and Facilitation Skills.	27	Representatives of LGBT, NGO, Police, health services	
6, 10	Key Affected Populations, Human Rights	650	HCWs, Police, other security personnel	
6	Computer training	6	MSM and SWs	
4	Craft production (floral decorations)	5	SWs	
	Training-of-trainers workshop on Case Tracking Management System	18	HCWs from public and private health care facilities	PMTCT
	Integrated Paediatric Care	15	HCWs including health centre supervisors	
	Review of draft Integrated PMTCT Curriculum	15	HCWs	
	Review of Safe Motherhood and STI Training	33	Different categories of HCWs including training facilitators	
	VCT training	45	Staff of Guyana Defence Force	Voluntary Counselling and Testing
1, 3, 4, 8, 9	VCT Refresher Training	104	Counselor/ Testers	
2, 4, 5, 9, 10	STI Syndromic Management	145	117 HCWs of different categories 28 Education officials	STI
4	Regional training of the trainer exercise to provide training in performing the VIA procedure	10	Participants from Trinidad, Suriname,	

Region	Topic	Number of Persons Trained	Target Audience	Training Category
			Antigua, St. Lucia and Guyana	
5, 6	Peer Education on Key Affected Populations	15	MSM	Peer Education
1	Peer Education	24	In and out-of-school youth	
6	Peer Education (training done in collaboration with MCYS)	39	In and out-of-school youth	
10	Peer Education	31	Kids Sake Foundation peer educators	
4	Peer Education	27	Members of Guyana Society for the Blind, other disabled persons	
1	Peer Education	21	In and out-of-school youth belonging to an FBO	
9	Peer Education	34	Students, including those from remote areas in Region 9	
1	Peer Education	24	HCWs of different categories attached to Mabaruma Hospital	
2, 4, 9	TB/HIV Peer Education	34	Representatives of the public and private sectors	
2, 5, 9, 10	PEP Sensitisation	82	Different categories of HCWs	Post Exposure Prophylaxis
3, 4, 6	Tuberculin Skin Test	44	HCWs	Tuberculosis
Treatment and Care				
6 Regions	HIV Continuum of Care in Guyana	60	NAPS/MoH staff, civil society members	Clinical management of HIV
4	Clinical Management of HIV/TB	35	HCWs	
7	Customer Service Excellence (with a focus on migrants)	32	Different categories of Bartica Hospital staff	Migrant services

Region	Topic	Number of Persons Trained	Target Audience	Training Category
7	Basic Portuguese	34	Different categories of Bartica Hospital staff	
7	HIV Basics, VCT, S & D, Confidentiality of Patient Information	34	Bartica Hospital staff	
	Stigma, Discrimination, Cultural Sensitivity and Human Rights Related to Health and Migration (4 workshops)	60	HCWs, government Ministries, Guyana Defence Force	
	Training of Trainers: Stigma, Discrimination, Cultural Sensitivity and Human Rights Related to Health and Migration	14	HCWs, government Ministries, NGOs	
	TB/HIV Management and Infection Control	17	Physicians	TB Infection Control
7, 8	Dried Blood Sampling (for DNA/PCR Testing)	22	Different categories of HCWs	Laboratory Training
4	Quantimed Training on Forecasting of ARVs and Other Supplies	17	HCWs	Forecasting for ARVs
Support Services				
3 locations in Region 3	Sensitization on Parenting, Early Childhood Development, Child Abuse (3 sessions)	106	Members of the community, including parents and teachers	OVC Care and Support
	Refresher Training in Home Based Care	29	Caregivers	Home Based Care
Strategic Information				
4	Methodology for Surveillance on HIVDR	1	MoH/NAPS M&E staff	Data Management
	Completion of Patient Forms (at HIV treatment sites)	20	Social Workers/ Counselors	
	Patient Monitoring System	16	Social workers and data entry clerks	
4	Applied Public Health Leadership and Management	1	MoH/NAPS M&E staff	

Region	Topic	Number of Persons Trained	Target Audience	Training Category
2, 4, 6, 10	Monitoring and Reporting Tools for Capturing Information on Key Affected Populations	11	M & E and Prevention Officers from 10 organizations	
4	Profiling the HIV Continuum of Care	19	Staff of NAPS/MoH, NPHRL, NBTS	
4	Leadership for Data Demand & Use	2	MoH/NAPS M&E staff	
Total number of persons trained		*5,217		

* This number excludes persons who were trained but the numbers of persons trained were not recorded for the specific training activity (as in the case of some of the above activities)

ANNEX 2: Core Indicators for Global AIDS Response Progress Reporting

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	DHS	2009	-	No new survey
	Note: There were fewer than 25 unweighted cases for females 15-19 and 20-24, 25-29, 30-39, 40-49, and have				

Targets	Indicator	Data	Period	Value	Remarks
	<i>been suppressed in DHS report.</i>				
	All Females	DHS	2009	-	
	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 <i>Note: Data not disaggregated by sex</i>	ANC Programme data	2014	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	2014	48.2%	Data reflects male, female and Transgender Sex Workers
	1.8 Percentage of sex workers reporting the use of a condom with their most recent client	BBSS	2014	75.7%	

Targets	Indicator	Data	Period	Value	Remarks
	1.9 Percentage of sex workers who have received an HIV test in the past 12 months and know their results	BBSS	2014	47.6%	
	1.10 Percentage of sex workers who are living with HIV	BBSS	2014	6.1%	
Men who have sex with men	1.11 Percentage of men who have sex with men reached with HIV prevention programmes	BBSS	2014	37.5%	Data includes Transgender
	1.12 Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	BBSS	2014	64.4%	
	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	2014	37.8%	
	1.14 Percentage of men who have sex with men who are living with HIV	BBSS	2009	4.9%	
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	-	-		

Targets	Indicator	Data	Period	Value	Remarks
	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	2014	188	Numerator is inputted and reflects data from the National Care and treatment programme and the PMTCT programme. 183 women received ARVs and 5 women single dose nevirapine. Denominator is derived from Spectrum file and will be finalized in May 2015
	3.1a Percentage of women living with HIV who are provided with antiretroviral medicines for themselves or their infants during breastfeeding period	PMTCT Programme Report & Spectrum	2014	NA	2 babies were being exclusively breastfed at admission during 2014. The denominator is derived from Spectrum file and will be finalized in May 2015
	3.2 Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth	NPHRL & PMTCT data	2014	59.5%	115 samples were processed within 2 months; 159 between 2 to 12 months and 16 samples beyond 12 months.

Targets	Indicator	Data	Period	Value	Remarks
	3.3 Mother-to-child transmission of HIV modeled	Modeled using Spectrum	2014	Not Available	This indicator will be updated from the finalized Estimates File in May 2015. Denominator: 193 HIV positive pregnant women who delivered in 2014
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	2014	4295	4295 persons were receiving treatment at the end of 2014. Denominator will be available in May 2015 from finalized Spectrum file.
	4.2 Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy <i>Note: This is the average survival values of 16 cohorts after 12 months on treatment. The cohorts cover the period January to December 2010.</i>	Patient Monitoring System (NAPS)	2014	81.2%	

Targets	Indicator	Data	Period	Value	Remarks
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	2014	103	Numerator reflects number of co-infected patients at TB sites who received ART (both new and retreatment cases). Denominator will be available from WHO later in 2015. Programme coverage reflects 69.6% (103/148)
Target 6: Reach a significant level of annual global expenditure (US\$22-24 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			The NCPI was not required for the 2015 GARPR report
	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%	

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	1.15	Number of health facilities that provide HIV testing and counselling services	VCT Programme report	Jan-Dec 2014	60	Public: 47; private: 2; NGO: 11; TB clinic: 16; STI Clinic 21
	1.16	HIV Testing and counseling in women and men aged 15 and older	VCT and PMTCT Programmes	Jan-Dec 2014	68,655	Total Number of persons tested (68,655) represents testing through VCT sites (54,815 with 1034 positives) and pregnant women tested in the ANC/PMTCT setting (12,416 with 123 positives) AND male partners of pregnant women who were also tested in the ANC/PMTCT setting (1,424 with 17 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 2014	54,815	
		HIV+ out of number tested	VCT Programme	Jan-Dec 2014	1034	
		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 2014	12,621	
	1.16.1	Percentage of health facilities dispensing HIV rapid test kits that experienced a stock-out in the last 12 months	VCT Programme report	Jan-Dec 2014	8.3%	
		Number of health facilities dispensing HIV rapid test kits that experienced a stock-out in the last 12 months			5	
		Total number of health facilities dispensing HIV rapid test kits			60	

	Indicator #	Indicator	Data Source	Period	Value	Comments
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%	2014 data is not yet available.
		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%	2014 data is not yet available
		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				2014 data is not yet available
		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				
	1.17.4	Percentage (%) Percentage of sex workers (SWs) with active syphilis	BBSS		1.6%	
		Numerator Number of sex workers who tested positive for syphilis			6	
		Denominator Number of sex workers who were tested for syphilis		2014	386	
	1.17.5	Percentage men who have sex with men (MSM) with active syphilis	BBSS	2014	1.0%	
		Numerator Number of men who have sex with men who tested positive for syphilis			4	
		Denominator Number of men who have sex with men who were tested for syphilis			388	
	1.17.6	Number of adults reported with syphilis (primary/secondary and latent/unknown) in the past 12 months	MOH Surveillance data		23	Data reflects all Syphilis cases reported to the MOH surveillance Unit among adults. Disaggregation of data based on stage is not available. There were 5 cases among males and 18 cases among females.
		Number of adults reported with syphilis during the reporting period		Jan-Dec 2014	23	

	Indicator #	Indicator	Data Source	Period	Value	Comments
		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	2014 data is not currently available. This will be updated in May 2015.
		Number of reported congenital syphilis cases (live births and stillbirths) in the past 12 months			0	
		Number of live births				
	1.17.8	Number of men reported with Gonorrhoea in the past 12 months	MOH Surveillance data	Jan-Dec 2014		
		Number of men reported with Gonorrhoea in the past 12 months			17	
		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 2014	829	
		Number of men reported with urethral discharge in the past 12 months			829	
		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 2014	167	66 males and 101 females

	Indicator #	Indicator	Data Source	Period	Value	Comments
		Number of adults reported with genital ulcer disease during the reporting period			167	
		Number of individuals aged 15 and older	2002 Census		448,012	
	1.18	Percentage of pregnant women with a positive syphilis serology whose sexual contacts were identified and treated for Syphilis.	-	-	NA	Data is not available
	1.19	Diagnosis of HIV cases	MOH Surveillance Unit	Jan-Dec 2014	HIV: 751 AIDS: 158	From 2014, AIDS cases were reported to include persons with CD4≤350. Previously, AIDS cases were reported as persons with CD4≤200
				Jan-Dec 2013	HIV: 758 AIDS: 88	
				Jan-Dec 2012	HIV: 820 AIDS: 105	
				Jan-Dec 2011	HIV: 972 AIDS: 62	
				Jan-Dec 2010	HIV: 1039 AIDS: 146	
	3.3a	Mother-to-child transmission of HIV (based on programme data)- Estimated percentage of child HIV infections from HIV-positive women delivering in the past 12 months	PMTCT and NPHRL reports	Jan-Dec 2014	2.6%	
		Number of children newly infected with HIV due to other-to-child transmission among children born in the previous 12 months to HIV-positive women			5	
		Number of HIV –positive women who delivered in the previous 12 months			193	

	Indicator #	Indicator	Data Source	Period	Value	Comments
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 2014	81.2%	Denominator is the actual number of women attending antenatal care in 2014
		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)			14,623	
		Total number tested and received results (including previously known positives)			12,586	
		Total number testing positive (including previously known positives)			293	
		(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)			13,370	
		Number tested and received results (including previously known positives)			11,333	
		HIV+ out of number tested (including previously known positives)			278	
		(a.i) Number of pregnant women with unknown HIV status attending ANC who were tested during ANC and received results				
		Number tested			13,200	

	Indicator #	Indicator	Data Source	Period	Value	Comments
		Number tested and received results			11,163	
		HIV+ out of number tested			108	
		(a.ii) Number of pregnant women with known HIV+ infection attending ANC for a new pregnancy				
		Number of HIV+ pregnant women			170	
		(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			962	
		Number tested and received results			962	
		HIV+ out of number tested			10	
		(c) Number of women with unknown HIV status attending postpartum services within 72 hours of delivery who were tested and received results				
		Number tested			291	
		Number tested and received results			291	
		HIV+ out of number tested			5	
		Denominator Estimated number of pregnant women			15,494	
	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 2014		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			9.2%	
		Denominator Number of pregnant women attending antenatal care			1424	
					15494	

	Indicator #	Indicator	Data Source	Period	Value	Comments
	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				
	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 2014	92.2%	There were 190 live births to HIV positive women in 2014.
		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)			178	
		Denominator Estimated number of HIV-infected pregnant women giving birth			193	

	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 2014	81.9%	The denominator represents the actual number of HIV+ women who delivered in 2014. 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			158	
		Denominator Estimated number of HIV-infected pregnant women giving birth			193	
	3.10	Distribution of Outcomes of HIV-Exposed Infants	PMTCT Programme	Jan-Dec 2013		2013 data is reported
		Number of infants born to HIV positive mothers born in 2013(or latest data)			192	
		Number of infants born in 2013 to HIV positive mothers, classified as indeterminate (i.e. lost to follow up, death before definitive diagnosis, indeterminate lab results)			0	
		Number of infants born to HIV positive mothers in 2013 that are diagnosed as positive for HIV			4	
		Number of infants born to HIV positive mothers in 2013 that are diagnosed as negative for HIV			188	
	3.11	Number of pregnant women attending ANC at least once during the reporting period	ANC Programme		15,494	
	3.12	Number of ANC facilities providing HIV testing and counseling services			188	Public: 184 Private: 4
		Number of ANC facilities providing HIV testing and counseling services and dispensing ARVs			20	Public: 18 Private: 2
		Percentage of health facilities that provide virological testing services for diagnosis of HIV in infants on site or from dried blood spots			3.7%	

	Indicator #	Indicator	Data Source	Period	Value	Comments
		Number of health facilities that provide virological testing services for diagnosis of HIV in infants on site or from dried blood spots			1	On site: 0 Through DBS:1 The National Public Health Reference lab is the only facility that conducts virological testing for HIV exposed infants via DBS.
		Total number of health facilities that provide follow up for HIV exposed infants			27	
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 2012-Dec 2014	75.1%	Lost to follow up: 60 (11.2%) Stopped Therapy: 29 (5.4%) Died: 46 (8.6%)
		Numerator Number of adults and children who were still alive and known to be on treatment 24 months after initiation of antiretroviral therapy			402	
		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)			535	
	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	Jan 2009-Dec 2014	61.2%	Lost to follow up: 24 (13.5%) Stopped Therapy: 10(5.6%) Died: 32 (17.9%)

	Indicator #	Indicator	Data Source	Period	Value	Comments
		Numerator Number of adults and children who were still alive and on antiretroviral therapy 60 months after initiating treatment			109	
		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)			178	
	4.3a	Health facilities that offer antiretroviral therapy	ART Programme	Jan-Dec 2014		The unspecified site is the national care and treatment centre which is the largest care and treatment facility and does not fit into any of the categories
		Numerator Number of health facilities that offer antiretroviral therapy (ART) (i.e. prescribe and/or provide clinical follow-up)			22	
		Disaggregation by public/private:				
		Public			20	
		Private			2	
		Unknown/unspecified				
		Disaggregation by health centre type:			13	
		Hospital				
		Health centre			7	
		ANC			20	
		TB Service			12	
		STI			22	
		Unknown/unspecified			1	
	4.3b	Health facilities that offer paediatric antiretroviral therapy	ART Programme	Jan-Dec 2014		All the HIV care and treatment facilities offer pediatric ART.

	Indicator #	Indicator	Data Source	Period	Value	Comments
		Numerator Number of health facilities that offer paediatric antiretroviral therapy (ART) (i.e. prescribe and/or provide clinical follow-up)			22	
		Disaggregation by public/private:				
		Public			20	
		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	ART Programme	Jan-Dec 2014	0	
		Denominator Number of health facilities dispensing ARVs			22	
	4.5	Late HIV diagnoses: Percentage of HIV positive persons with first CD4 cell count < 200 cells/ μ L in 2013	National Public Health Reference Lab	Jan-Dec 2013	37.5%	Data represents 13 out of 22 care and treatment facilities (59%)
		Number of HIV-positive people with first CD4 cell count <200 cells/ μ L in 2013			197	
		Total number of HIV-positive people with first CD4 cell count in 2013			526	
	4.6	Number of adults and children enrolled in HIV care at the end of the reporting period	ART Programme	Jan-Dec 2014	746	There were 539 patients newly enrolled in ART at the end of 2014 and 4295 patients receiving

	Indicator #	Indicator	Data Source	Period	Value	Comments
		Number of adults and children newly enrolled in HIV care during the reporting period			605	ART.
	4.7	a. percentage of people on ART tested for viral load who were virally suppressed in the reporting period	ART Programme	Jan-Dec 2014	70.1%	Data represents 13 out of 22 care and treatment facilities (54.5%)
		Numerator number of people on ART tested for viral load in the reporting period with suppressed viral load (i.e. ≤ 1000 copies)			940	
		Denominator number of people on ART tested for viral load in the reporting period			1340	
		b. percentage of people on ART tested for viral load (VL) with VL level below $\leq 1,000$ copies after 12 months of therapy			78.7%	Data represents 12 out of 22 care and treatment facilities (59%)
		Numerator number of people tested after 12 months therapy for VL and have suppression (VL ≤ 1000 copies) during the reporting period			381	
		Denominator Number of people tested after 12 months therapy for VL during the reporting period			484	
		c. Percentage of people on ART tested for viral load with undetectable viral load in the reporting period				Data is not available.
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	ART and Pre ART Registers	Jan-Dec 2014	2.8%	
		Total number of adults and children newly enrolled in HIV care who are diagnosed as having active TB disease during the reporting period			32	

	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			1114	
	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 2014	3.8%	
		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			44	
		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)			1144	
	5.4	Percentage (%) of adults and children enrolled in HIV care who had TB status assessed and recorded during their last visit	Patients' charts (ART Care and Treatment Sites)	Jan- Dec 2014	96.5%	
		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			4864	
		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)			5041	

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: Contributors to the Reporting Process

Country Team

1. Dr. Shanti Singh - Programme Manager, NAPS, Ministry of Public Health
2. Ms. Fiona Persaud - M&E Lead, NAPS, Ministry of Public Health
3. Dr. Morris Edwards, Director - Disease Control, Ministry of Public Health
4. Dr. Roberto Luiz Brant Campos - UNAIDS Country Director
5. Ms. Yaye Kanny Diallo - M&E Advisor, UNAIDS, Guyana
6. Ms. Stephanie Joseph De Goes - PEPFAR Coordinator
7. Mr. Oleksander Cherkas - Health Team Leader, USAID
8. Dr. Rosalinda Hernandez - FCH/HIV/STI Advisor/PAHO/WHO
9. Dr. Jean Seme Fils Alexandre, PAHO/WHO
10. Ms. Cornelly McAlmont - Child Survival and Development Officer, UNICEF
11. Mr. Dimitri Nicholson - Civil Society Representative
12. Ms. Preeta Saywack - Strategic Information Officer, PEPFAR
13. Mr. Dale Phoenix - Monitoring & Evaluation Officer, APC
14. Mr. Oswald Alleyne - Public Health Specialist, CDC
15. Ms. Mena Carto - Consultant, Country Progress Report

Agencies that Contributed Reports for the GARPR Preparation Process

1. Ministry of Public Health
2. National AIDS Programme Secretariat/ Ministry of Public Health
3. Ministry of Education
4. Ministry of Labour, Human Services and Social Security
5. Pan Caribbean Partnership against HIV/AIDS
6. President Emergency Plan for AIDS Relief
7. Advancing Partners and Communities
8. Guyana Defence Force
9. United Nations Development Programme
10. United Nations Children Fund
11. United Nations Population Fund
12. Pan American Health/World Health Organization
13. Guyana Business Coalition for HIV/AIDS
14. Guyana Responsible Parenthood Association
15. Society against Sexual Orientation Discrimination
16. Help and Shelter

Participants at the Consensus Meeting

1. Dr. Shanti Singh-Anthony, Program Manager, NAPS/Ministry of Public Health
2. Ms. Nafeza Ally, Social Services Coordinator, NAPS/Ministry of Public Health
3. Mr. Somdatt Ramessar, Food Bank Manager, NAPS/Ministry of Public Health
4. Mr. Murvin Chalmers, Data Entry Clerk, NAPS/Ministry of Public Health
5. Ms. Fiona Persaud, M & E Lead, NAPS/Ministry of Public Health
6. Ms. Gina Arjoon, Key Populations Coordinator, NAPS/Ministry of Public Health

7. Ms. Deborah Success, VCT Coordinator, NAPS/Ministry of Public Health
8. Ms. Yanita Jaundoo, Care and Treatment Coordinator, NAPS/Ministry of Public Health
9. Mr. Nazim Hussain, Community Mobilization Coordinator, NAPS/Ministry of Public Health
10. Ms. Roslyn Allen, Hotline Facilitator, NAPS/Ministry of Public Health
11. Ms. Shevonne Benn, HBC Coordinator, NAPS/Ministry of Public Health
12. Mr. Delon Braithwaite, VCT Qual Officer, NAPS/Ministry of Public Health
13. Ms. Romona Morgan, STI Coordinator, NAPS/Ministry of Public Health
14. Ms. Samantha Dhanraj, NAPS/Ministry of Public Health
15. Ms. Tamica Allen, NAPS/Ministry of Public Health
16. Mr. Joseph Hamilton, Parliamentary Secretary, Ministry of Public Health
17. Ms. Shamin Williams - PMTCT Programme, Ministry of Public Health
18. Ms. Debra Rose, Ministry of Public Health
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21. Dr. Bendita Lachmansingh, Epidemiologist, Ministry of Public Health
22. Ms. Diana Khan, NTP/ Ministry of Public Health
23. Ms. Oslyn Crawford, MoLHS&SS
24. Ms. Hymawattie Lagan, Women's Affairs Bureau, MoLHS&SS
25. Ms. Janelle Sweatnam, MoE
26. Ms. Evelyn Hamilton, MoE
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37. Mr. Dimitri Nicholson - Civil Society Representative
38. Ms. Gloria Joseph, Executive Director, Lifeline Counseling Services
39. Ms. Roshana Rawlins, Linden CARE Foundation
40. Ms. Merica George, AIDS
41. Mr. Richard Collymore, FACT
42. John Quelch, SASOD
43. Ms. Suzanne French, Executive Director, GBCHA
44. Ms. Renuka Anandjit, GRPA
45. Ms. Shivanie Rampersaud, GINA
46. Ms. Shaundell Gomes, MTV
47. D. Daniels, Kaiteur News
48. Ms. Mena Carto, GARPR Consultant