
# GLOBAL AIDS MONITORING REPORT 2019

**Guyana Country Report**

**Reporting Period: January- December 2018**

# FOREWORD

The Joint United Nations Programme on HIV and AIDS (UNAIDS) Strategy 2016 to 2021 seeks to Fast Track the AIDS response and achieve the 90-90-90 treatment targets. Achievement of these targets will mean that by the year 2020, 90 percent of People Living with HIV (PLHIV) in Guyana will know their status, 90 percent of these persons will be receiving anti-retroviral treatment and 90 percent of those on ART will achieve viral suppression. The body of this report provides evidence that point to the further stabilizing of the HIV epidemic. There has been an annual reduction in the number of HIV cases reported when compared to 2009, a reduction in AIDS cases, and a reduction in the number of AIDS-related deaths.

Guided by HIVision 2020 which was aligned to the 90-90-90 target in 2016, Guyana continues to deliver a comprehensive multi-sectoral response with the involvement of a variety of partners and stakeholders. Civil Society Organizations 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 especial in providing nutritional support for persons living with HIV/AIDS. 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 in achieving sustainability. Our technical partners - local, regional and global, continue to provide important technical guidance in the national response to HIV.

HIV prevention programmes continue with national coverage and with greater emphasis on reaching the key populations at higher risk. The investment over the years in prioritizing the provision of services to key populations has yielded good results as is evident in the reduced HIV prevalence among these populations according to the findings of the Biological and Behavioural Surveillance Survey (BBSS) of 2014. Faced with a number of challenges in engaging sub recipients for the delivery of services to key population the reporting period has seen a decline in the number of key populations reached and tested when compared to 2017. This nonetheless did not translate to an increase in the overall number of new cases reported as well as the adult prevalence for the country.

Other prevention programmes continued to show good progress in 2018 with greater than 88% uptake of HIV testing among the antenatal populations visiting the health facilities, 100% screening of blood and blood products and sustained HIV testing for the general population. During the year, key

populations accounted for 9% of all HIV testing done in 2018. Condom programming and cervical cancer screening continued in 2018 with the distribution of 6,012,721 pieces of condoms, building on the gains of previous years, and there was continued training and sensitization of young persons, persons in the workforce and the general population.

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 on antiretroviral therapy and aiming at 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 88% among the TB patients and a reducing co-infection rate from 31% in 2012 to 16% at the end of 2018. Co-infected patients continue to benefit from the expertise of the multidisciplinary care and treatment team who very skillfully manage the treatment for both infections.

Laboratory support to the programme continued despite the challenges of human and material resources. Strengthening of the HIV surveillance system has also enabled the reporting of HIV, advanced HIV, and AIDS cases which included revision of the case based surveillance for to improve case tracking via the use of a unique identifier for HIV clients.

Notwithstanding our achievements, 2018 recorded its own challenges - particularly those of transitioning which continued to affect 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 on ensuring that our programmes are transitioned to full local ownership while maintaining a comprehensive evidence-based scope and scale. The Government of the Cooperative Republic of Guyana commits to ensuring that no baby is born HIV positive, that every Guyanese knows their HIV status, that HIV prevention methods are available and accessible, 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 an AIDS-free Guyana. The Government of the Cooperative Republic of Guyana stands committed.

*Ms. Volda Lawrence*

*Hon. Minister of Public Health, Guyana*

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## ACRONYMS

| | |
|---|---|
| AIDS | Acquired Immune Deficiency Syndrome |
| ANC | Antenatal Clinic |
| APC | Advancing Partners and Communities |
| ART | Antiretroviral Therapy |
| ARV | Antiretroviral |
| BBSS | Biological and Behavioral Surveillance Survey |
| CAA | Client Advocate Associate |
| CBOs | Community-based Organizations |
| CCJ | Caribbean Court of Justice |
| CCM | Country Coordinating Mechanism |
| CCPA | Child Care Protection Agency |
| CDC | US Center for Disease Control and Prevention |
| CSO | Civil Society Organization |
| CSW | Commercial Sex Worker |
| CVC | Caribbean Vulnerable Communities Coalition |
| GCWAG | Community Based Organization of Guyana Positive Women and Girls |
| DOTS | Direct Observed Therapy |
| DNA | Deoxyribonucleic Acid |
| FBO | Faith-based Organization |
| FCSW | Female Commercial Sex Worker |
| FSW | Female Sex Worker |
| GAM | Global AIDS Monitoring |
| GBCHA | Guyana Business Coalition on Health Awareness |
| GBoS | Guyana Bureau of Standards |

| | |
|---|---|
| GBV | Gender Based Violence |
| GDF | Guyana Defence Force |
| GDP | Gross Domestic Product |
| GDS | Genital Discharge Syndrome |
| GF | Global Fund |
| GFATM | Global Fund to Fight AIDS, Tuberculosis and Malaria |
| GFCHA | Guyana National Faith Coalition on HIV and AIDS |
| GPlus | Network of Guyanese living with and affected by HIV |
| GoG | Government of Guyana |
| GRPA | Guyana Responsible Parenthood Association |
| GSWC | Guyana Sex Worker Coalition |
| GUD | Genital Ulcer Disease |
| GUM | Genito-Urinary Medicine |
| HAART | Highly Active Antiretroviral Therapy |
| HBC | Home-Based Care |
| HCW | Health Care Worker |
| HDI | Human Development Index |
| HFLE | Health and Family Life Education |
| HIV | Human Immuno-deficiency Virus |
| HIV DR | HIV Drug Resistance |
| HPV | Human Papilloma Virus |
| HTC | HIV Testing and Counseling |
| HTLV | Human T-Lymphotropic Virus |
| IEC | Information, Education, Communication |
| IPT | Isoniazid Preventive Therapy |

| | |
|---|---|
| LEEP | Electrosurgical Excision Procedure |
| LGBT | Lesbian, Gay, Bisexual and Transgender |
| LTFU | Loss to Follow Up |
| MARPs | Most At-Risk Populations |
| M&E | Monitoring and Evaluation |
| MICS | Multiple Indicator Cluster Survey |
| MoPH | Ministry of Public Health |
| MSM | Men Who Have Sex with Men |
| MSW | Male Sex Worker |
| MTCT | Mother-to-Child-Transmission |
| NAPS | National AIDS Programme Secretariat |
| NCTC | National Care and Treatment Centre |
| NGOs | Non-Governmental Organizations |
| NHA | National Health Accounts |
| NPHRL | National Public Health Reference Laboratory |
| 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 |
| PITC | Provider-Initiated Testing and Counseling |

| | |
|---|---|
| PLHIV | Persons Living with HIV |
| PMS | Patient Monitoring System |
| PMTCT | Prevention of Mother-to-Child-Transmission |
| PrEP | Pre-exposure Prophylaxis |
| SASOD | Society against Sexual Orientation Discrimination |
| SDG | Sustainable Development Goal |
| SOGI | Sexual Orientation and Gender Identity |
| SRH | Sexual and Reproductive Health |
| SRHR | Sexual and Reproductive Health and Rights |
| STIs | Sexually Transmitted Infections |
| SVA | Single Visit Approach |
| SW | Sex Workers |
| TB | Tuberculosis |
| TG | Transgender |
| THE | Total Health Expenditure |
| TST | Tuberculin Skin Testing |
| TWG | Technical Working Group |
| UN | United Nations |
| UNAIDS | Joint United Nations Programme on HIV and AIDS |
| UNDP | United Nations Development Programme |
| UNFPA | United Nations Population Fund |
| UNICEF | United Nations Children Fund |
| USAID | United States Agency for International Development |
| VCT | Voluntary Counseling and Testing |
| VIA | Visual Inspection with Acetic Acid |

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# BACKGROUND

In 2015, UNAIDS set a goal to "end AIDS as a public health threat" by 2030. The campaign's code name "Fast Track approach" is based on a mathematical model that says that the epidemic will peter out if enough people keep the virus in check. To achieve this, by 2020, at least 90% of the estimated eight thousand one hundred (8100) people in the Guyana living with HIV must know their status, 90% of them must start treatment, and 90% of those treated must stay on the medication and keep the virus fully suppressed. Guyana endorsed the United Nations 2016 Political Declaration on HIV/AIDS on ending the AIDS Epidemic by 2030 which is an integral part of the Sustainable Development Goals. Ending the AIDS epidemic by 2030 required countries to adopt the Fast-Track approach to accelerate their programme within the short window of time 2016 to 2020 (i.e. 5 years Fast-Track window).

The following report captures the progress made by the Ministry of Public Health and all country partners during the period January to December 2018 in achieving the ten commitments outlined by the UN partners. It is expected that the achievements and challenges highlighted will inform future programmatic planning and identify the resources and investments needed to achieve the 90-90-90 targets by the end of 2020, thereby ensuring an AIDS free Guyana by 2030. Information contained in this report was extracted from reports shared by our partners during the reporting period and compiled by the National AIDS Program Manager, Coordinators and a local consultant. The draft report was then shared with the Chief Medical Officer for his review and approval of its contents before submission to the GAM online platform for sharing with the rest of the world.

# STATUS AT A GLANCE

Based on the UNAIDS 2019 estimation exercise, Guyana's adult HIV prevalence is 1.5%.

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 2017, a total of 961 new HIV cases were diagnosed while in 2018, a total of 695 new cases were diagnosed. While the trend since 2010 has shown a greater number of reported HIV cases among females compared to males, the male female ratio began to increase again from 2013 and showed a male female ratio of 1.1 in 2018. (MoPH Surveillance data). In terms of notified AIDS cases, the male female ratio continues to show a higher proportion among males with a male female ratio of 1.3 in 2017 and 1.6 in 2018.

A total of 449 cases were reported within the combined age group of 25-49 which accounted for 64.6% of all HIV cases reported during 2018 compared with the 2017 figure of 62.9% of all HIV cases for this combined age group. Children aged 0-4 accounted for 0.3% (3/961) of the reported HIV cases in 2017 compared to 0.4% (3/695) in 2018. Persons 50 years and above accounted for 14.1% (98/695) of all cases of HIV in 2018 compared to 11.9% (114/961) in 2017 (MoPH Surveillance Unit).

Region 4 continued to have the highest proportion of all new HIV cases reported with 67.6% in 2017 and 68.8% in 2018 compared with 72.6% in 2016 (MoPH 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.

HIV prevalence among pregnant women was 2.2% in 2017 and 1.7% in 2018 compared with 2.2% in 2016 (PMTCT programme reports). In 2017 and 2018, 1.4% (2/141) and 3.6% (7/190)) respectively of babies born to HIV-positive mothers were infected with HIV compared to 1.4% (2/141) in 2016 (PMTCT programme reports). HIV prevalence among blood donors was 0.85% and 0.64% in 2017 and 2018 respectively of all blood screened compared with 0.85 % in 2016 (Blood Bank Programme data). TB/HIV co-infection was 23% in 2016 then 22% in 2017 and 16% in 2018.

## Policy Response

During 2016 and 2017, the National Advisory Committee for a National Dialogue on HIV and the Law that was created to provide a safe space for addressing HIV-related discrimination issues, continued to receive submissions from persons who had experienced discrimination. The Advisory Committee reviewed each submission and proposed recommendations to address the issues raised. One concern raised by the transgender community was the existence of the cross-dressing law which was observed to be stigmatizing and discriminatory. During the reporting period, members of the transgender community achieved a landmark victory in November 2018 when the Caribbean Court of Justice (CCJ) made a ruling that the section of Guyana's law which prohibits cross-dressing be struck out as *it serves no legal or social purpose and inhibits the right to freedom of expression*. The decision was in response to a case presented by four transgender persons who had been arrested by Police in Guyana during a crackdown on male cross-dressers during 2009. Guyana's Prime Minister, speaking on behalf of the Government, has since stated that Guyana respects the decision of the CCJ on its recent ruling that the criminalization of cross-dressing in Guyana is unconstitutional.

In further support of the rights of the LGBT community, an amendment is currently being drafted to the Prevention of Discrimination Act to stipulate that Sexual Orientation, Gender Identity and Expression should not be used as grounds for discrimination.

A Sexual and Reproductive Health (SRH) Policy and also a Strategy that were drafted in 2013 are currently being reviewed among the key stakeholders for finalization and presentation to Cabinet for approval. This Policy and Strategy seek to address universal access to Sexual and Reproductive Health for all - including adolescents.

Additionally in May 2018 the Honourable Minister of Public Health officially endorsed the "treat all" policy which was being partially implemented unofficially since 2017 resulting in full implementation at all treatment sites across the country.

In June of the same year, the Ministry also endorse the use of differentiated model of service delivery and with funding support from the Center for Disease Prevention and Control (CDC) established an Extended Hours clinic at its premier treatment site in the capital city of Georgetown. This service while accessible to both general and key population resulted in an increase of Men who have sex with men accessing a public health facility for services.

The country with support from the USAID also developed its 5 year sustainability plan during 2017 and deliberated on it during 2018 with plans to begin implementation of same during 2019. Among the many interventions identified in the plan was the refocus of the function of the NAPS to strengthen

coordination and for government to begin to put systems in place sustain the work of civil society through Social Contracting, both of which will be implemented in 2019.

## Programmatic Response

In recognition of the decreasing levels of donor support and the need for country ownership with regard to the sustainability of the national HIV programme, the Government of the Cooperative Republic of Guyana during 2018, continued to increase the national budget allocation for the national HIV programme. The government funded more than 90% of the procurement of antiretrovirals and 100% of the commodities for viral load and CD4 testing. Additionally, human resources that were partially donor-funded for the national HIV response, were being gradually absorbed by the country's Public Service Commission. A National Health Accounts exercise conducted for the year 2016, in addition to an Allocative Efficiency and Program Effectiveness Study conducted for the year 2015, served to inform the development of a detailed costing of the National Strategic Plan for HIV and AIDS that was finalized early 2018.

Guyana's HIVision 2020 which is the guiding document for national HIV programme, focuses on five priority areas: Coordination; Prevention; Treatment, Care and Support and; Integration and Strategic Information.

Coverage of HIV-related services during 2018 continued with a focus on prevention, treatment, care and support. Special emphasis was placed on improving testing and treatment coverage for all persons living with HIV/AIDS. The HIV programme continued to benefit from financial and technical support from its country partners and donor agencies.

## Prevention

In pursuit of the Elimination of Mother to Child Transmission (eMTCT) of HIV and Congenital Syphilis, the national PMTCT programme continued to make strides through a proactive case tracking management system which seeks to ensure that each HIV infected pregnant woman is followed throughout pregnancy, delivery and the post-partum period, along with the HIV-exposed infant. MTCT of HIV among infants tested using DNA/PCR decreased significantly from 5.8% in 2010 to 2.5% in 2011 and further decreased to 2.2% in 2018 with the lowest rate of transmission occurring during 2016 (1.4%). The prevalence of HIV among the antenatal population was 1.7% at the end of 2017 compared with 1.9% in 2018. The percentage of HIV positive women who received ART in Labour and Delivery during the period was approximately 56.9% while approximately 98% of HIV-exposed infants received NVP and AZT. The first draft of the Elimination Initiative report was completed in 2016, reviewed by the Regional Validation Committee and recommendations proposed. During 2017, a national verification exercise was launched countrywide and the final report was submitted with ongoing review and implementation of the recommendations during the reporting period 2018

During 2018, VCT continued to be provided country-wide through 51 active fixed sites and 1 mobile unit targeting high burden communities of the coast and the hinterland and key populations. Along with the 191 Antenatal clinic and one National Blood Transfusion Center that provided HIV testing. A total of 73,303 HIV tests were done during 2017 while 72,582 tests were done during 2018. The latter year showed a decrease in testing since the VCT programme targeted communities with a higher yield of HIV positive persons. Females continued to access VCT services more than males, accounting for 65.1 % of testing in 2017 and 69% in 2018. VCT was routinely provided to TB patients and TB screening was provided to HIV-infected patients. The TB/HIV co-infection rate was found to be 23% in 2017 and 16% in 2018. Co-infected patients were referred between HIV and TB treatment sites as required.

Special emphasis was placed on reaching key populations to provide PPVCT and other prevention services. Key populations accounted for 18.5% of the total number of persons tested during 2017 and only 6% in 2018. These populations also accounted for 15.5% (155/961) of the total number of positives nationally in 2017 while in 2018 this decreased to 13.5% (107/696) of the total number of positives. During 2017 and 2018, 20,175 and 2678 members were reached with a package of prevention services respectively. Client Advocate Associates (CAAs) were also proactive in identifying KPs within the larger patient population, initiating VCT, conducting intensive contact and defaulter tracing and navigating clients in accessing services. VCT provided in the main prisons found 4.2% (4/96) HIV positive in 2017 compared to 1.1% (1/89) in 2018. HIV testing was also conducted in collaboration with 29 FBOs and 29 Private Sector Organizations during the reporting period.

The mandatory screening of blood and blood products during 2018, revealed that 0.53% (51/9687) of the blood screened was found to be HIV positive. The percentage of screened blood that tested positive for STIs was 1.1%. Hepatitis B was the most commonly occurring STI followed by Hepatitis C.

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. Prevention education was interwoven into the various components of the National HIV programme. National commemorative activities such as World AIDS Day and International Women's Day also served as a good media for providing HIV education and sensitization regarding HIV services including testing, screening for STIs and referral to treatment services. A number of public service announcements were aired during the reporting period as well as there were television interviews of members of the National AIDS Programme Secretariat.

Workplace programmes, community mobilization (trainings and outreaches), peer education and the Health and Family Life Education in primary and secondary schools also continued to be used as

effective tools in reaching members of the public with prevention messages - including youths, community leaders and members of the key populations with prevention messages.

During 2018, the three government health facilities that were upgraded to facilitate delivery of SRH services to adolescents and men, as part of the effort to rebrand SRH as family health services continued to provide services and collaborated with the NAPS to provide testing for HIV and other STIs for men. The Youth Friendly Health Services Initiative also included special antenatal clinics for pregnant teenagers.

With regard to STI screening, the majority of STI cases were among the 15 – 24 age group. Females also comprised a higher proportion of cases: 76% in 2017 and 2018. A total of 6,626 in 2017 when compared with 4893 reported cases in 2018. Genital discharge syndrome (GDS) remained the most frequently reported STI during the period 2013-2018 (ranging between 86% and 95%), while genital ulcer disease (GUD) remained the second highest (ranging between 3.3 and 6.6%). During 2018, seventeen government health facilities and two private institutions provided Post Exposure Prophylaxis (PEP) for HIV. The PEP kits included the Standard Operating Procedures/Guidelines, ARVS, medications for other STIs, and emergency contraceptives.

## Treatment

During 2018, HIV treatment and care continued to be provided at 22 treatment sites countrywide. At the end of 2017, the total number of persons enrolled in care and treatment programme was 5,543 (5237 on ART and 306 in care) while at the end of 2018, the total was 5775 (5557 on ART and 218 in care). Of the total in 2017, 54.4% were females and 45.6% were males while in 2018, 54.2% were females and 45.8% were males. During 2017, 587 adults (48.7% males and 51.3% females) and 15 children (47% females and 53% males) were initiated on ART while in 2018, 532 adults (49.1% males and 50.9% females) and 11 children (45.5% females and 54.5% males) were initiated on ART. During 2017 and 2018, 85.8% and 89.4 respectively of those on ART were on first line therapy compared to 89.4% in 2015. During 2017, 74 prisoners at the main prison were provided with HIV care and treatment services (46 on ART and 28 in pre-ART) while in 2018, treatment was provided to 155 prisoners (126 on ART and 29 on pre-ART).

Among the 2017-2018 national cohort of patients, 12-months survivability and retention on ART was 86% (564/658) which was a slight increase from the 82% that was reported for the 2016-2017 cohort. Of the remaining 14%, mortality accounted for 5%, those who stopped treatment accounted for 1% and 8% were lost to follow-up. During 2018, 78.5% of the children on ART and 80.5% of the adults on ART were found to be virally suppressed.

## Care and Support

HIV-sensitive care and support continued to be provided to persons living with and affected by HIV through the provision of nutritional support and the hosting of PLHIV support group meetings. The 15 existing support groups had a total membership of 363 in 2018 compared with 429 in 2017. Group

meetings provided a forum for skills building and the provision of psychological and social support. To address the specific needs of adolescent PLHIV, 3 separate support groups were facilitated through which members shared their experiences at different group forums – including at an annual youth camp. The nutritional needs of PLHIV were addressed through the provision of food hampers to 835 patients in 2018 compared to 754 patients in 2017. During 2018, capacity building sessions were also conducted with PLHIV to equip them with peer education skills as well as culinary skills, resulting in one female member establishing a small business for the sale of healthy fruit and vegetable juices.

During 2018, Private Sector organizations, NGOs, CBOs and community members continued to play an active role in supporting the delivery of HIV support services. These entities were actively involved in providing HIV prevention education, VCT, home visits, psychosocial support and facilitating linkages to HIV care, treatment and support services.

## Monitoring and Evaluation

Throughout the reporting period, Monitoring and Evaluation (M & E) of the national response continued. Patient Monitoring System (PMS) site visits continued at the care and treatment sites throughout Guyana to provide oversight, conduct chart reviews and training, and obtain feedback. Clinical mentoring was provided to health care workers to increase the pool of medical personnel providing HIV care and treatment as well as in an attempt to standardize the quality of care provided to persons living with HIV/AIDS. National HIV estimates for 1990 - 2018 were developed using UNAIDS Spectrum estimates tool and the 2017 and 2018 cascades were developed for Guyana.

| Name of Training | Date | Target Population | Topic | # of People Trained |
|---|---|---|---|---|

| | | | | |
|---|---|---|---|---|
| **Data Entry Training** | April 12th, 2018 | Data Entry clerks, Nurses, Social Workers, and Outreach workers | Monitoring Evaluation Fundamental | 25 |
| **Regional Data Analysis, Dissemination & Use** | September 12-15, 2018 | NAP Managers, Strategic Information and Monitoring & Evaluation Officers | To strengthen capacity in data analysis and use of data to improve programming and policy<br><br>To strengthen mechanisms for regional information sharing<br><br>▪ To the increase the availability of strategic information to inform and guide policy and program development. | 2 |

## OVERVIEW OF THE AIDS EPIDEMIC

Guyana the only English speaking Country in South America has a population of 746,955 and a landmass of some 215,000 square kilometers. According to the 2012 census report of the Guyana Bureau of Statistics (GboS), 50.2% of the population are females while 49.8% are males. The 15-19 age range makes up the highest proportion (11.4%) of the population followed by the 10-14 age group (11.1%). The productive sector (20-49 yrs.) of the society represents 41.6%of the total population. Guyana is made up of 10 administrative regions and according to the 2012 census, most of the population (89.1%) is concentrated in the coastal areas (regions 3, 4, 5 and 6).

Guyana's per capita gross domestic product (GDP) was 3871.39 US dollars in 2018 (2018 est.). Guyana has been classified as a middle income country by the World Bank. The country has maintained its position in the Medium Human Development category on the Human Development Index (HDI) scale with an HDI rank of 125 out of 189 countries in the Human Development Report 2018 updates.

The HIV Epidemic in Guyana continues to be generalized with key population groups - men who have sex with men (MSM), female sex workers (FSWs) and transgender (TG), being disproportionately affected. Based on the UNAIDS 2019 estimation exercise Guyana's HIV adult prevalence (15-49 yrs.) was 1.5%, while the prevalence among MSM, FSW and TG was 4.9%, 5.5% and 8.4% respectively according to the 2014 BBSS.

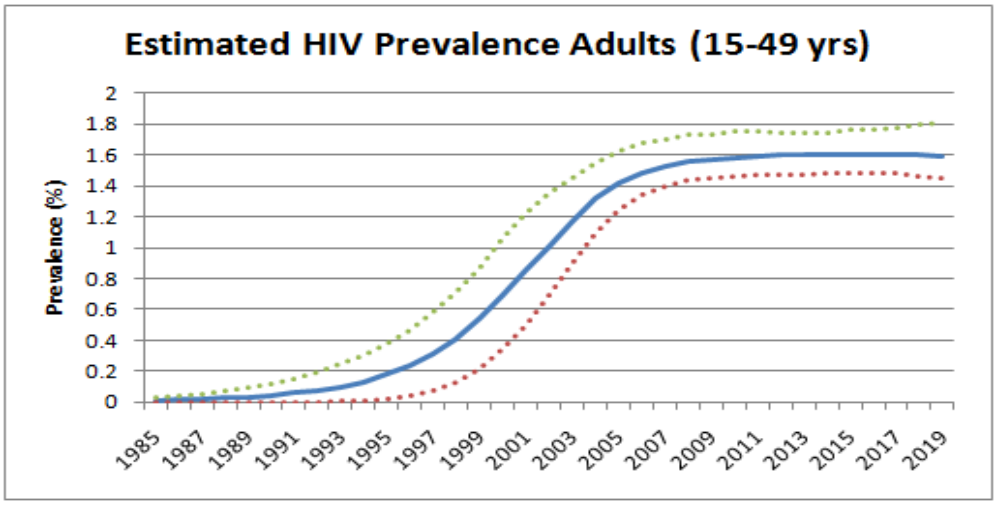
The first case of AIDS in Guyana was reported in 1987 followed by a progressive increase in the number of reported cases. The epidemic in Guyana is considered generalized as an HIV prevalence of greater than 1.0% has been consistently found among the general population. Since the introduction of VCT in 1998, there has been a fluctuating trend in the number of HIV cases diagnosed peaking during the period 2003 – 2004. Since then, there has been a continuous reduction in the number of new cases being diagnosed each year with the exception of the year 2017 which reported more cases than 2016.

## Trends in the Epidemic

***National HIV estimates for 1985 – 2019 developed in 2019 using Spectrum, revealed the following trends in relation to the HIV epidemic. The figures below reflect the estimates along with their upper and lower values.***

**Figure 1** below shows the estimated HIV prevalence among adults (15-49 years) during the period 1985 – 2019.

*Figure 1: Estimated HIV prevalence among adults: 1985-2019*

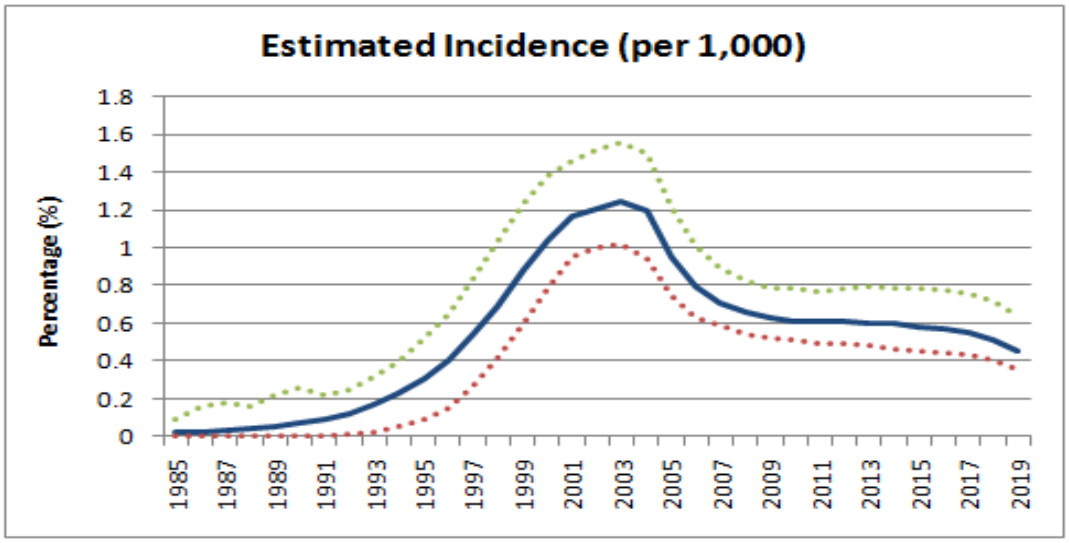



***Data source - National HIV Estimates File, 2019 (draft File which indicates this result is tentative until the acceptance and finalization of the estimates)***

According to the above figure, HIV prevalence among adults ranged from 0.1% in 1994 steadily increasing to 1.5% in 2007. During the period 2008 – 2018 the rate plateaued at 1.6%.

**Figure 2** below shows the estimated HIV incidence per 1,000 for all ages during the period 1985 - 2019.

*Figure 2: Estimated HIV incidence for all ages: 1985 – 2019*

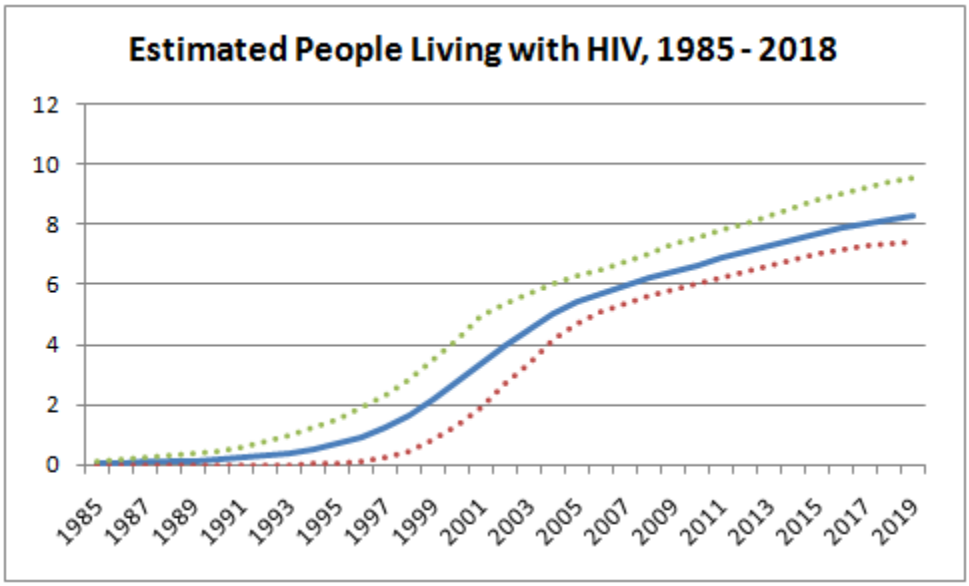



***Data source - National HIV Estimates File, 2019 (draft File which indicates this result is tentative until the acceptance and finalization of the estimates)***

According to the above figure, HIV incidence was estimated at 0.07 in 1990 then increased steadily with a peak in 2003 to 1.11. Since then, the incidence has decreased steadily to the 2018 figure of 0.55.

**Figure 3** below shows the estimated numbers of people living with HIV for all age groups, during the period 1985 – 2018.

*Figure 3: Estimated numbers of people living with HIV: 1985 – 2018*

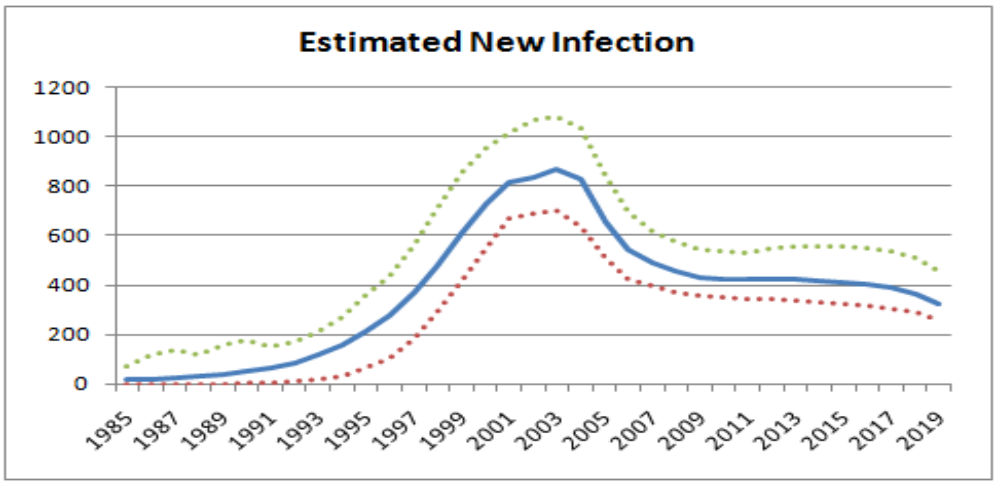



***Data source - National HIV Estimates File, 2019 (draft File which indicates this result is tentative until the acceptance and finalization of the estimates)***

According to figure 3 above, the numbers of PLHIV of all age groups increased steadily from 2,600 in 2000 to 8,200 in 2018. The number of PLHIV among children was estimated at less than 100 in 2000 with an increase to less than 500 <200 – 500> in 2018. Estimates among adults ranged from 2,500 in 2000 to 8,100 in 2018.

The estimated number of new HIV infections for all ages during the period 2000 – 2018 is shown in figure 4 below.

*Figure 4: Estimated number of new HIV infections for all age groups: 1985 – 2019*



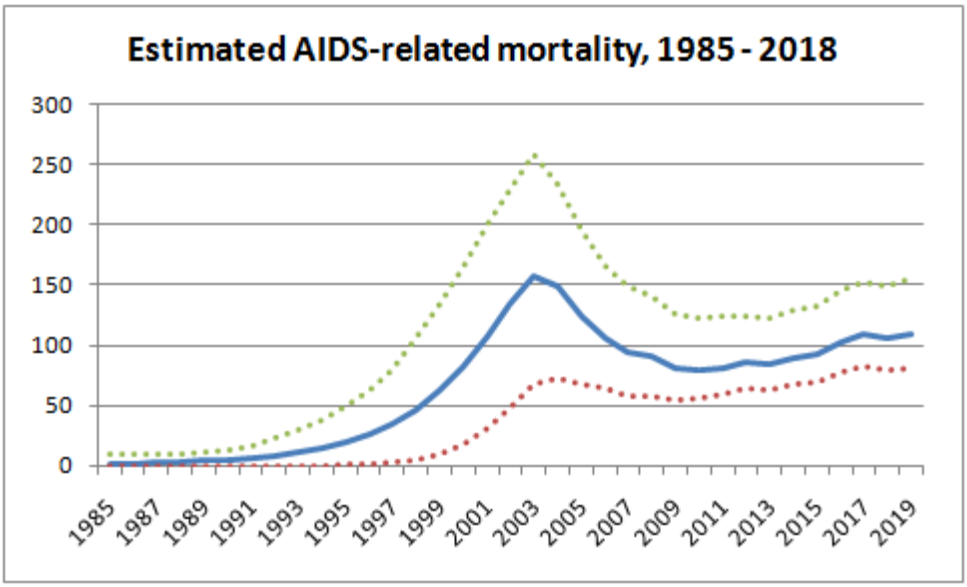
***Data source - National HIV Estimates File, 2019 (draft File which indicates this result is tentative until the acceptance and finalization of the estimates)***

The number of new HIV infections for all age groups was estimated at 670 in 2000 then peaked at 770 during 2002 and 2003. There was then a steady decline to <500 new infections <500 – 580> in 2018. New infections among children remained at <100 each year during the period. Among adults, new infections were estimated at 630 in 2000 with a peak of 730 new infections during 2002 and 2003 then gradually decreasing <500 in 2018.

While HIV was initially more prevalent among males, by 2003 the annual number of reported cases of HIV was higher among females and this 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 and this continued into 2018.

Figure 5 below shows the estimated AIDS-related mortality for all ages during the period 1985 – 2018.

***Figure 5: Estimated AIDS-related mortality for all age groups: 1985 – 2018***




***Data source - National HIV Estimates File, 2019 (draft File which indicates this result is tentative until the acceptance and finalization of the estimates)***

The number of AIDS-related deaths for all ages was estimated at <100 in 2002 then increased to <200 in 2018. The estimates were the same for adults during the period. AIDS-related mortality among children was estimated at <100 throughout the period.

**Table 1** below illustrates the pattern of decreasing prevalence among key populations.

**Table 1: 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) | |
| | | 2015 | 1.9 (1.0) | |
| | | 2016 | 2.2 (1.2) | |
| | | 2017 | 1.7 (0.7) | |
| | | 2018 | 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 | |
| | | 2015 | 0.48 | |
| | | 2016 | 0.85 | |
| | | 2017 | 0.64 | |
| | | 2018 | 0.65 | |
| **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) | |
| | | 2007 | 35.32 | |
| | | 2008 | 22.0 | |
| | | 2009 | 28.0 | |
| | | 2010 | 26.0 | |
| | | 2011 | 23.4 | |
| | | 2012 | 31 | |
| | | 2013 | 25 | |
| | | 2014 | 22 | |
| | | 2015 | 20 | |
| | | 2016 | 22 (91% tested) | |
| | | 2017 | 23 | |
| | | 2018 | 16 | |
| **Miners** | Male | 2000 | 6.5 | Special Survey<br>One mine study |
| | | 2003 | 3.9 | Special Survey<br>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, 2018***

# NATIONAL RESPONSE TO THE AIDS EPIDEMIC

## COMMITMENT 1: Ensure that 30 million the people living with HIV have access to treatment through meeting the 90–90–90 targets by 2020. Commit to the 90–90–90 targets.

Guyana has committed itself to achieving the UNAIDS 90-90-90 goal i.e. by 2020, 90% of Guyana's PLHIV should be diagnosed; 90% of those who have been diagnosed should be on ARV; and 90% of those should be virally suppressed. According to this goal, by 2020:

- 90% of Guyana's PLHIV should be diagnosed
- 81% of Guyana's PLHIV should be on ARV (which is the same as 90% of those diagnosed being on ARV)
- 73% of Guyana's PLHIV should be virally suppressed (which is the same as 90% of those on ARV being virally suppressed)

According to Guyana's 2019 HIV country estimates, the country had approximately 8,000 PLHIV at the end of 2017 and 8,100 at the end of 2018. According to these estimates, the Guyana's HIV continuum of care cascade for 2017 and 2018 is as shown in figure 7 below.

***Figure 6: Guyana's continuum of care cascade: 2016 – 2018***

**Note that the number on PLHIV for 2016, 2017 & 2018 are based on Guyana's 2019 HIV country estimates. These values are still preliminary pending final publication.*

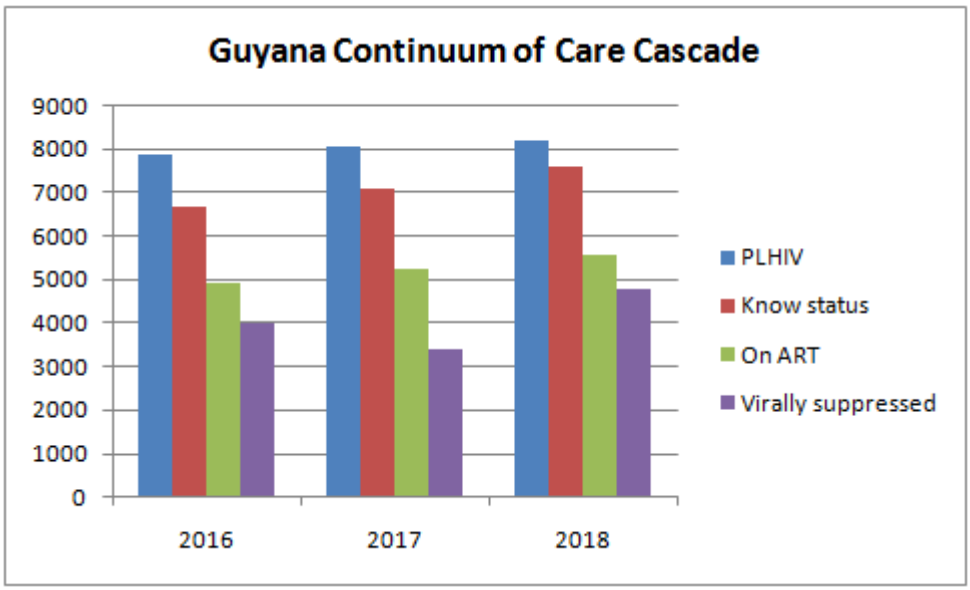
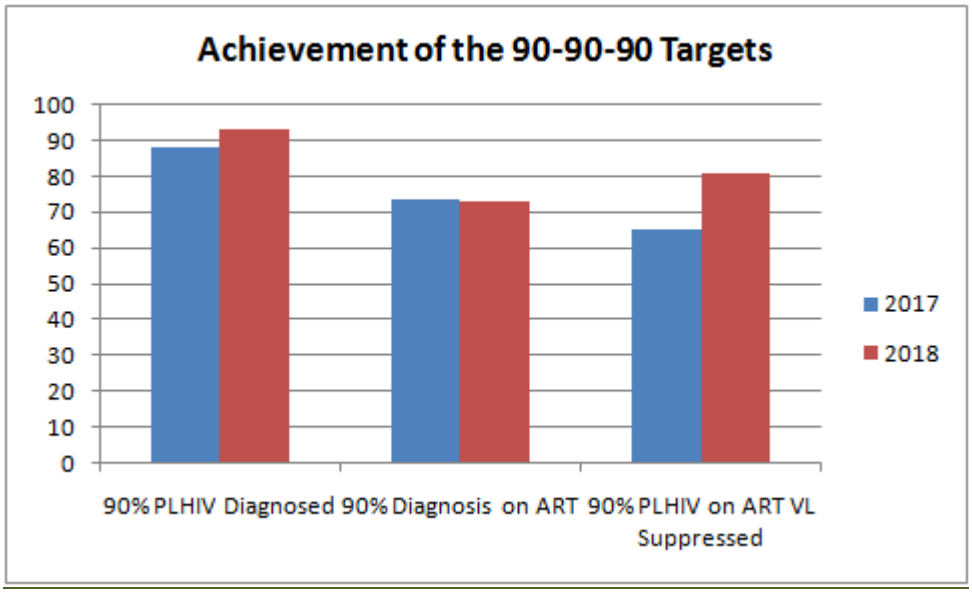



**Figure 6** above shows that at the end of 2018, an estimated 8,100 PLHIV were living in Guyana, 5557 were on placed on ART and 4474 were virally suppressed.

***Guyana is on track in achieving the 90-90-90 targets!!!***

A review of Guyana's progress in achieving the 90-90-90 targets when compared with the targets set for 2017 and 2018 indicate that the first and third 90s are on track and that these can be achieved by 2020 if the present momentum of Guyana's response continues and is accelerated. The second 90 however, is lagging behind somewhat and special efforts need to be made in the area of linkage, retention and adherence of PLHIV who are placed on ART. During the reporting period the country officially endorsed the "treat all" global policy as well as developed a lost to follow up program to actively track clients and return them to treatment.. The latter was a combined effort between civil society organizations and the public health facilities. An after-hours clinic was also piloted in the capital city and was accessed by over 1000 individuals who received both testing and treatment services where applicable. Proactive efforts continue to encourage persons to "Know Your Status" through a campaign set in motion by the national program in collaboration with country partners and with a special focus on men.

*Figure 7: Achievement of 90-90-90 targets: 2017 & 2018*



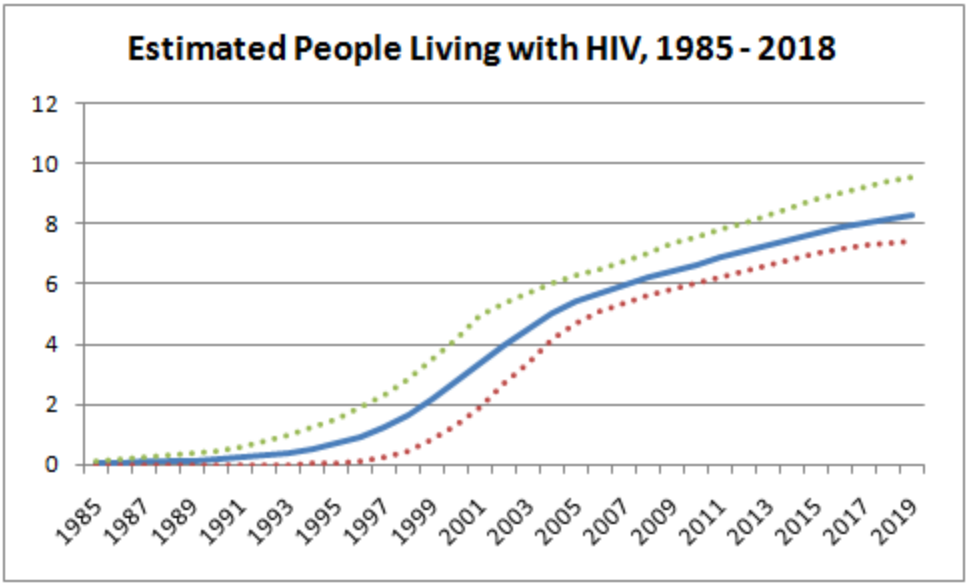

***Note that the number on PLHIV for 2017 & 2018 are based on Guyana's 2019 HIV country estimates. These values are still preliminary pending final publication.***

**Figure 7** above shows that at the end of 2018, 93% of Guyana's PLHIV were diagnosed, 73% of those diagnosed were placed on ART and 81% of those on ART were virally suppressed.

## 1.1 People living with HIV who know their HIV status

During 2017, the cumulative number of PLHIV who were diagnosed was reported as being 13,893 (6675 males and 7218 females). The number of people diagnosed with HIV and reported to the surveillance system as still being alive was reported at 7615. In 2017, approximately 83% of PLHIV knew their status and this increased to 93% in 2018. Estimates of PLHIV produced through Country Spectrum estimation 2019 shows a trend graph in figure 9 below.

*Figure 8: People living with HIV: 1985 – 2018*

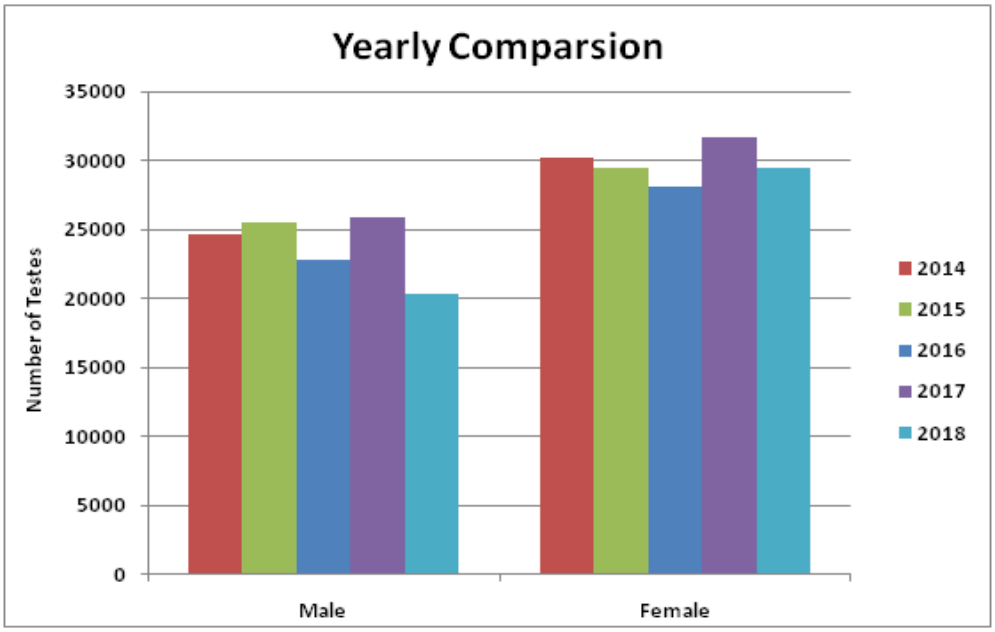



According to the above estimates the number of PLHIV rose steadily during the period 2000 – 2018. During the period 2014 – 2018, the number of PLHIV ranged between 7,400 and 8,200 for all ages and between 7,200 and 8,000 for adults above 15 years. For women above 15 years of age however, the number of PLHIV ranged between 3,400 and 3,800 during the period. Estimates of new infections during the five-year period was also less than 500 <500 – 600> per year for all age groups and adults over 15 years and less than 200 for women over 15 years.

HIV testing is provided nationwide in Guyana through: client-initiated testing and counselling; provider-initiated testing and counselling; routine antenatal testing; community-based testing and counselling and; lay provider testing. During 2017 and 2018 VCT continued to be provided through fifty one (51) active fixed VCT sites spread across the 10 regions with 1 mobile unit targeting high burden coast and hinterland communities. A total of 57,524 HIV tests (25,846 among males and 31,678 among females) were done during 2017 while 49,783 persons (20,340 males and 29,443 females) were tested during 2018 via the VCT Programme. The latter year showed a decrease in VCT which was due the approach of targeted and focused testing where positivity yield was higher.

**Figure 9** below shows the number of tests done according to gender during the period 2013 – 2018. Females continued to access VCT services more than males, accounting for 55.1 % of testing in 2017 and 59% in 2018. 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 trend, the male to female ratio for HIV testing has been somewhat lower than the male to female ratio of the general population.

*Figure 9: Number of VCT done according to gender: 2014–2018*

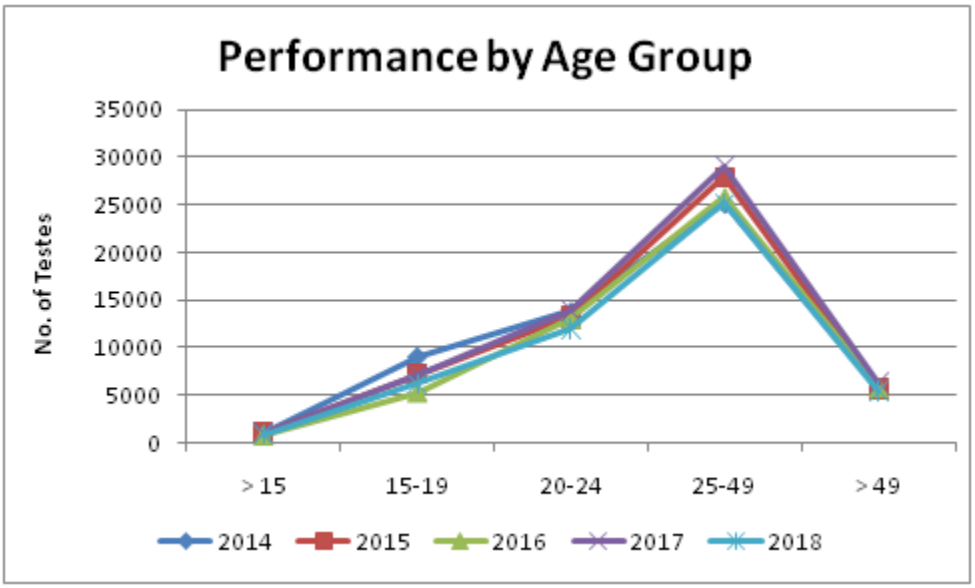



During 2017, among all testing done, 943 tests (487 males and 456 females) were found to be HIV positive while in 2018, 793 tests (444 males and 349 females) were HIV positive. This comprised 1.9% of the total tests done in 2017 and 1.59% of the tests done in 2018 respectively. Females accounted for 48.4 % of those testing positive in 2017 and 44.9% in 2018 compared to 46.3% reported in 2016. Worthy of note is that while the proportion of men accessing testing is generally lower than that for females, the proportion of men who tested positive for HIV during the period was higher.

During 2018, the 25-49 year age group had the highest proportion of tests (50.6%) country-wide which was almost the same when compared with the figure for 2017 (50.7%). This age group also had the highest percent of positives of 2% (585/29094) in 2017 and 1.8% (448/25179) in 2018.

**Figure 10** below shows the breakdown of positives by age groups during the period 2014 – 2018.

*Figure 10: HIV testing according to age groups: 2014 - 2018*




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. During 2017 and 2018, 0.65% and 0.52% respectively of the blood screened was found to be HIV positive. Table 2 below shows the number of tests done within these settings during the period 2008 – 2018.

*Table 2: HIV testing in various settings for the period 2007-2018*

| Testing Setting | 2008 | 2009 | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **VCT** | 63,876 | 85,554 | 93,532 | 106,491 | 63,465 | 49,674 | 54,815 | 55,095 | 50,857 | 57,524 | 49,783 |
| **PMTCT** | 15,702 | 11,776 | 11,441 | 13,490 | 12,697 | 13,413 | 12,592 | 12,820 | 13,256 | 11,024 | 13,112 |
| **Blood Screening** | 7,360 | 7,700 | 7,654 | 7,929 | 7,712 | 11,148 | 10,016 | 9,859 | 10,200 | 9,755 | 9687 |
| **Total Tested** | 86,983 | 105,030 | 112,627 | 127,910 | 83,874 | 74,235 | 77,424 | 77,774 | 74,313 | 78,303 | 72,582 |
| **Total HIV Positive (Notified cases)** | 959 | 1,176 | 1,039 | 972 | 820 | 758 | 751 | 789 | 855 | 641 | 695 |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Percentage Positive** | 1.1 | 1.1 | 0.9 | 0.8 | 1 | 1 | 0.9 | 1.0 | 1.2 | 0.8 | 0.96 |

The annual Valentine's Day Couples Testing, continued during the period in 2 Regions under the theme "Test of Love". 1,480 persons (54% females and 46% males) received VCT during 2017 and 1247 persons (65% females and 35% males) received VCT in 2018. Of the persons tested in 2017, 0.3% (2/646) were found to be positive and while of those tested in 2018, 1.2% (15/1247) were found to be positive. All positive clients were referred to care and treatment.

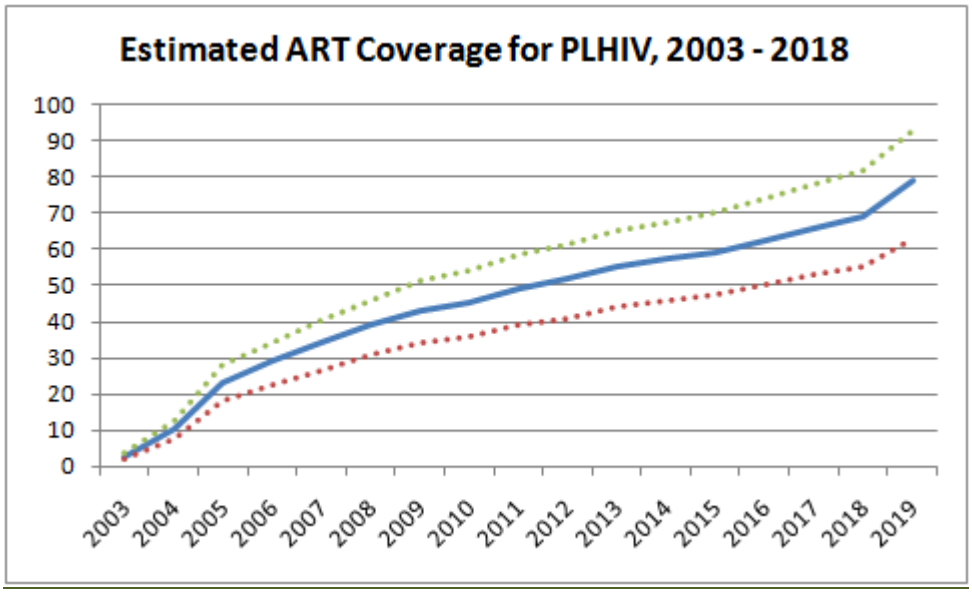
During 2018, VCT training was provided for 20 FSWs and 24 MSM who work in key population areas and training continued to be provided to HIV Counselor/Testers in the new Serial Testing Algorithm for HIV. Quarterly Feedback Meetings for counselor/testers continued to be held during 2018 to build their capacity, update them on developments within the VCT program, monitor their progress and address any challenges encountered. Additionally, counselor/testers received training in ART literacy and Positive Health Dignity Prevention in order to improve and increase the demand for linkage to the treatment services. In the continuous effort to educate and sensitize persons with regard to HIV prevention, outreach activities (including HIV testing) were conducted in the 10 administrative regions of Guyana for public and private sector employees. This was done in collaboration with various organizations and resulted in 7399 persons receiving VCT during 2017 and 4304 in 2018.

## 1.2 People living with HIV on antiretroviral therapy

Guyana has moved towards adopting the TREAT ALL policy in accordance with the 2016 WHO Consolidated Guidelines on the Use of Antiretroviral Drugs for Treating and Preventing HIV Infections. The country has begun a phased approach at the three largest sites in 2017 which accounted for approximately 70% of the HIV population, and with official policy document in place was able to fully implement "treat all" during 2018. The estimated coverage of adult PLHIV receiving ART ranges from 54% in 2013 to 64% in 2018 with a similar range of coverage for all ages.

**Figure 11** below shows the trend line for the percentage of PLHIV receiving ART for the period 2003 when ART commenced in Guyana, up to 2018.

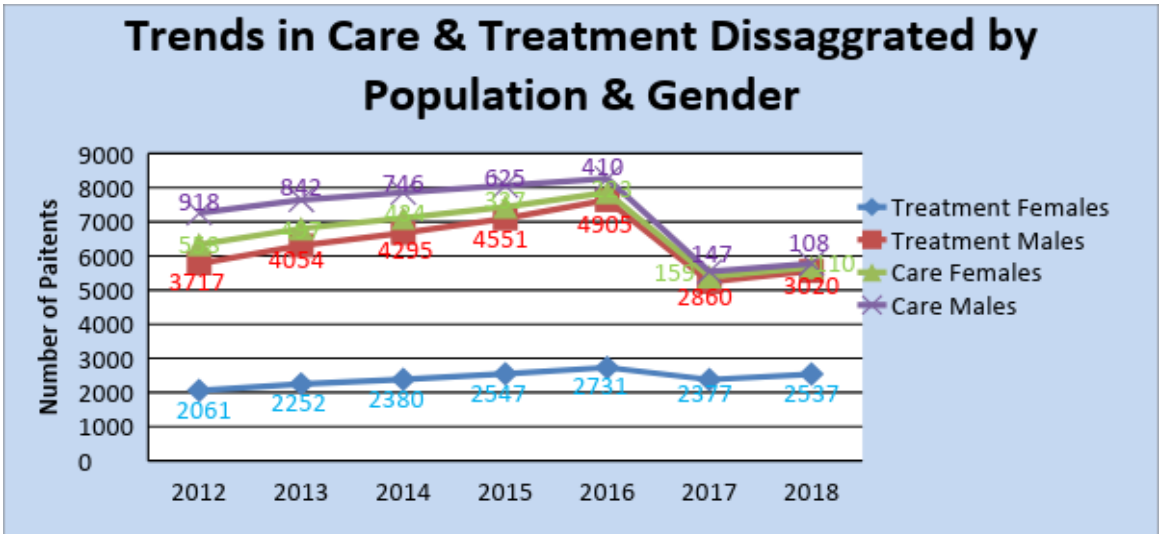
*Figure 11: Trend line showing estimated ART coverage for PLHIV: 2003 – 2018*




During 2018 HIV treatment and care continued to be provided at 22 treatment sites across the 10 Regions of Guyana. As at end of December 2017, the total number of persons enrolled in the national care and treatment programme stood at persons 5,543 (5237 on ART and 306 in care) while at December 2018, the total in care and treatment was 5775 (5557 on ART and 218 in care). Of the total in 2017, 54.4% were females and 45.6% were males while in 2018 this trend changed with 45.8% being females and 54.2% were males. Of the total in care and treatment during 2017, 3.1% (164/5,315) were children compared to 3.2% in 2018.

**Figure 12** below shows the trend of the HIV population at the treatment sites by gender during the period 2012 – 2018.

*Figure 12: Persons in care and treatment disaggregated by gender: 2012-2018*

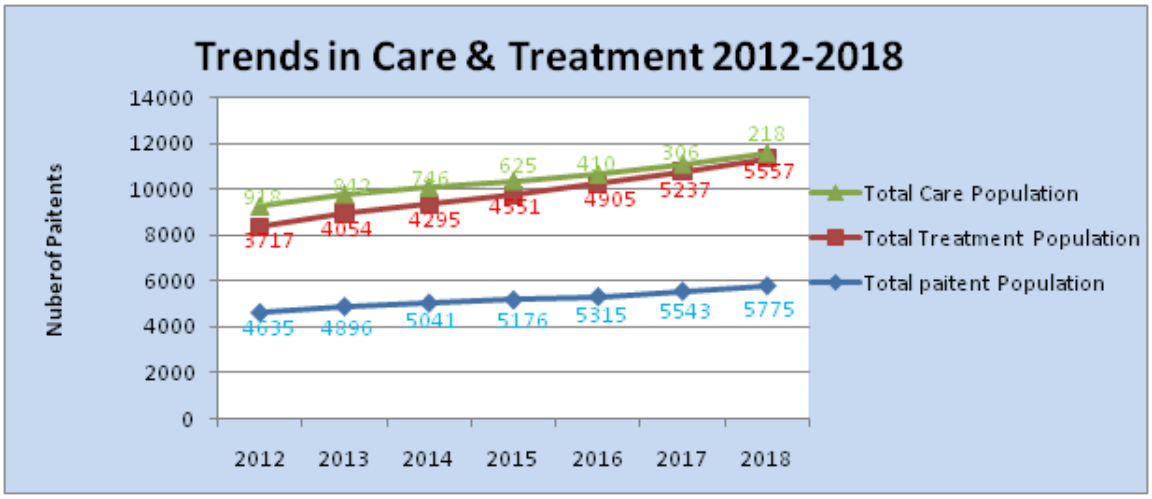



During 2017, there were 528 adults (53% males and 47% females) and 7 children (57% females and 43% males) newly enrolled into HIV Care, while during 2018 there 548 adults (53.3% males and 46.7% females) and 8 children (25% females and 75% males). Of this total in 2018, the National Care and Treatment Centre (largest treatment site) enrolled 38.4% (213/554), St. Joseph's Mercy Hospital accounted for 8.5 (47/554)% and Davis Memorial 6.8% (38/554). As at December 2017, the total number of persons in pre-ART care nationally was 306 while at the end of 2018, the number was 218 persons.

During 2017, 587 adults (48.7% males and 51.3% females) and 15 children (47% females and 53% males) were initiated on ART while in 2018, 532 adults (49.1% males and 50.9% females) were initiated on anti-retroviral therapy and 11 children (45.5% females and 54.5% males). At the end of 2017 and 2018, the total number of persons receiving antiretroviral therapy was 5237 (65.1% of all persons living with HIV) and 5557 (67.9% of all persons living with HIV) respectively. During 2018, females comprised 54.3% (3020/5557) of those on ART while males comprised 45.7% (2537/5557). Of the total on ART in 2017, 129 (3.2%) were children while in 2018, 107 (1.9%) were children.

**Figure 13** below shows the trend in care (Pre ART) and treatment (ART) for the period 2011 – 2018.

*Figure 13: Persons in Care (Pre-ART) and Treatment (ART) for the Period 2012-2018*




Since the commencement of ART in 2002, there has been a steady increase in the number of persons on ART by the end of each year. Figure 14 above shows a steady increase on treatment and a gradual decrease among patients in pre-ART care during the period 2012 to 2018.

During 2016 and 2017, 88.5% and 85.8% (data up to November 2017) respectively of those on ART were on first line therapy compared to 89.4% in 2015. As at December 2018, 85% of the patients on ART were on a first line regimen and 15% were receiving a second line and "salvage" regimen. As of 2006, there has been a steady increase in the proportion of adult patients on second line therapy, rising from 3.6 % in 2006 to 11.6% in 2014, with a slight drop (10.6%) in 2015 then rising again in 2016, 2017 and 2018 to 11.5%, 11% and 15% respectively. This was an indirect indication of increased challenges with adherence which, along with the affordable cost, prompted the country's Technical Working Group to review the national guidelines and recommend the introduction of Dolutegravir based regimen, specifically Tenofovir/Emtricitabine/Dolutegravir as a fixed dose combination to improve adherence.

During 2017 and 2018, the clinical management of HIV was further strengthened through a number of capacity building programmes for health care workers to provide efficient and effective services to PLHIV. Activities implemented are presented in table 3 below.

*Table 3: Activities implemented to support the ART programme: 2017 – 2018*

| **Activities implemented to support the ART programme: 2017 – 2018** |
|---|
| 1. Training in the Clinical Management of HIV and its Co-Morbidities provided to 25 physicians in 8 regions. |

2. Paediatric conferencing services provided to 21 physicians from 8 regions.

3. Training in data entry of PLHIV patient records provided to 20 health care workers from 7 regions.

4. Training in providing care and support for PLHIV conducted for 65 health care workers including 25 physicians selected from 8 regions. Topics included HIV and cardiovascular diseases; initiation of ART among children and; introduction of the new HIV case surveillance form.

5. Training provided to 20 social workers on how to address adherence and loss to follow-up among PLHIV on treatment.

6. Strengthening the linkage to care and treatment through the provision of training to 47 health care workers to identify issues/barriers related to linkage to care. Seven key recommendations were developed among which was the need for closer collaboration among government ministries and the need for personnel who are dedicated to follow up on referrals.

7. A series of training sessions on HIV treatment literacy were held for frontline workers attached to NGOs – with the purpose of them sharing this information during their outreach sessions. Sessions focused on ART regimens available in Guyana, how ART works, their side effects, the importance of adherence and the need for routine laboratory monitoring.

8. Edutainment sessions at popular outreach locations that highlighted the importance of knowing one's HIV status and the benefits of starting ART early.

## Retention on antiretroviral therapy at 12 months

**Table 4** below shows the survivability and retention on ART by gender and age group for the national cohorts during the period 2010 - 2018.

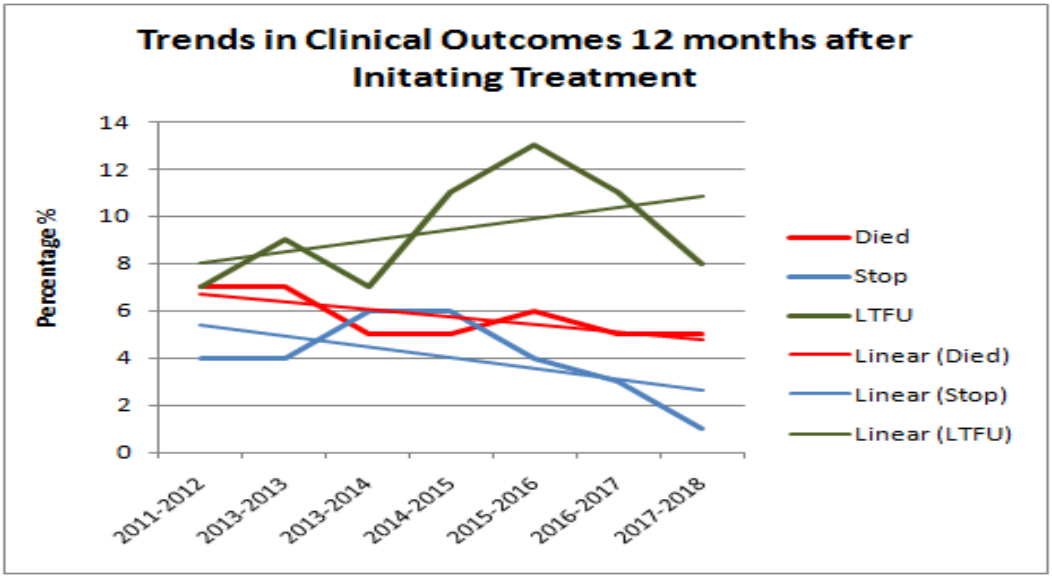
***Table 4: Survivability and retention on ART: 2010 – 2018***

| Indicators | Cohorts | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | 2010-2011 | 2011-2012 | 2012-2013 | 2013-2014 | 2014-2015 | 2015-2016 | 2016-2017 | 2017-2018 |
| Total | 80.4 | 81.5 | 79.7 | 81.2 | 78.1 | 76.5 | 82 | 86 |
| Adult Male | 76.9 | 80.8 | 78.8 | 82.8 | 77 | 75.2 | 83 | 86 |
| Adult Female | 83.8 | 80.7 | 81.4 | 79.1 | 78 | 77.6 | 81 | 85 |
| Children Male | 80 | 92.9 | 66.7 | 100 | 89 | 75.2 | 100 | 88 |
| Children Female | 85.7 | 94.1 | 57.1 | 86.7 | 86 | 57.1 | 83 | 75 |

The 2017-2018 national cohort of patients report revealed that 553 persons were initiated on ART with 86% (564/658) 12 months survivability and retention on ART overall. This represents a slight increase from the 82% that was reported for the 2016-2017 cohort. Among adults, 12 months survivability and retention in care among males in the 2017-2018 cohort was 86% which was higher than that for females (85%). Survivability was also higher than in the 2016-2017 cohort (83% for males and 81% for females). Of the 12 children (8 males and 4 females) in the 2017-2018 cohort, there was 88% survivability and retention on ART among male children, compared with 100% in the previous cohort. Survivability among female children was 75% in the 2017-2018 cohort compared to 83% in the previous cohort.

**Figure 14** below shows the trends in outcomes for patients who were not included among those in the survivability and retention in ART outcome.

***Figure 14: Trends in outcomes for patients not included in the survivability measure***




Of the 2017-2018 cohort, among the 14% who were not retained on ART, mortality accounted for 5%, those who stopped treatment accounted for 1% and 8% were lost to follow-up. The adult mortality rate was 5% for the 2017-2018 cohort which was much lower than the mortality rate among children (17%). The mortality rate among males and females adults were the same 5%. However, the treatment interruption (stop) rate was higher among female adults at 2% when compared to male adults 1%. Also, the treatment Lost-to-follow-up rate was higher among female adults at 9% when compared to male adults 7%

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 and referral for support services. To promote retention in care and

treatment, enhanced linkage services and peer support were provided during the period, including support for disclosure as well as the lost to follow up program at the largest treatment site providing support to track defaulters. Adherence support included reminders via text messages and training in adherence to ART.

During the period, ART literacy training was provided to 33 Voluntary Counselor Testers with the aim of preparing them to interact with clients known positives to create the demand for linkage to care. Sensitization in the guidelines of Positive Health Dignity Prevention was provided for 58 PLHIV (40 adults and 18 adolescents). The objective of this training was to reinforce the importance of adherence, condom use, nutrition, clinic visits, and treatment literacy among other issues to enhance the participant's ability to live a health life. Fifty-seven (57) PLHIV also received capacity building in Mental Health. Topics covered included psycho education on depression, psychoses, epilepsy/seizures, developmental disorders, Behavioural disorders, Dementia, Alcohol Use disorder, drug use disorders, and self-harm/suicide.

## 1.4 People living with HIV who have suppressed viral loads

Viral load testing was initiated in Guyana in 2010. Samples were previously sent overseas for processing, however processing is currently being done at the National Public Health Reference Laboratory in Guyana. Guyana's policy for viral load testing is in keeping with WHO's 2016 ART guidelines which recommend viral load testing within six months of treatment initiation, again at 12 months, and at least annually thereafter. There is no system for monitoring ART resistance or ART toxicity. During 2012, Guyana conducted an acquired drug resistance survey among 130 adults at one treatment site. Since the introduction of viral load testing in Guyana, occasional surveys were done to collect early warning indicators of HIV drug resistance, with the most recent one being done in 2017 among the 2015-2016 cohort of PLHIV on ART at four high-volume treatment sites in region 4.

Samples for viral load testing are collected at the treatment sites and sent to the Reference Laboratory for processing. During 2018, the timely processing of viral load samples was impacted by occasional malfunctioning of the viral load machine at the Reference Laboratory, stock-outs of viral load reagents, and personnel shortages both at the treatment sites and at the Reference laboratory. Patient-related reasons for delays in VL testing included irregular clinic attendance, exiting of patients from the treatment site and lack of follow-up by patients when VL tests were ordered by the clinician. These various factors surrounding VL testing thus meant that while the tests were requested at the required intervals, they were not always done within the time frame required. Data on viral load testing is maintained by the Reference Laboratory.

**Table 5** below provides data for viral load tests done among patients on ART, for the period 2015 to 2018.

*Table 5: Viral load tests done during 2015 - 2018*

| Year | % of patients virally suppressed | % of males virally suppressed | % of females virally suppressed | % of children virally suppressed (<15 years) | % of adults virally suppressed (>15 years) |
|---|---|---|---|---|---|
| 2015 | 79.2% (536/677) | unavailable | unavailable | unavailable | unavailable |
| 2016 | 81.7% (3338/4088) | unavailable | unavailable | 60.2% (100/166) | 82.6% (3238/3922) |
| 2017 | 81.9% (3414/4166) | 84% (1376/1638) | 81.2% (1949/2399) | 69% (89/129) | 82.4% (3325/4037) |
| 2018 | 86% (4474/5210) | 88% (2040/2313) | 84% (2434/2897) | 65% (84/129) | 86% (4390/5081) |

As indicated above, viral suppression rate for all age groups ranged between 79.2% and 86% during 2015 – 2018 for patients who accessed a VL test. While viral suppression was relatively high among adults, suppression among children was comparatively low, ranging from 60.2% to 69%. This may have been due to poor adherence to treatment and lack of the required commitment by caregivers.

During 2017, in the effort to build staff capacity, two persons attended the Caribbean Cytometry and Analytical Society (CCAS) Annual Conference in Barbados where the theme was "From care to cure-shifting the HIV paradigm". This forum provided the opportunity for clinicians and laboratory personnel to discuss issues relating to treatment failure among PLHIV on ART and to develop recommendations on how best to address these issues.

## 1.5 Late HIV diagnosis

During 2017, the percentage of persons who were diagnosed with an initial CD4 count of <200 cells/mm$^3$ was 5.2% (28/535). The percentage of persons diagnosed with an initial CD4 cell count of <350 cells/mm3 was 15.5% (83/535). While for 2018 the percentages for CD4 count <200 cells/mm$^3$ was 9.2% (50/543 and CD4 count of 200-349 cells/mm3 was 5.2% (30/543). Late diagnosis was noted especially in the age group 34-39 and may be attributed to stigma and discrimination, mostly self-stigma preventing persons from accessing the testing services.

## 1.6 Antiretroviral medicines

In Guyana, during the reporting period 2018 TDF/3TC or (FTC)/EFV was the preferred first-line ARV combinations for treatment among adults, adolescents and pregnant women. Guyana uses fixed-dose antiretroviral therapy combinations as the preferred first-line therapy, specifically, 3 drugs fixed-dose combination taken once a day. The preferred second-line ARV combination for adults and adolescents with HIV in the national guidelines was TDF/FTC + AZT + LPV/r. A revision of the treatment guidelines was undertaken during 2018 and moving forward for 2019 the country will be implementing the WHO recommendations of 2018 for first line therapy in adults, adolescents, women of reproductive age and pregnant women.

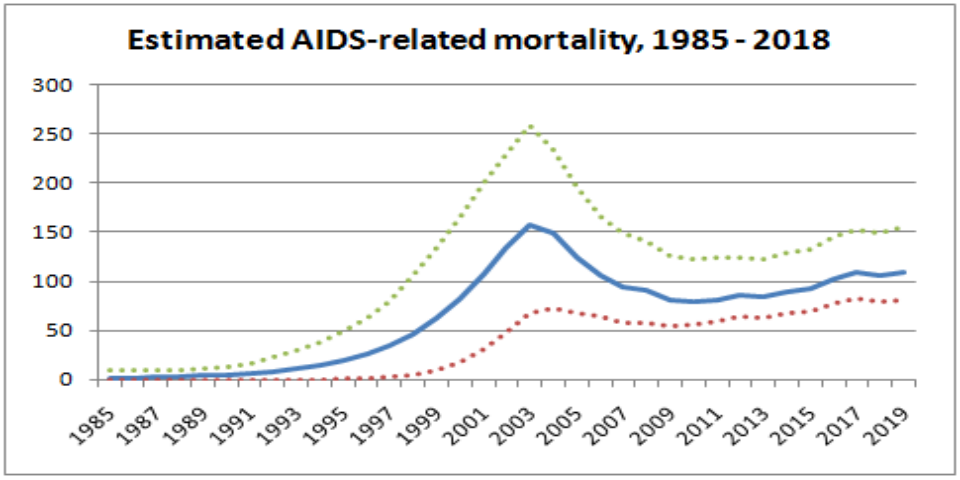
During 2018, among children, Abacavir (ABC) is the preferred nucleoside reverse transcriptase inhibitor (NRTI) for treatment initiation in children aged less than three years old with HIV. LPV/r based-regimens while they were not the preferred treatment option for all infants and children <36 months with HIV (irrespective of NNRTI exposure) in the national guidelines, it will be introduced as such during 2019. Efavirenz (EFV) was recommended as the preferred NNRTI for treatment initiation in children aged three and older and this will be replaced in 2019 by Dolutegravir for all children who have achieved the required weight for its use. ABC + 3TC (or FTC) is the recommended NRTI backbone in the national guidelines for treatment initiation in children aged 3–10 years and adolescents >35kg and at least 10 years of age. However, where the adolescent is Tanner stage 3 or above a TDF containing regimen is considered.

In order to address the challenges of stock-outs attempts are currently being made to improve the supply management chain of ARV through better inventory management, forecasting, procurement and distribution and training for procurement and NAPS staff.

## 1.7 AIDS mortality

**Figure 15** below shows a trend graph with the estimated number of HIV-related deaths and the lower and upper estimates.

*Figure 15: Trend graph showing AIDS mortality: 2000 - 2018*




During 2018, the cumulative number of AIDS-related deaths was reported as 6,278. Data obtained from SPECTRUM modelling indicates that the estimated number of deaths due to AIDS during the period 2014 – 2018 was less than 200 <100 – 200> per year for all age groups and for adults 15 years and over. The estimated number of AIDS – related deaths per year for the same period among children (0 – 14 years) and women above 15 years was less than 100 <100 – 100>.

## COMMITMENT 2: Eliminate new HIV infections among children by 2020

***The data for 2018 for Prevention of Mother to child transmission is still under review and will be shared when available.***

During 2014, a national evaluation committee was established to prepare Guyana's application for Elimination of Mother to Child Transmission (eMTCT) of HIV and Congenital Syphilis. The 2015 target for eMTCT of HIV was a reduction of transmission to 2% or less and the elimination target by 2020 was set at 0.3 cases or less per 1000 live births. During 2016, country partners in collaboration with the Ministry of Public Health also developed a work plan for fast-tracking eMTCT of HIV and Congenital Syphilis. The first draft of the Elimination Initiative report was completed in 2016, reviewed by the Regional Validation Committee and recommendations proposed. During 2017, a national verification exercise was launched countrywide and the final report was submitted. During 2017, the PMTCT data collection system was also reviewed and updated and the data verification process continued for Guyana's submission to the Regional Validation Committee.

In the effort achieve elimination status, 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 in keeping with the national guidelines. The case tracking system continues to make strides with the expansion of its database system and ongoing efforts to ensure that all health care workers are trained in case tracking.

**Table 6** below shows key indicators in relation to the national PMTCT programme during the period 2010 to 2018.

***Table 6: Key indicators of the national PMTCT programme: 2010 – 2018***

| INDICATORS | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 |
|---|---|---|---|---|---|---|---|---|---|
| **ANTENATAL** | | | | | | | | | |
| No. of service outlets that offer PMTCT services | 165 | 181 | 183 | 187 | 188 | 190 | 190 | 191 | 191* |
| No. of health workers trained in PMTCT | 98 | 306 | 89 | 48 | 189 | 96 | 187 | 84 | n/a |
| No. of pregnant women who received VCT and results for PMTCT | 11,058 | 11,641 | 11,315 | 12,356 | 12,592 | 10,725 | 10,379 | 11,024 | 13,112 |
| Uptake of VCT | 93.7% (ANC only) | 94.8% (ANC, L&D) | 93.3% (ANC, L&D) | 97.2% (ANC, L&D) | 94.4% (ANC, L&D) | 81% (ANC,L&D) | 95% (ANC, L&D) | 98% ANC, L&D) | 88%* ANC, L&D) |
| No. of HIV positive mothers | 164 | 233 (116 new, 117 known) | 241 (106 new, 135 known) | 279 (121 new, 158 known) | 293 (123 new, 170 known | 299 (155 new, 144 known | 290 (164 new, 126 known) | 252 (88 new, 164 known) | 262 (86 new, 176 known) |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| HIV prevalence among women (pregnant and postnatal, new and known positives/ total population) | 1.2% (1.0 incidence) | 1.6% (0.9) | 1.7% (0.7) | 1.9% (0.8) | 1.9% (0.8) | 1.9% (1.0) | 2.2% (1.2) | 1.7% (0.7) | 1.9%* |
| Percentage of male partners tested | 5.5% | 8.9% | 10.4% | 9.2% | 9.2% | 8.4% | 9% | 9% | n/a |
| **LABOUR & DELIVERY** | | | | | | | | | |
| No. of HIV positive pregnant women delivering | 191 | 201 | 180 | 191 | 193 | 154 | 142 | 133 | 190* |
| No. women who received ARVs on Labour and Delivery Ward | 158 | 171 | 161 | 187 | 187 | 160 | 132 | 129 | n/a |
| **POSTNATAL AND LABORATORY TESTING** | | | | | | | | | |
| No. of infants born to HIV+ women who were tested before 18 months | 159 | 213 | 263* | 189* | 284* | *226 | 272* | 239* | 239* |
| Percentage of infants born to HIV+ mothers who tested positive | 5.8% (11/191) | 2.5% (5/201) | 1.7% (3/180) | 2.1% (4/191) | 2.6% (5/190) | 2% (3/151) | 1.4% (2/141) | 2.2% (3/133) | 3.6%* 7/190 |
| Percentage of infants who received ARV/AZT | 98.43% | 99.5% | 99.4% | 100% | 93.7% | 100% | 98% | 98% | 98%* |

***This data reflects number of samples tested not infants, based on data submitted by the National Reference Laboratory. In addition a review and validation of 2018 data is still ongoing, results may vary after this process is completed***

## 2.1 Early infant diagnosis

The National Guidelines for Management of HIV-Infected and HIV-Exposed Adults and Children recommend that infants be tested for HIV at birth using the PCR-DNA (Dry Blood Spot) test. Blood samples are taken at health facilities using a heel stick and sent to the National Public Health Reference Laboratory for testing. For infants testing negative, confirmatory Rapid tests are done when the infant is 12 months old then again at 18 months. For infants who are breastfed, a final confirmatory test is also done 3 months after breastfeeding ends. For infants with a positive PCR-DNA test, a confirmatory PCR-DNA test is done within 2 weeks of receiving the first test results. The infant is treated as positive if the second PCR-DNA test is positive. HIV testing for children older than 18 months follows the same algorithm as for adults. In accordance with the WHO guidelines, Guyana has introduced testing at birth for all HIV exposed infants. The second PCR-DNA will be done at 4-6 months and a final PCR-DNA test will be done at 12 months. The new algorithm is currently being finalized.

Under the existing algorithm, a child is considered HIV negative if the following is established:

1. A negative DNA/PCR test at birth.
2. If asymptomatic from 6 weeks until 12 months as established by the HIV clinician and well child clinic.
3. A negative HIV rapid test at 18 months

A child is considered HIV positive if the following is established:

1. A positive DNA/PCR test at birth
2. A second confirmatory DNA/PCR test within two ( 2 ) weeks of receiving the first DBS sample results
3. Any exposed infant showing clinical signs of HIV infection as established by HIV clinician and/ with any danger signs highlighted by the child health clinic

During 2010-2017, MTCT of HIV among infants tested using DNA/PCR, decreased significantly from 5.8% in 2010 to 2.5% in 2011 and further decreasing to 2.2% in 2017. The lowest rate of transmission occurred during 2016 (1.4%).

Stakeholders' consultations are currently taking place with regard to revision of the protocols for DNA-PCR testing for exposed infants, as recommended by the Regional Validation Committee for Guyana's Elimination of MTCT of HIV and Congenital Syphilis. As part of the effort to increase the knowledge of Dry Blood Spot testing among health care workers, a five-day workshop on Dry Blood Spot testing was conducted for 23 members of the multi-disciplinary maternal and child health team during 2016. During 2017, two paediatric conferences were held to identify the challenges and develop solutions for increasing virological testing among HIV-exposed infants.

## 2.2 Mother-to-child transmission of HIV

As indicated in table 6 above, during 2016, 1.4% (2/141) of the infants born to HIV positive mothers tested positive for HIV while in 2017, 2.2% (3/133) tested positive. MTCT of HIV was similar in 2015 with 2% (3/151) transmission. The national guidelines recommend that all infants and children living with HIV receive ART irrespective of symptoms (see Commitment 1 for ART provided to children during the period 2015 – 2017). Paediatric clients are seen at the same facilities as adult PLHIV. The nutrition and growth of children receiving ART is routinely monitored along with adherence to ART through the use of infant registers.

The thrust of provider initiated testing and counseling (PITC) continued in 2016 with the uptake of VCT among pregnant women increasing from 81% in 2015 to 95% in 2016 and further increasing to 98% in 2017. Figure 18 below shows the trend in VCT uptake by antenatal women during the period 2013 – 2017. The data for 2018 is under review and will be provided when available.

The prevalence of HIV among the antenatal population was 2.2% (290/13,256) at the end of 2016 and 1.7% (252/14, 366) at the end of 2017 compared with 1.9% (262/13,112) in 2018. 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 pregnant women and pregnant women with previously known HIV positive status.

During 2016, the incidence of HIV among the antenatal population was 1.2% (164/14,035) while in 2017 it decreased to 0.7% (99/14,098) compared with an incidence of 1% in 2015.

Male partner testing constitutes part of the PMTCT programme couples' counseling and testing initiative and the promotion of family planning services at all PMTCT sites. At the end of 2016, male partners tested within the ANC settings stood at 9% (1,226 partners of 13,256 pregnant women) while in 2017 this figure remained the same (1266/14,366). The figure for 2015 was within the same range

with 8.4% (1,350 partners of 16,015 pregnant women) tested. Of those tested in 2016, 1.2% (15) were found to be positive compared with 0.81% (11) in 2015 (the number of positives for 2017 is not available). All HIV-positive male partners were referred for treatment.

## 2.3 Preventing the mother-to- child transmission of HIV

Guyana's PMTCT programme was first launched in 2001 with 11 pilot sites. The number of sites has since grown to 191 (one new site was added in 2017) across the 10 regions of Guyana. These range from the most basic Level 1 (health post) to Level 5 (national referral hospital), including public and private ANC sites and Labor & Delivery wards that offer joint PMTCT/MCH services. During 2014, ART for HIV positive pregnant women was changed to Option B+ - provision of ART during pregnancy and the continuation of ART for life. The national PMTCT policy was also updated in 2016 in accordance with World Health Organization guidelines.

The current first line regimen used for PMTCT is TDF/3TC(FTC)/EFV. The nationally recommended regimen for preventing mother-to-child transmission of HIV for HIV-exposed infants is single dose NVP at birth and oral AZT given twice daily for six weeks. In addition, Co-trimoxazole is administered from 6 weeks until the infant is confirmed as HIV-negative. Exposed infants who are enrolled at care and treatment sites are tracked through the use of the Exposed Infants Register and the case tracking system. In addition, HIV positive mothers are provided with infant-feeding counseling and exposed infants are provided with breast milk substitute (BMS) free of cost up to the age of 18 months (infant formula up to 6 months and full cream milk from 7 to 18 months of age). During the period 2010 to 2017, the proportion of HIV positive women who delivered and received ART on the Labour & Delivery ward increased from 83% to 97%. During the same period, approximately 98% of HIV-exposed infants received NVP and AZT.

**Table 7** below provides a summary of the PMTCT services provided during 2016, 2017 and 2018 with 2015 included for comparison purposes.

***Table 7: Summary of PMTCT services: 2015 – 2017***

| Indicators | 2015 | 2016 | 2017 | 2018 |
|---|---|---|---|---|
| No. of HIV positive women receiving PMTCT services | 299 | 290 | 252 | 290* |
| No. of HIV positive women who delivered | 154 | 142 | 133 | 190* |

| | | | | |
|---|---|---|---|---|
| **% of HIV positive women who received ART in L & D** | **100%**<br>**(154/154)** | **93%**<br>**(132/142)** | **97%**<br>**(129/133)** | **Data not yet available** |
| **No. of live HIV-exposed births** | **151** | **141** | **133** | **139*** |
| **% of exposed infants who tested positive for HIV** | **2%**<br>**(3/151)** | **1.4%**<br>**(2/141)** | **2.2%**<br>**(3/133)** | **3.6***<br>**(7/190)** |
| **% of HIV-exposed infants who received NVP and AZT** | **100% (151/151)** | **98% (139/141)** | **98% (131/133)** | **Data not yet available** |
| **% of HIV-exposed infants who received Co-trimoxazole** | **Information not available** | **94% (133/141)** | **Information not available** | **Data not yet available** |
| **%. of HIV-exposed infants who received BMS** | **Information not available** | **96% (153/159)** | **Information not available** | **Data not yet available** |
| **Quantity of BMS distributed** | **4,393 tins infant formula**<br>**2,558 tins full cream milk** | **15,193 tins infant formula**<br>**3,658 tins full cream milk** | **8,385 tins infant formula**<br>**1,770 tins full cream milk** | **Data not yet available** |

As indicated in the above table, at the end of 2018, 290 HIV positive women of childbearing age had enrolled at ANC sites and were receiving support, care and treatment while 139 HIV-exposed infants were receiving services. During 2016, of the 142 HIV positive mothers who delivered, 93% (132) received ART on the Labour & Delivery ward. Of the 141 HIV-exposed live births, 98% (139/141) received Nevirapine and Zidovudine and 94% (133) received Co-trimoxazole at 6 weeks. At the end of 2017, total of 252 HIV positive women were enrolled and accessing integrated PMTCT services. Of these women, 133 delivered live births and 97% (129/133) received ART on the Labour & Delivery ward. Of the 133 live HIV-exposed births, 98% (131/133) received Nevirapine and Zidovudine. During 2016, ninety six percent (153/159) of the HIV-exposed infants enrolled were provided with breast-milk substitutes (15,193 tins of infant formula and 3,658 tins of full cream milk) while in 2017,

HIV-exposed infants who were enrolled received a total of 8,385 tins of infant formula and 1,770 tins of full cream milk.

2016 and 2017, a series of capacity building and other activities were implemented to support the PMTCT programme. These are presented in table 8 below.

***Table 8: Activities implemented to support the PMTCT programme: 2016 – 2017***

**Activities implemented to support the PMTCT programme: 2016 – 2017**

**1.** Ninety seven (97) and 52 members of the multi-disciplinary healthcare team respectively received training in case tracking.

2. Thirty two (32) members of the multidisciplinary health care team received training in PMTCT.

3. Training in surveillance was provided to 38 HCWs in the hinterland region 9 as part of the eMTCT Initiative.

4. Indicators for PMTCT case management were developed and SOPs for clinicians were printed to facilitate the management of HIV positive pregnant women.

5. A mapping of Traditional Birth Attendants (TBAs) was conducted in 2016 to assess the human resources capacity in this area and in 2017, training was provided to 30 TBAs on how to perform safe deliveries in a culturally appropriate manner.

6. Under the Baby Friendly Hospital Initiative (BFHI), 5 additional hospitals were accredited and certified bringing the total number of BFHI hospitals to 11 in 2016.

7. Efforts to tackle the Zika virus focused on the strengthening of early detection and capacity building of health workers to provide adequate information and support to mothers whose children were born with Zika-related disabilities. Mosquito repellents were also distributed to 16,000 pregnant women and women of reproductive age.

8. Seventy three (73) health care workers based at interior locations were trained in cross-border interventions using the C4D (communication for development) approach to prevent and manage Zika and its related congenital microcephaly syndromes.

9. Training in psychosocial support was provided to clinic attendees and community members in the prevention and management of Zika-related conditions in 5 regions of Guyana.

10. Zika care and support initiatives continued with specialized training for HCWs in screening for developmental issues in babies and young children, and the equipping of

government health centres with 100 ECD kits. Support was also provided to 16 babies born with microcephaly and their families.

11. During 2016, the legal framework for Code of Marketing of Breast milk Substitutes was developed and reviewed by a national technical working group and counselling cards were developed to assist health care workers in counseling mothers/other caregivers on Infant and Young Child Feeding – including breastfeeding.

## 2.4 Syphilis among pregnant women

Data on syphilis-reactive mothers was not captured in previous years. A database is currently being developed for capturing this data moving forward.

## 2.5 Congenital syphilis rate

Guyana has a national plan for the Elimination of Mother-to-Child Transmission of HIV and Congenital Syphilis. Syphilis tests used are: laboratory-based non-treponemal (e.g. RPR/VDRL) and laboratory-based treponemal (e.g. TPPA, TPHA), rapid syphilis treponemal tests (e.g. Bioline, Determine, Chembio). The Antenatal Clinic protocol provides for syphilis and HIV testing for all pregnant women, however there is no data available on the number of pregnant women tested in 2015, 2016 or 2017. It was however reported that 4 pregnant women tested positive for syphilis in 2015. Guyana's Family Health Manual 2012 requires that treatment is provided to all women who test positive for syphilis. Information on the congenital syphilis rate is also not presently available. There is a need for improved documentation with regard to syphilis testing within the maternal and child health programme.

## COMMITMENT 3: Ensure access to combination prevention options, including pre-exposure prophylaxis, voluntary medical male circumcision, harm reduction and condoms, to at least 90% of people by 2020, especially young women and adolescent girls in high-prevalence countries and key populations.

Guyana continued its delivery of targeted prevention interventions among young women and girls in keeping with the national strategic plan, through collaborative efforts between the NAPS and the various line ministries. During 2016 the WHO Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations were reviewed and standards of care for KPs were identified and partially included in the national HIV policy/plans during 2017. During the second semester of 2018, discussions continued around the possible introduction of Pre-Exposure Prophylaxis for serodiscordant couples with commitments to begin preparations for a pilot during 2019.

There is no national strategy for voluntary medical male circumcision. With regard to HIV prevention for persons who inject drugs, at the present time there is no needle and syringe programme operational within Guyana. Drug users are addressed through the national HIV prevention efforts that are directed towards the general population. More targeted educational sessions are however conducted by organizations that provide rehabilitative services for drug users. At the present time, there are two major centres that are privately operated. Injection drug use is not popular in Guyana. Substance abuse is mostly linked to the use of alcohol, marijuana and recreational drugs, fundamentally among the youth population.

During 2018, Information, Education and Communication along with Behaviour Change Communication, continued to be a prominent part of the national strategy to reach the general population with HIV/AIDS prevention messages. Prevention education was interwoven into the various components of the National HIV programme. National commemorative activities such as World AIDS Day also served as a good media for providing HIV education and sensitization regarding HIV services including testing, screening for STIs and referral to treatment services. The theme adopted for WAD 2018 was *'Know Your Status'*. The national programme issued a clarion call for men to come out and get tested and also conducted a series of mobile community outreaches to target them. This was all part of a 'Know Your Status' campaign.

Workplace programmes continued to be utilized during the period as a means of providing comprehensive health and wellness education including: HIV education/HIV-AIDS Workplace Policy; promotion of human rights and social security; prevention of gender-based violence; occupational safety and health and; industrial relations. Among the armed forces, the military is considered to be a relatively vulnerable group due to their mobility and length of time spent away from home. In recognition of these risk factors, HIV and STI prevention interventions were integrated into all military training programmes - including the provision of VCT and risk reduction materials.

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 12 participating supermarkets. The participating supermarkets through their appointed staff focal points, reinforced HIV prevention measures among their staff. As part of this initiative, free condoms and IEC health materials were also provided to the public.

## 3.1 HIV incidence

According to the Guyana HIV 2019 Estimates, HIV incidence per 1,000 for all age groups was 0.51 <0.40 – 0.72> in 2018. HIV incidence during the five-year period 2014 – 2018 showed a yearly decrease from 0.57 in 2013 to 0.51 in 2018. The highest incidence during the period 1985 to 2018 was 1.25 in 2003.

## 3.2 Estimates of the size of key populations

***Table 9: 2019 size estimates for sex workers and MSM***

| Category | Country estimates |
|---|---|
| Sex worker | 6480 |
| Men who have sex with men | 4192 |

***UNAIDS Spectrum estimates 2019***

## 3.3 HIV prevalence among key populations

HIV prevalence among key populations is presented in table 10 below that reflects the findings of surveys conducted among these groups at different periods.

*Table 10: HIV prevalence among key populations*

| Category | Prevalence in 2014 (%) | Prevalence in 2008/2009 (%) | Prevalence in 2005 (%) |
|---|---|---|---|
| MSM | 4.9 | 19.4 | 21.2 |
| Male sex workers | 5.1 | | |
| Female sex workers | 5.5 | 16.6 | 26.6 |
| Transgender | 8.4 | | |
| Miners | 1 | | 3.9 (in 2003) |
| Loggers | 1.3 | | |
| Prisoners | | 5.2 | |

The results of the 2014 BBSS indicated that HIV prevalence among MSM had decreased from 21.2% in 2005 to 4.9% in 2014 while among female sex workers prevalence had decreased from 26.6% in 2005 to 5.5% in 2014. Prevalence among miners had decreased from 3.9% in 2003 to 1% in 2014. During the 2014 BBSS, male sex workers and transgenders were surveyed for the first time and were found to have a prevalence of 5.1% and 8.4% (10/119) respectively. Among the transgender, HIV prevalence among the under 25 years of age was found to be 9.1% (5/55) while that in the over 25 years age group was 7.8% (5/64).

The above decline in HIV prevalence among key populations can be attributed to aggressive preventative efforts targeting these populations through the national HIV programme. The HIV prevalence found among key population groups during the 2014 BBSS was however still high when compared with that found among the general population (1.4% in 2014).

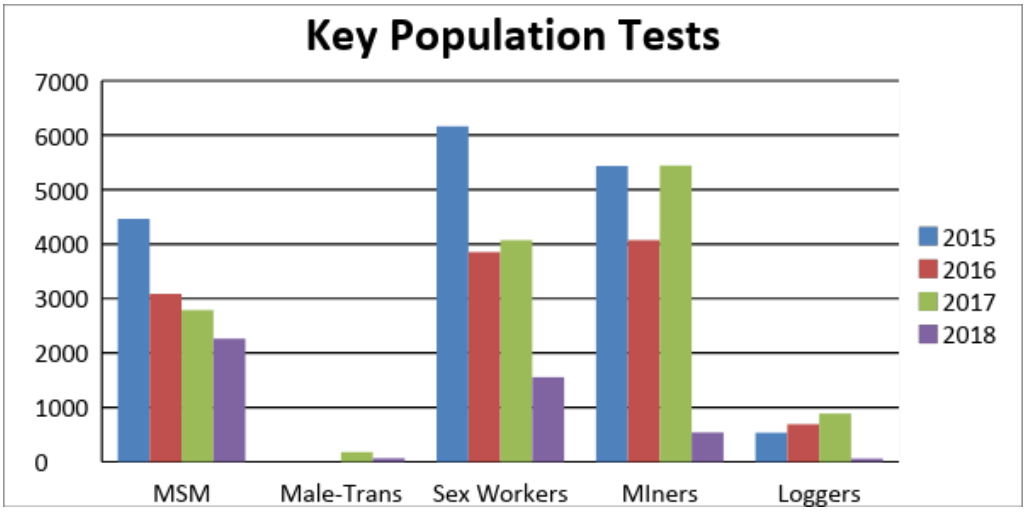
## 3.4 Knowledge of HIV status among key populations

In 2018 the Key Populations testing accounted for 9% (4477/49783). Due to delays in engaging and disbursement of funds to the Civil Society Organizations in 2018, the proportion of HIV testing done among key Population yielded its lowest 9% in 2018 compared to 30.1% in 2015

*Table 11: HIV testing among key populations: 2015 - 2018*

| Year | MSM | Female transgender | Sex workers | Miners | Loggers | Total tests among key populations | % of total tests done nationally |
|---|---|---|---|---|---|---|---|
| 2015 | 4460 | 0 | 6165 | 5435 | 533 | 16593 | 21.3% (16,593/77,774) |
| 2016 | 3089 | 0 | 3852 | 4073 | 690 | 11704 | 15.7% (11,704/74,313) |
| 2017 | 2788 | 179 | 4071 | 5446 | 887 | 13371 | 17.1% (13,371/78,303) |
| 2018 | 2260 | 65 | 1555 | 538 | 59 | 4477 | 6.2% (4,477/72,582) |

*Figure 16: Number of tests done among key populations in 2015 – 2018*




Key populations testing was carried out in all 10 administrative regions of the country with VCT being offered by both public and private health facilities in addition to NGOs. Testing among key populations during 2016 comprised 21.3% (11704/74313) of the total number of tests done country-wide with a slight increase in 2017 to 15.7% (13371/78303) of the national total number of tests done.

Key populations testing during both these years represented a decrease when compared to 2015 during which key populations testing made up 21.3% (16593/77774) of the total number of tests done country-wide. There was however a significant decrease in the number of key populations tested during 2018 (4477) when compared with 2017 (13371).

**Figure 17** and **table 12** below show the numbers of key population members who tested HIV positive during the period 2015 – 2018.

*Figure 17: Key populations that tested HIV positive during 2015 – 2018*

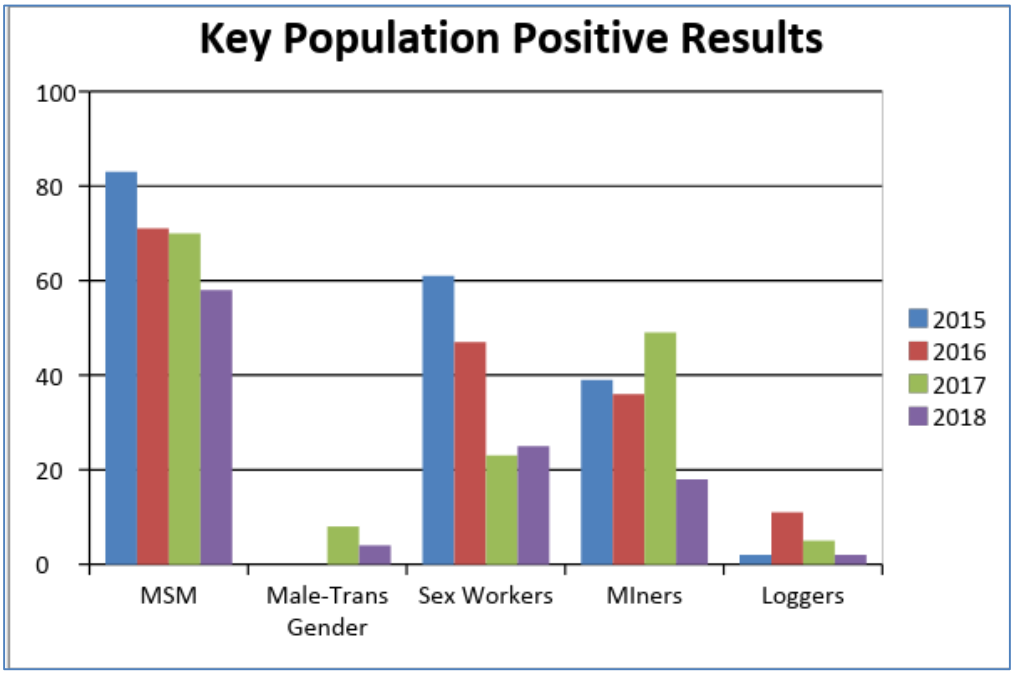



*Table 12: Key populations that tested HIV positive during 2015 - 2018*

| Category | Year | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | 2015 | | 2016 | | 2017 | | 2018 | |
| | % of KP positives | % of national positives | % of KP positives | % of national positives | % of KP positives | % of national positives | % of KP positives | % of national positives |
| MSM | 45.4% (83/185) | 8.8% (83/939) | 43% (71/165) | 7.5% (71/943) | 45% (70/155) | 7.5% (70/936 | 54.2% (58/107) | 7.3% (58/793) |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Sex workers | 33% (61/185) | 6.5% (61/939) | 28.5% (47/165) | 5% (47/943) | 14.8% (23/155) | 2.5% (23/936) | 23.4% (25/107) | 3.2% (25/793) |
| Transgender females | | | | | 5.2% (8/155) | 0.9% (8/936) | 3.7% (4/107) | 0.5% (4/793) |
| Loggers | 1.1% (2/185) | 0.2% (2/939) | 6.7% (11/165) | 1.2% (11/943) | 5% (5/155) | 0.5% (5/936) | 1.9% (2/107) | 0.3% (2/793) |
| Miners | 21.1% (39/185) | 4.2% (39/939) | 21.8% (36/165) | 3.8% (36/943) | 31.6% (49/155) | 5.2% (49/936) | 16.8% (18/107) | 2.3% (18/793) |

During 2017, key populations accounted for 15.5% (155/936) of the total number of positives nationally while in 2018 this decreased to 13.5% (107/793) of the total number of positives. The figures for both years represent a further decrease in proportion of key population positives when compared with 17.5% (165/943) in 2016. Throughout the period 2015 to 2018, MSM accounted for the highest percentage of positives among the key populations with an average of 46.9% followed by sex workers then miners with an average of 24.9% and 22.8% respectively. During 2018, sex workers were the second highest among the positives while miners were the third highest. Transgender females who were reported separately for the first time in 2017, ranked fourth highest of the positives with 5.2% (8/155) and maintained that position in 2018. The constant mobility among key populations within and across Guyana, presented a constant challenge for follow-up testing among these populations who had an initial negative result.

With regard to prisoners, during 2013, a permanent VCT site was established within the Camp Street Prison, the largest prison in the country. Only male prisoners are housed within this prison. Figure 21 below shows the VCT services provided to this prison during 2015 – 2017.

***Figure 17: HIV testing among prisoners at Camp street prison: 2015 – 2018***

During 2016, one hundred and seventy four (174) male prisoners were tested and 1.7% (3) found to be HIV positive. During 2017, ninety six (96) male prisoners were tested 4.2% (4) were found to be HIV positive while in the year 2018, 89 were tested with only 1 reported as positive. In comparison, during 2015, four hundred and thirty four (434) male prisoners were tested and 2.1% (9) were found to be HIV positive. The decrease in testing among prisoners during the 2016 – 2017 period was partially due to safety concerns expressed by counselor/testers due to prison outbreaks occurring during the period, and this continued to affect access to prisoners during 2018. The national program is currently in discussions with the prison authorities to improve the service delivery for the year 2019.

## 3.5 Antiretroviral therapy coverage among people living with HIV in key populations

As a result of limitations of the data collection tools, the key population (MSM, FSW and Transgender females) receiving ART is not possible to report; they are aggregated and accounted for among all patients on ART. During 2018, the MoPH sought to correct this via revision of the case base surveillance form and implementation of training in the use of same. It is expected that for 2019 Guyana will be able to clearly determine ART coverage among this group.

With regard to ART provision among 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. A system is currently in place whereby a team comprising a physician, social worker and a multipurpose technician/phlebotomist makes monthly visits to this prison to provide treatment, care and support for HIV positive inmates. Inmates from two other prisons outside of the city are also brought to this prison for treatment. In addition, prisoners from other parts of the country are escorted to the treatment sites nearest to their prison to obtain HIV care and treatment.

During 2018, eleven (11) visits were conducted to the prison excluding December 2018 and this was due to the Christmas holidays. Four (4) Visits were made to Lusignan and seven (7) to Georgetown Prison for the year. The medical team comprised a medical doctor, a social worker and a phlebotomist.

**Table 13** below depicts the number of prisoners who benefited from care and treatment service during 2018

***Table 13: Number prisoners provided with care and treatment services during 2018***

| Timehri | Lusignan | Georgetown | Other | Total |
|---|---|---|---|---|
| **16** | **78** | **48** | **13** | **155** |

Of the 155 enrolled 126 were ART clients while 29 were Pre-Art. Seventy clients were seen by the team while thirty two refused to be seen. The refusal was as a lack of result of the lack of sufficient privacy and fear of other inmates becoming privy to their HIV status. During the period, fifty-five (55) clients had laboratory investigations done.

## 3.6 Condom use among key and general populations

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 and significant efforts were made to increase the awareness, availability and use of condoms to prevent the transmission of HIV/AIDS and STIs. During 2018, free condoms continued to be distributed to the general public, among the Armed Forces, civil society organizations, stakeholder agencies, health facilities, hotels, taxi bases, private sector agencies and government ministries in the effort to reach all ten (10) administrative regions of Guyana.

***Table 14: Condom distribution during 2011 – 2018***

| Year | Public Sector (MoPH) | Private Sector | Total |
|---|---|---|---|
| **2011** | 2,216,857 | 571,439 | 2,788,296, |
| **2012** | 6,833,948 | 629,637 | 7,463,585 |
| **2013** | 5,869,326 | 395,281 | 6,264,607 |
| **2014** | 2,646,976 | 614,898 | 3,263,874 |
| **2015** | 2,416,671 | 185,320 | 2,601,991 |
| **2016** | 1,808,820 | 18,100 | 1,826,920 |
| **2017** | 3,826,541 | 63,450 | 3,648,323 |
| **2018** | 5,900,732 | 111,989 | 6,012,721 |

## 3.7 Coverage of HIV prevention programmes among key populations

During 2018, interventions targeting key populations (KPs) continued with a focus on MSM, Sex Workers, their clients, transgender persons, miners and loggers. As a result of limited funding and delays in contracting CSOs there was a significant reduction in the percentage of key populations reached and tested, an all-time low of 9% of all testing done nationally. The Guyana Trans United (GTU) a transgender-focused and led organization continued to receive funding to provide HIV-related services specifically for transgender persons – previously, prevention programmes targeted transgender people under the MSM umbrella.

To effectively reach key populations with combination prevention, the prevention package of services defined in the national Most at Risk Population (MARPs) guidelines of 2012 and in HIVision 2020, continued to be delivered to KPs. This package includes: peer education and outreach; risk reduction counselling 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 counselling and testing; STI screening and treatment; HIV care and treatment and; reproductive health services. Peer education and outreaches were used as the primary mechanism for reaching key populations in all 10 regions of Guyana in addition to the services provided through fixed sites that were operated mainly by NGOs.

As a result of the change in trends globally and the need for a more rights based approach to health service delivery, the Ministry of Public Health, National AIDS Programme Secretariat collaborated with Measure Evaluation and facilitated the revision and updating of the 2012 MARPs Guidelines Standards for Non-Governmental Organizations. The revision was done in the form of a stakeholder meeting and saw participation from developmental partners, donors, civil society organizations and representatives from the key populations groups. The aim of the meeting was to hold discussions on how the current guidelines could be updated to meet international standards and best practices.

The discussions were centered on the gaps in the guidelines, definitions of key populations', what should be included in the package of services, critical enablers that should be considered, revision of the tools and monitoring and evaluation. Recommendations were made for several changes to the guidelines including the removal of the standard operating procedures and some of the tools in the appendices.

At the completion of the revision, the revised guidelines were circulated to stakeholders for feedback however only two stakeholders provided feedback. Another stakeholder meeting will be held in 2019 to review the revised guidelines and finalize same.

During 2017 the prevention package of services was provided to 29,175 members of the key populations while in 2018 this package was provided to 2578 members of this population. Table 14 below shows the key populations reached during the 2-year period.

***Table 15: Key populations reached with prevention package of services: 2017 - 2018***

| Category | Number of KPs reached | | Number of fixed sites providing services | |
|---|---|---|---|---|
| | 2017 | 2018 | 2017 | 2018 |
| MSM | 2629 | 1406 | 14 | 2 |
| Sex workers | 4275 | 1092 | 12 | 2 |
| Transgender | 161 | 6 | 2 | 1 |

| | | | | |
|---|---|---|---|---|
| Miner | 11008 | 0 | Not known | 0 |
| Logger | 2102 | 0 | Not known | 0 |
| Total KPs receiving package of services | 20175 | 2578 | | |

During the period, community mobilization and outreach sessions were conducted at hotspots where key populations congregated. Work continued in sensitizing the proprietors of venues (bars, clubs and other places) on HIV/STIs prevention and stigma reduction. Venues were equipped with IEC materials on HIV prevention and condoms were made readily available. 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.

During the period, monthly capacity building/support group meetings were held with members of the FSW and MSM populations to offer psycho-social support and to assist them in identifying high risk behaviours e.g. alcoholism, gender-based violence, unsafe sexual practices. The Guyana Trans United and Artistes In Direct Support were the NGOs that fundamentally provided these services and they operated in region 4.

During 2018, six Client Advocate Associates (CAAs) were engaged in proactively identifying KPs within the larger patient population, initiating VCT, conducting intensive contact and defaulter tracing, navigating clients in accessing services and issuing appointment reminders. Through this venture, 3329 persons were tested for HIV, of which KPs accounted for 15%. Among those tested, 204 were sex worker of which 5.4% (11/204) were positive while 6.5 %( 19/294) of the MSM tested were found to be HIV positive. The MSM and FSW linked to care and treatment where 85% and 100% respectively. The CAAs further provided support to 672 persons, most of whom were from the general population and who had defaulted or missed their appointments and were able to re-engage 255 of them into the care and treatment services.

## 3.8 Active syphilis among sex workers

Data on active syphilis among sex workers is not currently available.

## 3.9 Active syphilis among men who have sex with men

Data on active syphilis among MSM is not currently available.

## 3.10 Active syphilis among men who have sex with men Prisoners

Data on active syphilis among prisoners is not currently available.

## 3.11 HIV prevention programmes in prisons

In keeping with HIVision 2020, National HIV Strategic Plan (2013 – 2020) which identifies prisoners among the key populations at higher risk, through the VCT site set up in the Camp Street prison (largest prison), HIV testing is routinely offered to prisoners. HIV prevention interventions are also offered by a multi-disciplinary team that pays monthly visits to this prison to provide prevention, care and treatment services. Condoms are made available to prisoners to a limited extent.

## 3.12 Viral hepatitis among key populations

Data for viral hepatitis among key populations is not currently available.

## 3.13 People receiving pre-exposure prophylaxis

During the reporting period, there was no national commitment to provide pre-exposure prophylaxis to the at-risk population. Priorities for the allocation of funding have thus far been directed towards providing ART for PLHIV and for post-exposure prophylaxis. Some members of the key populations have however indicated that PrEP is available through private providers. These providers are however not known to or registered with the National HIV Programme.

During the first half of 2018, the Society against Sexual Orientation and Discrimination (SASOD), with external funding, undertook a PrEP assessment among key populations entitled *Assessment of Knowledge, Attitudes and Delivery Preferences for HIV Pre-Exposure Prophylaxis (PrEP) among Key Populations in Guyana*. The study was conducted among 47 HIV negative members of the key populations taken from 5 of the 10 regions of Guyana. The exercise sought to ascertain the level of knowledge, attitudes and delivery preferences with regard to PrEP.

The findings of the study were that: 60% of the participants had never heard of PrEP while the remainder were confusing PrEP with PEP; participants felt that PrEP would be beneficial and they would use it if available; LGBT persons, persons with previous STI infections, persons with multiple sexual partners, and youths, were felt to be important potential beneficiaries of PrEP; PrEP should be delivered through NGOs and the government and it should be made available to the wider population and not only among KPs.

Concerns expressed by the participants included: the cost and side-effects of PrEP; the effects on pregnant women; possible interactions with alcohol and other medications; the stigma surrounding HIV; the possibility of the medication increasing sexual promiscuity in both HIV- negative persons and PLHIV; the need to adhere to taking the pill every day and; the need to have regular blood tests taken.

The next steps recommended by SASOD following the study were to: engage the MoPH and appeal for partnerships with governmental and private sector entities to distribute PrEP; start by offering free PrEP to sero-discordant couples and; engage NGOs serving KPs with regard to the distribution of PrEP among this population.

Currently discussion are ongoing for the introduction of PrEP for serodiscordant couples and for this service to be provided via synergies with the private sector and CSOs.

### Delivery of post exposure prophylaxis (PEP)

Post Exposure Prophylaxis sites are equipped with a special PEP kit that includes the Standard Operating Procedures/Guidelines, ARVS, medications for treatment of other STIs (gonorrhea and chlamydia), and emergency contraceptives. During 2018, ninety four (94) PEP cases were reported from three treatment sites. Needle stick injuries (occupational) accounted for 29 PEP cases while the remaining 65 were due to sexual assault (non-occupational). Which differs from the usual trend of the majority of cases being attributed to needle stick injuries. To address the number of needle stick injuries, ongoing PEP sensitization was conducted among health care workers however more work needs to be done in this regard. There is also a need for increased PEP sensitization among police officers and key populations.

## 3.14 Condom use at last high-risk sex

Guyana's condom strategy addresses the needs of the general population with more targeted programmes directed towards key populations, PLHIV, youths and persons with STIs. There are no age restrictions for accessing condoms nor restrictions regarding distribution in public places.

The 2014 Multiple Indicator Cluster Survey (MICS) revealed that multiple sexual partnerships existed among 1.9% of females and 13.8% of males. The MICS also revealed that condom use at last sex among persons with multiple sexual partnerships was 42.2% among females and 59% among males. The 2014 BBSS also found that condom use among male sex workers was 52.4% when with clients. Preliminary data obtained from a BBSS conducted in 2017 indicated that in response to the question relating to condom use at every sexual encounter within the past 6 months, the results were: FSW: 7.4 (weighted, n = 503); MSM: 4.7 (weighted, n = 690); Trans women: 30.5 (weighted, n = 82).

## COMMITMENT 4: Eliminate gender inequalities and end all forms of violence and discrimination against women and girls, people living with HIV and key populations by 2020.

Guyana's HIVision 2020 (NSP 2013-2020) contains as one of its strategic lines of action to "Create a supportive environment that is based on human rights and facilitates delivery of services." Another strategic line of action is to "decrease stigma and discrimination across all sectors." Guyana has policies in place requiring healthcare settings to provide timely and quality health care regardless of gender, nationality, age, disability, ethnic origin, sexual orientation, religion, language, socio-economic status, HIV or other health status, or because of selling sex, using drugs, living in prison or any other grounds. Key populations and people living with HIV are protected from violence through the provision of general criminal laws prohibiting violence against persons. There are no laws criminalizing the transmission of, non-disclosure of, or exposure to HIV transmission and no laws or policies restricting the entry, stay and residence of people living with HIV.

During 2016, APC, and NGO facilitated the performance of a gap analysis of the MoPH's HIV Stigma and Discrimination Policy used by healthcare workers. This was done in collaboration with Civil Society groups in order to ensure synergy. The finalization of the report is currently awaiting the inputs of key MoPH and other stakeholders in order to move forward in addressing the gaps.

Despite the gains that have been made over the years in safeguarding the rights of PLHIV and the LGBT community however, HIV-related stigma continues to impact the number of persons reached in terms of providing HIV prevention, treatment, and support services. Stigma and discrimination impacts the rate of reduction of transmission of HIV, particularly among the LGBT population. The national programme continues to address this issue using a multi-sectoral approach that involves all stakeholders.

## 4.1 Discriminatory attitudes towards people living with HIV

Data from MICS 2014 indicated that only 23 percent of women and men respectively expressed accepting attitudes towards PLHIV based on four statements: would care for a family member with AIDS in own home; would buy fresh vegetables from a vendor who is HIV positive; thinks that a female teacher who is HIV positive should be allowed to teach in school; and would not want to keep it a secret if a family member is HIV positive. However, the great majority of women (98%) and men (99%) who have heard of AIDS agree with at least one accepting statement.

The most common accepting attitude is caring for a family member with AIDS in own home: women (91%) and men (90%). They were however least keen on not keeping it a secret that a family member is HIV positive (43% women and 47% men). Also, the 15-19 and 40-49 age groups were less likely than the 20-39 age group to buy fresh vegetables from an HIV positive shopkeeper or vendor, or believe that an HIV positive female teacher who is not sick should be allowed to continue teaching. The 15-29 age group was also more likely than the older age groups to want to keep secret that a family member is HIV positive. In addition, while men were more likely than women to buy fresh vegetables from an HIV positive shopkeeper or vendor, women are more likely to believe that an HIV positive female teacher who is not sick should be allowed to continue teaching.

## 4.2 Avoidance of HIV services because of stigma and discrimination among key populations

During 2018, CSOs and other agencies continued to implement activities that targeted attitudes, social norms and institutional practices that contribute to stigma and discrimination and which create barriers to the use of HIV services by key populations. These activities are listed below.

***Activities undertaken to address S & D against KPs: 2018***

**Activities undertaken to address stigma and discrimination against key populations: 2018**

1) Thirteen frontline workers of the Guyana Trans United benefited from and S&D and SOGI capacity building training. The training aimed at improving technical competency to support targeted interventions focused on S&D and SOGI.

2) Hotline staffers of the Ministry of Social Protection were also trained in stigma and discrimination and sexual orientation and gender identity. The staffers were from the Probation and Social Services Department and the Childcare and Protection Agency.

3) Advancing Partnership and Communities conducted Stigma and Discrimination and Sexual Orientation and Gender Identity sensitization training for 54 final year student nurses at the Georgetown School of Nursing. The overall training objectives were: **(1)** to increase their awareness and knowledge of gender and sexual orientation; and **(2)** equip participants with basic knowledge and skills to identify and address stigma and discrimination within healthcare setting.

4) Five frontline staff from Artiste In Direct Support were trained as trainers in Sexual Orientation and Gender Identify. Using educational videos, presentations and participatory activities, frontline workers were introduced to in-depth information on biological sex, sexual orientation, gender identity, and expression. These sessions will be continued in FY 19, and frontline workers' facilitation skills will be assessed using a standard grading tool. Five frontline workers including the social worker, nurse, HTC officer, and peer educators.

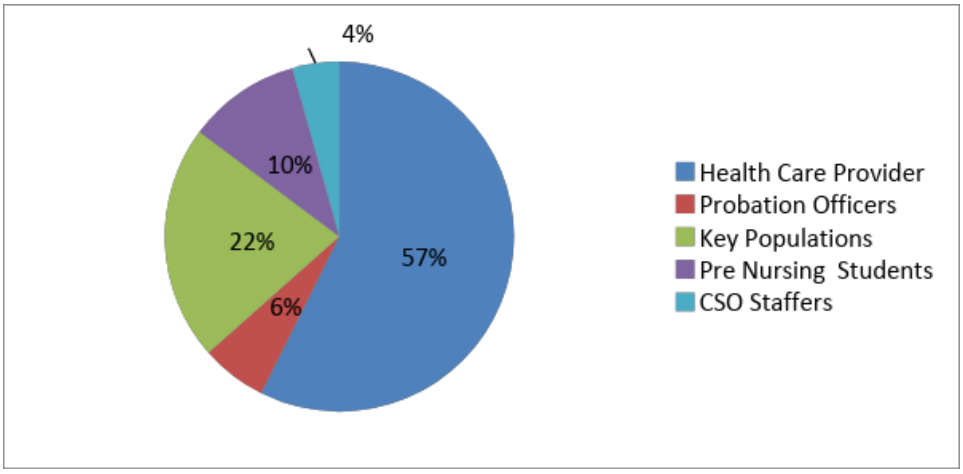
5) Similar series of Training of Trainers (ToT) was conducted for the frontline workers of the Guyana Trans United (GTU). However, a major setback of the ToT was the constant turnover of frontline workers at GTU, which impedes on APC's efforts to build the capacity of a stable cohort of key population members who will take the lead in the delivery of such sessions.

6) Stigma and discrimination sensitization and sexual orientation and gender identity sessions were held with health care workers and members of the key populations in region 4, 6 and 8. The overall objective of these sessions is to create a more enabling environment by raising awareness on the effects of stigma and discrimination on Key Populations and

People Living with HIV (PLHIV)'s health. Through a combination of presentations and participatory activities, participants were introduced to a foundational understanding of key terms and concepts related to sex, gender and sexuality, and forms, causes, and effects of stigma. The sessions were facilitated by staffers of the National AIDS Programme Secretariat and APC Project with support from the CBOs. The session in region 6 concluded with participants committing to stigma and discrimination reduction within their individual health facilities.

7) FACT provided regular stigma and discrimination sensitization sessions held with the staff at the Skeldon Hospital Care and Treatment Clinic. These regular sessions targeted the auxiliary staff and health care providers

***Figure 18: Disaggregation of beneficiaries of S&D Training based on profession: 2018***




## 4.3 Prevalence of recent intimate partner violence

Gender-based violence crosses both racial and socioeconomic lines in Guyana. The Bureau of Statistics Report 2015 indicates that Guyana's population stood at 746, 955 (male 371,805 or 49% and female 375,337 or 51%). The number of persons reporting intimate partner violence in 2017 was is 1,787 with 81% being female and 17% male (2% were missing case files). Two hundred and twenty seven (227) were reported cases of rape. Of the cases reported 92% mentioned some form of emotional/psychological abuse which included stalking, cursing, destruction of property, 44% mentioned being threatened and 48% mentioned physical abuse. As at May 2018, seven hundred and fifty-five cases (755) of gender-based violence were reported through the courts, with the majority of the victims being female and the perpetrators being male. Reports made of women killed by their male partners/ex partners during 2016 and 2017 were 17 and 14 respectively with 13 such deaths reported

during the period January to August 2018. The means of killing over the years have included stabbing, shooting, beating to death, strangulation, setting the victim alight or chopping.

According to Inter-American Development Bank's study 'Understanding and Combating Crime (2017)', Guyana has the highest tolerance for violence against women in the Caribbean, with 48% of the population being of the view that beating an unfaithful woman is justified. Rural areas show greater acceptance of wife beatings and on average, 28% of males coming from interior, rural and rural coastal areas believe that a husband has a right to beat his wife. Data from MICS 2014 indicate that the attitude towards domestic violence in Guyana is the same regardless of the sex of the respondent. Ten (10) percent of women and men between the ages of 15 – 49 years feel that a husband is justified in hitting or beating his wife/partner in at least one of the following five situations: neglecting children; arguing with the husband; going out without telling him; refusing to have sex with him or; burning the food.

Guyana does not have a national plan or strategy to address gender-based violence however the Domestic Violence Act has provisions for court injunctions regarding the safety and security of survivors, and protection services for survivors such as legal services or shelters. A National Domestic Violence Oversight/Policy Committee, established by the Ministry of Social Protection oversees the effective implementation of the Domestic Violence Policy (2008-2013). The Women/Gender Affairs Bureau that forms part of this Ministry's structure also engages in public awareness efforts against gender based violence and provides support to the victims and survivors of gender based violence, supported by an emergency 24-hour hotline service. Guyana conducts GBV training sessions for police, other law enforcement personnel and members of the judiciary at the sub-national level. On a smaller scale, similar training has been provided to elected officials (lawmakers/parliamentarians).

Guyana has a certain number of service delivery points, in accordance with the recommendations of the 2013 WHO guidelines for Responding to Intimate Partner Violence and Sexual Violence Against Women. These service points provide appropriate medical and psychological care and support for women and men who have been raped or have experienced incest. Emergency contraception is available for women who seek services within five days and medical termination of pregnancy is permitted by law. Safe abortions are available if a woman becomes pregnant as a result of rape. Post-exposure prophylaxis is also available for sexually transmitted infections and HIV (within 72 hours of sexual assault) as needed.

### Reporting and Redress systems facilitated to address stigma and discrimination and Gender based violence/Intimate Partner Violence

One incident of Stigma and discrimination was reported by the Client Advocate stationed at one of the HIV treatment sites. It involved a security guard who gossiped about clients at the clinic with visitors and was reported to the Clinic Manager, who immediately addressed the situation. The USAID APC has committed to work with both the professional and auxiliary staff of HIV care and treatment site to reduce HIV related stigma and discrimination.

### Key Populations screened for Gender Based Violence by APC

Screening for GBV by the APC was conducted for 28 persons, majorities of whom were FSW (82%) while MSM and TG accounted for 14% and 6% respectively. Reported incident of violence varied. Ten percent of all persons experienced emotional violence. When experiences of emotional violence as disaggregated, MSM reported 25% compared to 4% among FSW. One FSW indicated sexual violence. None reported experiencing all forms of violence. Unfortunately, the victims of violence were unwilling to develop a safety plan or access referral services. Consistent with last quarter, providers continued to highlight reluctance on the part of survivors to seek GBV post care services.

### Society against Sexual Orientation Discrimination (SASOD) conducted sessions on sexual, gender and diversity and legal literacy

Throughout 2018, the Society Against Sexual Orientation Discrimination (SASOD) Guyana committed to working with 'Key Populations' in Guyana to sensitize and educate, especially taking into the consideration the need for co-curricular education within the community.

As such, SASOD Guyana completed a series of training workshops with key populations from regions 3 and 4. Whilst there were diverse groups reached in regions 5 and 6, the sessions conducted in regions 3 and 4 were garnered to ensure that key populations were key beneficiaries. As a result of SASOD Guyana's aims and objectives, the key populations met typically consist of MSM, transgender persons and sex-workers.

The sessions conducted were specially focused on Gender and Sexual Diversity and Legal Literacy, which, when taught in tandem create a better sense of self and provide the opportunity for key populations to self-actualize, taking into consideration the legislative climate in Guyana. One positive to note is that in November 2018 the Caribbean Court of Justice ruled in favour of striking down the law prohibiting cross dressing which is expected to ensure that persons are not victimized because of the gender expression, specifically mode of dress. In total, SASOD Guyana has trained a cumulative total of 61 persons who are part of key populations in Guyana.

Understanding the concepts of sex, sexual orientation, gender identity and gender expression, relative to the Guyanese context can shift thought patterns, enhance perspectives, reduce internal discrimination and xenophobic attitudes, enhance communication and improve lifestyles in the long run.

### Key Populations screened for Gender Based Violence by SASOD

Thirty-nine (39) persons were screened for Gender Based Violence. Of the 39, 38 % were MSM, 56% were FSW and 6 % were TG. Among all groups within the past twelve months, only 2% reported experiencing physical violence, 8% emotional and psychological violence, while no one reported

experiencing sexual violence. Only two safety plans were developed for clients, while one person requested and received referral services. It was noted that among all KP groups, emotional and psychological are most common.

**COMMITMENT 5: Ensure that 90% of young people have the skills, knowledge and capacity to protect themselves from HIV and have access to sexual and reproductive health services by 2020, in order to reduce the number of new HIV infections among adolescent girls and young women by 50%.**

## 5.1 Young people: knowledge about HIV prevention

The MICS 2014 reveals that the percentage of young people age 15-24 years who correctly identify ways of preventing the sexual transmission of HIV, and who reject major misconceptions about HIV transmission are 51.5% among women and 40.2% among men. The MICS 2014 also reveals that the percentage of young people age 15-24 years who had sexual intercourse before age 15 are 4.9% for women and 12.6% for men. The percentage of sexually active young people within 15 - 24 age group who had sex with a non-marital, irregular partner in the last 12 months was 12% for women and 36.7% for men. In addition to the MICS data, data from the Surveillance Unit MoPH showed the highest occurrence of STIs within the 15-24 years age group during 2018. This high occurrence would thus indicate that while knowledge of HIV prevention is approximately 50% among the young population, this knowledge does not necessarily translate into behaviour change with regard to sexual practices.

Young people (15-24 years old) in Guyana have a voice in developing policies, guidelines and strategies relating to their health in various decision-making spaces in the national HIV response including: technical teams for the development and updating of national AIDS strategies and plans and also programmes that relate to young people's access to HIV testing, treatment and care; the UN Joint Teams on AIDS; UN thematic teams on legal and policy reform and review; the National AIDS Coordinating Authority or equivalent, with a broad based multi-sector mandate; the Global Fund Country Coordinating Mechanism and; civil society coordination spaces for populations most affected by HIV.

A draft Sexual and Reproductive Health (SRH) Policy and also a Strategy were developed during 2013 and 2014 and submitted to the MoPH in 2015 for approval and subsequent presentation to Cabinet. There was some delay in the approval of these documents by MoPH and a request was made for the documents to be revised for re-submission to the Ministry. During the reporting period the revision was still in progress. The SRH Policy is intended to provide overall guidance for the provision of a basic package of SRH services to youths and 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.

### Training and sensitization sessions:

1. The Ministry of Education's Health and Family Life Education (HFLE) programme continued with its implementation in government primary and secondary schools across the country, as a time-tabled subject focusing on life skills education. Topics included: decision-making; self-esteem; disease prevention (include HIV); sexual and reproductive health; anger management; peer pressure; substance abuse and; teenage pregnancy

2. A programme of providing guidance and counselling to students was also piloted in 17 secondary school dormitories for indigenous adolescent boys and girls and the preliminary results indicated that the programme was very beneficial to the students.

3. Community mobilization and sensitization activities were conducted for various target groups and in collaboration with Government agencies, grassroots organizations, service organizations, youth groups, schools, and civil society members in the attempt to bring about awareness and behaviour change among persons at the community level. A number of the trainings and outreaches were done in the outlying regions of Guyana, and in particular in areas where the youth population was relatively underserved.

4. HIV peer education training and sensitization of in and out-of-school youth were conducted across Guyana. The sessions focused on: identifying ways in which young people can contract HIV; the ABC (Abstain, Be Faithful, Use Condoms) of HIV/AIDS prevention; eradicating stigma and discrimination and; equipping the participants with peer education skills. The workshop methodology included practical demonstrations and also the provision of HIV-related IEC materials

## 5.2 Demand for family planning satisfied by modern methods

There are no laws in Guyana requiring spousal consent for married women to access sexual and reproductive health services however there are laws and policies requiring parental consent for adolescents to access these services. The laws and policies in relation to adolescents also vary in terms of aspects of the service that can be accessed.

According to the MICS 2014, in Guyana, the percentage of women age 15-49 years currently married or in union who are using (or whose partner is using) a (modern or traditional) contraceptive method is 34.1%. The percentage of this age group that is using modern methods is 32.6%. The most popular method is the male condom, which is used by 9% of women currently married/in union, followed by

the pill, which accounts for 8% of married women. Between 3 – 6% of married women reported the use of the Intrauterine Device (IUD), injectable, and female sterilization. Implants were only used by 1% of married women. Less than one 1% reported the use of female condom, male sterilization, diaphragm/foam/jelly, periodic abstinence, or withdrawal.

The MICS 2014 also revealed that while contraceptive prevalence is similar between urban-rural and interior-coastal areas (between 32 and 35%), women's education level appears to have some relationship with contraceptive prevalence. The percentage of married women using any method of contraception was found to be 29% among those with no education, 33-34% among those with primary or secondary education, and 39% among those with higher education. Adolescents (young women between 15-19 years) were far less likely to use contraception than older women, with only 13% using contraceptives. Contraception use was highest among women aged 25-34 years (41 – 42%).

The MICS 2014 also revealed that among women 15 – 49 years, the total unmet need for contraception (fecund women who are married or in union and are not using any method of contraception, but who wish to postpone the next birth or stop childbearing altogether) is 28%. Unmet need is higher in urban areas than in rural areas (32% and 27%, respectively) and in interior areas than in coastal areas (34% and 27%, respectively). Unmet need was found to be high among adolescents (women aged 15-19 years).

The MICS survey will be conducted in 2019 which will provide updated information on the knowledge of HIV prevention among our youths

## COMMITMENT 6: Ensure that 75% of people living with, at risk of and affected by HIV benefit from HIV-sensitive social protection by 2020.

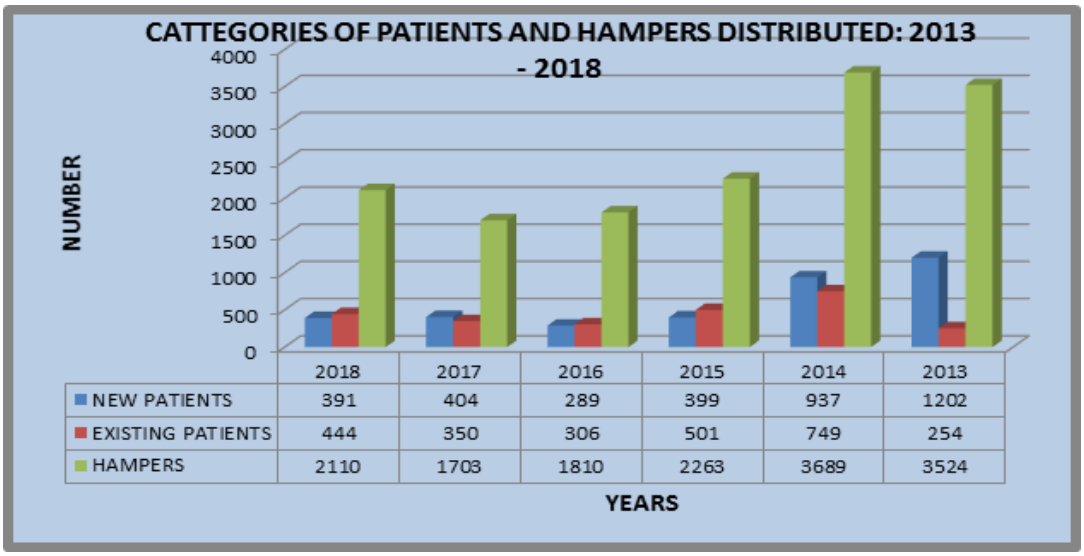
While Guyana's Ministry of Social Protection does not have an established Strategy/Policy that addresses the specific needs of PLHIV or their family members, this Ministry provides public assistance to persons who are in severely challenged economic circumstances and those who are permanently disabled. PLHIV and their dependents who meet the Ministry's criteria for public assistance are thus eligible to receive this type of support. Eligibility is determined by a socio economic assessment and the physical capacity of the individual to earn an adequate living. Persons eligible for support also include children who are orphaned (as a result of HIV or other reasons) and who live with persons who are unable to provide for their upkeep – such as elderly grandparents. Such children can receive a monthly allowance of approximately G$ 7,500 after an evaluation is done of their specific circumstances. There are however some existing barriers with regard to the uptake of these services by PLHIV and their dependents - due to fear of stigma and discrimination.

## Nutritional support for PLHIV

The MoPH/NAPS Food Bank provides nutritional support to PLHIV (including children) in order to have improved treatment outcomes and thus improve the quality of life of PLHIV. A patient's eligibility for nutritional support is reviewed every six months by the physician and other members of multidisciplinary care and treatment team and a decision made as to whether to continue providing support. During 2018, nutritional support for HIV, HIV/TB co-infected, and TB patients was provided through collaboration with the private sector, and support from the Guyana Government.

**Figure 19** below shows the distribution of hampers among eligible patients during the period 2013 – 2018.

*Figure 19. Hamper distribution: 2013 – 2018*




| | 2018 | 2017 | 2016 | 2015 | 2014 | 2013 |
|---|---|---|---|---|---|---|
| NEW PATIENTS | 391 | 404 | 289 | 399 | 937 | 1202 |
| EXISTING PATIENTS | 444 | 350 | 306 | 501 | 749 | 254 |
| HAMPERS | 2110 | 1703 | 1810 | 2263 | 3689 | 3524 |

During 2018, there was an increase in the number of patients receiving hampers as well as the number of hampers distributed. A total of 835 patients (391 new patients and 444 existing patients) received a total of 2,110 hampers, while in 2017 a total of 754 patients (404 new and 350 existing) received a total of 1,703 hampers. There was a decline in the number of patients that accessed the Food Bank during 2015 to 2017 due to reduced funding from the Global Fund, delays in the procurement system and the partial transitioning of the Food Bank to Government funding. During 2017, in order to ensure sustainability of the Food Bank, the Government funded 65.5% of the total cost in light of the decreasing donor funding.

Region 4 which has the largest number of treatment sites, accounted for 90.5% of the hampers distributed in 2017 and 92.5% in 2018. One third of beneficiaries to the Food Bank were unemployed (33%) while single parents continued to comprise a sizeable proportion of the recipients of hampers, ranging from 44% in 2007 to 40 % in 2018. During 2018, females accounted for more than half (53%)

of the beneficiaries while males benefitting represented the remaining 47%. For each of the age group categories 40-44, 45-49, 50-54 persons receiving hampers accounted for 14% of the beneficiaries. This was followed by 30-34 and over 60 which represented 13% and 10% respectively. The latter occurrence may be an indication that patients are living longer with access to medication and nutritional support. Of the 5557 patients on treatment, 15% were recipients of food hamper during the reporting period.

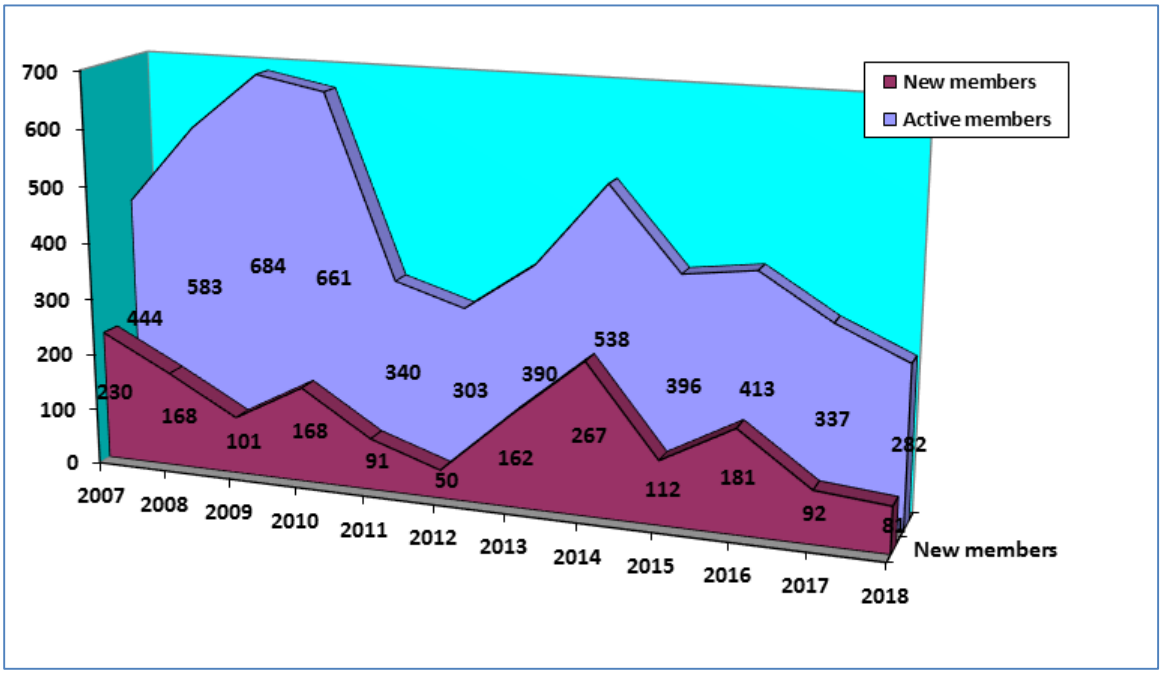
In the effort to empower PLHIV to better manage their nutritional status, the Food Bank with donor support, conducted a 12-days practical training programme in 2017 on Food Preparation and Healthy Eating, for 9 PLHIV and repeated the same in 2018. The aim of the training was to have the attendees impart the knowledge gained among their peers during PLHIV support group meetings and to encourage economic empowerment while at the same time healthy and nutritional eating practices among PLHIV within their homes and the community. During 2017, a draft Nutrition and HIV Guidelines for PLHIV was developed and is currently awaiting review.

### PLHIV Support Groups

During 2018, the HIV/AIDS support group programme which commenced in 2005, continued at 15 HIV treatment sites in 6 regions of Guyana. The aim of the programme is to provide support services to PLHIV and their affected families in the effort to improve their quality of life and reduce morbidity and mortality. During the period, the support groups continued to provide a forum for PLHIV to meet monthly to discuss health issues, adherence, proper nutrition, safe sexual practices and personal experiences. They were also engaged in recreational activities (within groups and among groups from the different regions). In addition, food items received through charitable organizations were also distributed among support group members. During 2018, 365 PLHIV attended support group meetings, of which 83 were new members. The majority of members were females which comprised 70.7% of the attendees. The fluctuation in membership during the period was due to members' unavailability to attend meetings due to the acquisition of employment in some cases. To encourage membership and attendance, efforts to create awareness included the posting up of flyers at strategic points of the treatment sites and also the distribution of calendars showing the dates and times of support group meetings.

**Figure 20** below shows the support group membership during the period 2007 – 2018.

*Figure 20: Support group membership 2007 – 2018*




A key component of the support group programme was the involvement of PLHIV in skills-building and income-generating activities. During 2018, a total of 58 PLHIV were trained in the Positive Health Dignity Prevention guidelines. The objective of the training was to reinforce the importance of adherence, condom use, proper nutrition, clinic attendance, and treatment literacy. Of the 58 persons trained, 18 were adolescents. Training was also provided in the area of mental health and focused mainly on providing psychoeducation on depression, psychoses, epilepsy / seizures, developmental disorders, Behavioural disorders, dementia, alcohol Use disorder, drug use disorders, and self-harm / suicide.

## Support to adolescents and children

During 2016, a number of Policies seeking to protect the rights of children were revised/approved. These included: the National Youth Policy which seeks to protect the rights of adolescents and youth (including those living with HIV) which was finalized and approved in Parliament in 2016; the operation of the family court that seeks to provide child protection services; a review of the Sexual Offences Act 2010; revision of the Juvenile Justice Bill; inclusion of legal regulations governing child care services into the Childcare and Development Services Act and; production of child-friendly booklets on key legislation in Guyana and child rights and the SDG's.

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 allows children who are the victims of rape, to tell their story to all of the relevant authorities in joint setting.

At the National Care and Treatment Centre, a special Adolescent Support Group is operated with the goal of providing psychosocial support that is tailored to the specific needs of children and youths.

As part of the psychosocial support programme for adolescents, The fourth annual youth camp for HIV positive adolescents was conducted in during 2nd to 5th August 2018. The main objective of the camp was to provide the necessary information to HIV positive adolescents to enhance their overall health and wellbeing by fostering positive adherence to their treatment. 89 HIV positive adolescents benefited from the camp over the 4 day period and were supervised by 19 adults. . The adolescents were selected by the respective social workers based on their adherence to medications, their attendance to clinic appointments and support group meetings and it is hoped it will further motivate and encourage them to continue these practices.

## COMMITMENT 7: Ensure that at least 30% of all service delivery is community-led by 2020.

Civil society organizations (CSOs) and community-based organizations (CBOs) play a major role in the delivery of selected HIV services in Guyana. The law allows for these organizations to become legally registered to provide such services to the general population – including key populations. These organizations can access funding from donor agencies, which have established reporting requirements that recipients are expected to adhere to. As a result of decreasing donor funding within recent years, CSOs have been pursuing more creative resource mobilization efforts such as developing partnerships with the business community. While social contracting between the Guyana government and CSOs/CBOs/NGOs was not yet established for the delivery of HIV services during 2018, it is planned for 2019.

Throughout 2018 CSOs that were operational ensured their efforts were directed to the general and key populations, focused on reduction of high-risk behaviors for HIV transmission and reinfection, and the empowerment and development of leadership among PLHIV and key population for modelling good HIV-prevention behaviours among their peers. In addition, the CSOs involved PLHIV in skills building activities and provided case management services to PLHIV to improve adherence and personal management of their condition.

**Community-led service delivery: 2018**

1. HIV outreach and prevention services were directly supported by two CBOs- Artistes in Direct Support (Artistes) and Guyana Trans United (GTU), both of which are located in Region Four and are supported by APC. Support for these CBOs included salaries, stipend and travel expenses for persons conducting HIV outreach and prevention activities targeting KP members who are at high risk for HIV. Artistes In Direct Support activities focused on reaching men who have sex with men (MSM) and female sex workers (FSW) while GTU's focus was on reaching MSM, FSW and transgendered persons (TG).

2. Members of outreach teams utilized enhanced peer-to-peer mobilization strategies, including the use of internet based social media platforms such as Facebook, Instagram, and dating applications such as Adam4Adam to reach peers. Team members also continue to visit locations where KPs are known to frequent. This resulted in a reduction in the number of persons being tested but a higher yield of persons diagnosed HIV positive. Key Populations who declined HTC were provided with risk reduction counseling, informed about the benefits of testing and provided with a list of testing sites (including the CBO sites) in case they decide to be tested at a later date.

3. Involvement of the PLHIV community in the national response to HIV included support groups that addressed social issues among fellow PLHIV through counseling and education. Support group meetings also provided a forum for assessing the quality of HIV services received by PLHIV through the national programme. Personal experiences with their own HIV status further enhanced the ability of PLHIV employed within the programme to conduct defaulter tracing within the community in the effort to improve retention in HIV care and treatment.

4. The Guyana Faith Coalition on HIV and AIDS coordinated the response among the faith community, with a focus on the strength of the family as the core unit of society. The coalition also held a forum to further discuss its role in the national HIV response.

5. Through the Supermarket Initiative which aims at promoting awareness of HIV and AIDS and general health and wellness, 12 participating supermarkets followed up on their staff training in HIV and other health-related matters.

6. Guyana's military service, the Guyana Defence Force (GDF) continued to integrate HIV education and behaviour change communication into its military training programmes, in recognition of the mobile lifestyles of its officers. VCT continued to be offered at different field locations and linkage was provided to treatment as required.

## COMMITMENT 8: Ensure that HIV investments increase to US$ 16 million by 2020, including a quarter for HIV prevention and 6% for social enablers.

In recognition of the decreasing levels of donor support and the need for country ownership with regard to the sustainability of the national HIV programme, the government of Guyana has established a Sustainability Planning Steering Committee comprising high level representatives of key government ministries and agencies, development partners and civil society representatives. The goal is to support the development of a National HIV sustainability plan, including the identification of resource needs, costing of the plan, and resource mobilization.

At the present time a detailed costing of the National Strategic Plan for HIV and AIDS is underway in the effort to inform the sustainability plan for HIV. UNAIDS also provided support in 2017 for the preparation of the National Commitments and Policy Instrument to measure progress in the development and implementation of national-level HIV and AIDS policies, strategies and laws.

During 2016 and 2017, Guyana continued to increase the national budget allocation towards the procurement of antiretrovirals and it is now fully funding commodities for viral load and CD4 testing. Additionally, human resources that were partially donor-funded for the national HIV response, are now being gradually absorbed by the country's Public Service Commission.

## 8.1 Total HIV expenditure Domestic and international HIV expenditure by categories and funding sources

### 2016 National Health Accounts

The most recently available data on HIV spending is provided through the systems of health accounts which was developed in 2017 utilizing 2016 expenditure.

Through a USAID-funded Abt Associates Health Finance and Governance Project, support was provided to the Eastern and Southern Caribbean in conducting National Health Accounts (NHA) for sustainable national responses to HIV. Through this process, the Guyana Ministry of Public Health in collaboration with PEPFAR and PAHO/WHO conducted its first exercise on the National Health Accounts for calendar year 2016. Table 22 below provides a summary of the 2016 National Health Accounts that was presented in August 2018.

*Table 16: Summary of 2016 National Health Accounts for Guyana*

| Indicator | Data (2016) |
|---|---|
| Total Health Expenditure (THE, GYD) | 28,595,303,655 |
| Current Health Expenditure (GYD) | 28,422,162,398 |
| Capital Expenditure on Health (GYD) | 173,141,256 |
| Health-Related Spending (GYD) | 28,772,368 |
| Health-Related Capital Spending (GYD) | 580,768,205 |
| THE per capita (GYD) | 38,207.28 |
| THE as a % of GDP | 3.93% |

The 2016 NHA exercise indicated that the contributions for Total Health Expenditure (THE) were: government (81%); households (9%); donors (6%); corporations (4%) and; NGOs (< 1%). The government's contribution to THE comprised 10% of the government's total spending during the fiscal year and it was the largest (81%) when compared to the respective government's contributions to THE in St. Vincent & the Grenadines (72%), Dominica (62%), Barbados (56%) and St. Kitts & Nevis (37%).

During 2016, 99.39% of Guyana's THE was on recurrent spending (health goods and services) while the remaining 0.61% was spent on capital investments. Public hospitals comprised 40% of the THE followed by health posts and health centers (32%), administrators (9%), and private hospitals and clinics (7%). Curative care comprised 64% of THE while preventative care comprised 19%.

HIV/AIDS and other STIs comprised 8% of the THE in 2016 while other infectious diseases comprised 22% of the THE. Health-related expenditure such as social care for PLHIV which totaled GY$ 28,772,368 was not included in the THE. HIV current health spending by source in 2016 was 62% by government, 35% by donors and 3% by others (NGOs, corporations, households). This represented a significant increase in government spending when compared with 2015 when government spending was 25%, PEPFAR funding was 68% and Global Fund contributed 7%.

During 2016, the majority of HIV/AIDS recurrent spending (52%) went towards prevention activities such as VCT while curative care for HIV/AIDS represented 21% (including ART). Twenty five percent (25%) of HIV spending was on administration, 1% was on capital spending and the remaining 1% was on other. While the government's spending on HIV was 150% higher than in 2015 to offset

declining donor financing, the NHA team found that there is a need to examine HIV expenditure by type of service to ensure allocative efficiency. For example, HIV prevention spending which exceeded UNAIDS recommendation of 25% of the HIV budget, needs to be assessed with regard to the efficiency and impact of prevention interventions. The recommendations of the NHA team were as follows:

- There should be increased spending on the prevention of non-communicable diseases within THE in light of the current epidemiological transition from communicable diseases to NCDs in Guyana. These prevention efforts will both improve the quality of life and reduce the costs of care
- Improve the balance of spending on secondary and primary facilities to increase accessibility of services, especially within remote areas
- Encourage greater involvement by the private sector – current spending is low in comparison with other countries that have a similar GDP per capita
- Assess options for improving allocative efficiency in government HIV spending e.g. assess the impact of HIV prevention spending
- Increase spending on treatment to implement Treat All and prevent transmission

### Allocative Efficiency and Program Effectiveness Study

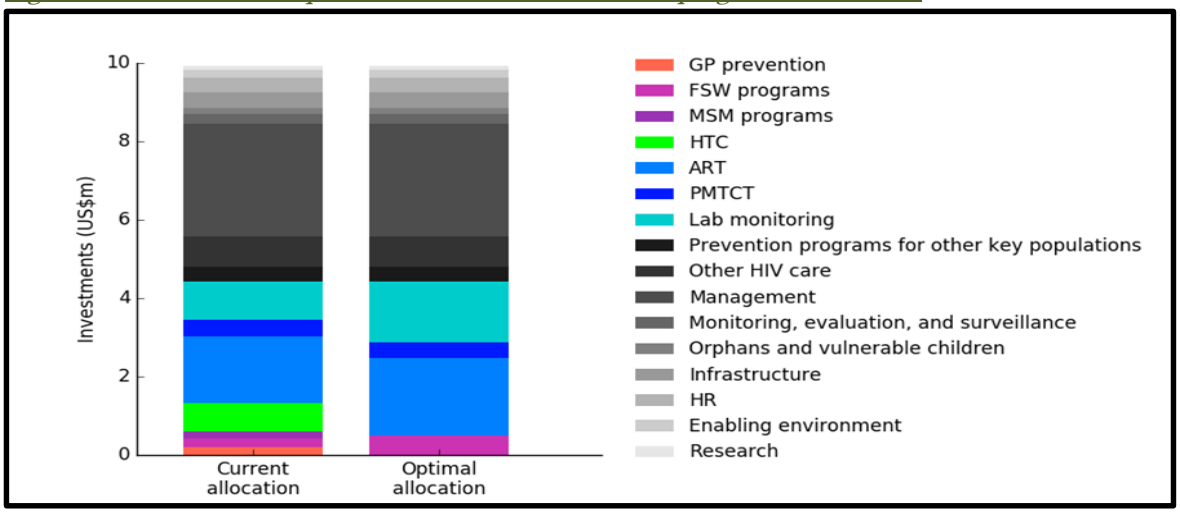
During March 2017, an Allocative Efficiency and Program Effectiveness Study was conducted in Guyana to inform its national HIV response and resource mobilization strategy. Different sources of data were reviewed as part of the analysis and incorporated into the Optima-HIV's epidemic model to produce estimates of the HIV epidemic in Guyana.

The estimates produced through Optima indicated that while US$9.9m was invested in the HIV response in Guyana in 2015 (25% domestically funded, 68% from PEPFAR and 7% from the Global Fund), continued investment in HIV will be crucial if Guyana's 2020 National Strategic Plan target of 50% incidence reduction from 2012 levels is to be realized. It was estimated that without increased investments from the Government of Guyana, that annual new infections would be 1.8 times higher in 2020 than in 2012.

Using estimates from the ongoing costing study of the costs of diagnosing, linking and treating an individual, the expected lifetime costs incurred by one HIV infection was estimated at US$4,529.52, depending on the life expectancy of PLHIV on treatment (excluding the costs of laboratory tests and the costs associated with social mitigation or lost economic productivity). The study found that an additional 37% of new infections and 22% of deaths could be averted between 2017-2020 if funds were optimally allocated across programs as reflected in figure 28 below. The NSP targets could be achieved with annual investments of just over US$7m across 7 core programmatic categories (general

population prevention programs, FSW programs, MSM programs, HTC, ART, PMTCT and lab monitoring/retention).

***Figure 21: Current versus optimal allocation of funds across programs: 2017 - 2020***

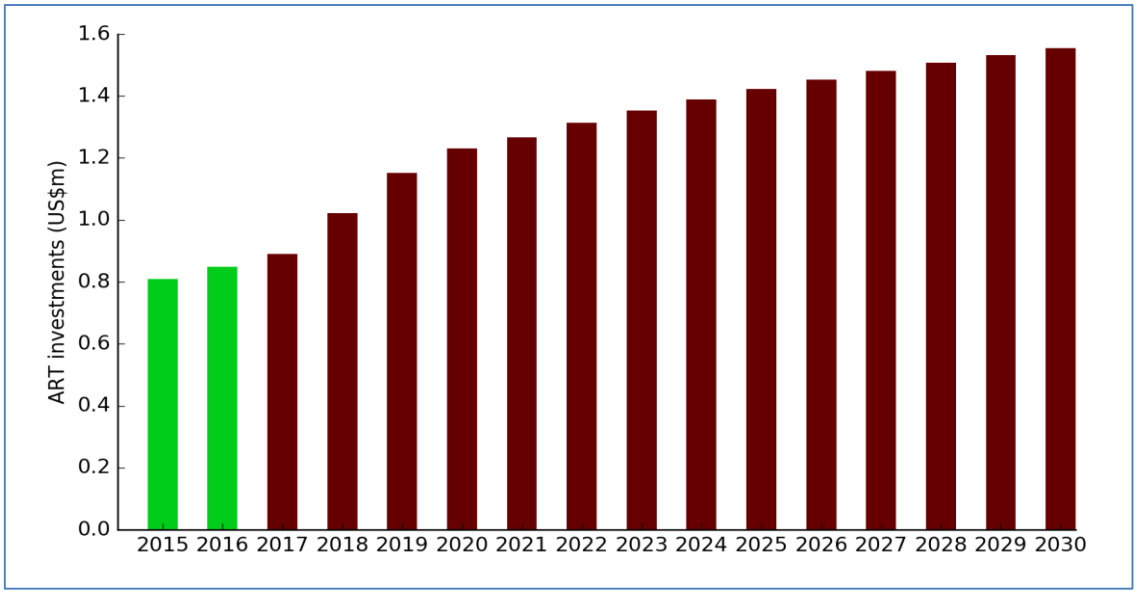



*Comparison of optimal and current allocations for each program. Source: Estimates from Optima-HIV model 2017.*

The highest priority was identified as scaling up care and treatment programs to reduce new infections and control the epidemic. Achieving 90-90-90 was found to be the optimal way to achieve this. Annual investments in ARVs and ART service delivery required to achieve the 90-90-90 targets in Guyana were estimated in accordance with figure 29 below.

*Figure 22: Estimated annual investments in ARVs and ART required: 2015 - 2030*

*Annual investments in ARVs and ART service delivery required to achieve the 90-90-90 targets in Guyana. Source: Estimates from Optima-HIV model 2017*




## COMMITMENT 9: Empower people living with, at risk of and affected by HIV to know their rights and to access justice and legal services to prevent and challenge violations of human rights.

Within Guyana, laws and procedures exist to record and address cases of HIV-related discrimination in the workplace or against employment, under the HIV in the Workplace Regulations made under the Occupational Safety and Health Act. There are also independent national institutions for the promotion and protection of human rights, including human rights commissions, law reform commissions, watchdogs, and ombudspersons that consider HIV-related issues. In addition, there is access to legal aid which persons discriminated against can seek in the pursuit of justice.

With regard to access to health care, the Guyana 2008 Regulations made under The Health Facilities Licensing Act 2007, provide in section 13 that all persons seeking service at a health facility shall be treated equally regardless of age, place of birth, race, creed, nationality, gender and sexual orientation. In addition, government health facilities have signed onto a Non-Discrimination Policy that is required to be on display in these health facilities. Accountability mechanisms in relation to discrimination and violations of human rights within healthcare settings include complaints procedures, mechanisms of redress and procedures/systems to protect and respect patient privacy and confidentiality. The use of

these mechanisms by persons discriminated against is however limited due to lack of awareness of how to use them.

Despite the above mechanisms for protection, barriers exist with regard to access to justice for key populations and people living with or affected by HIV due to the existence of discriminatory laws and stigma and discrimination. The selling and buying of sexual services are criminalized and male same sex sexual activity is a criminal offence that is punishable by imprisonment.

A recent landmark victory was however achieved in November 2018 (during the writing of this report) by members of the transgender society when the Caribbean Court of Justice (CCJ) made a ruling that the section of Guyana's law which prohibits cross-dressing be struck out as *it serves no legal or social purpose and inhibits the right to freedom of expression*. Caribbean Court of Justice is the court of last resort in hearing appeals for both civil and criminal matters from Guyana and other member states within the Caribbean. The recent landmark ruling was in response to a case presented by four transgender persons who had been arrested by Police in Guyana during a crackdown on male cross-dressers during 2009. In 2010, the four complainants in collaboration with the Society Against Sexual Orientation Discrimination (SASOD) brought an action challenging the constitutionality of the law and the treatment of the appellants during the legal process. Prior to reaching the CCJ, the case went through various stages in Guyana, including application to the High Court which did not rule in favour of the appellants. In further support of the rights of the LGBT community, an amendment is currently being drafted to the Prevention of Discrimination Act to stipulate that Sexual Orientation, Gender Identity and Expression should not be used as grounds for discrimination. This draft amendment will be submitted to the Attorney General for consideration and tabling in the National Assembly after the relevant committees of Parliament are sensitized.

With regard to children's rights, Guyana has established a Sexual Offences Court for effective prosecution, increased reporting and conviction rates, as well as to reduce the length of hearings and secondary victimization of children. Through a partnership with the Ministry of Social Protection and NGOs, a 'survivors' unit was also created with court-supported services for children. A study was also conducted on the deprivations faced by indigenous women and children in order to develop targeted interventions to address their specific situation.

During 2016, in the effort to employ a human-rights based approach in creating a space for addressing HIV-related discriminatory issues affecting civil society, the national HIV programme along with its country partners hosted a 'National Dialogue on HIV and the Law'. In preparation for the dialogue, submissions were solicited from individuals and civil society organizations on the chosen themes for the Dialogue. A total of 15 submissions were received that cut across multiple themes. Issues raised included: access by young LGBT to education; sex work; sexual orientation and gender identity; stigma and discrimination; access to HIV services (including for special needs population); violence against women and girls/gender-based violence; migrant and mobile populations; religion and; disclosure of HIV status to employers and insurance companies. Approximately 35 persons representing the various Government sectors, the police, civil society organizations and individuals participated in the National Dialogue. During the first day of the Dialogue, in a separate forum, the civil society groups and

individuals expressed their frustrations with the existing legal and policy framework while in a separate group, government representatives were made aware of the negative impact on access to HIV services caused by discriminatory laws/policies, criminalization of key populations, and the lack of legal protection.

During day 2 of the National Dialogue, civil society participants presented in an open forum, cases related to the submissions received prior to the Dialogue. Recommendations proposed during the discussions included: the removal of punitive laws, policies and practices that violate human rights, increase the risk of acquiring HIV and impede utilization of services, especially in relation to key populations; revision of national legal and policy frameworks to harmonize with human rights treaties ratified by Guyana, especially in relation to key populations; promotion of partnerships to promote and defend human rights in the context of HIV; improve access to HIV services for persons with special needs; update existing health, education and social policies to address the needs of PLHIV and key populations; include key affected populations as stakeholders in decision-making and public health measures for HIV; ensure speedier trials for sexual offences, including sexual abuse of children; revise systems and policies within prison settings to safeguard the privacy and confidentiality of prisoners who access HIV services; provide capacity building for Indigenous civil society organizations to equip them to resolve issues such as HIV-related stigma and discrimination, etc. and; elimination of stigma and discrimination against people living with, at risk of, or affected by HIV.

Subsequent to the Dialogue, the National Advisory Committee for National Dialogue on HIV and the Law held a number of follow up discussions on the above recommendations. During December 2017, the Committee met and determined the following as actionable priority areas in relation to the recommendations:

- Dissemination of the Report on the National Dialogue on HIV and the Law among key Ministries and identification of the issues that fall within their respective mandates
- A review the Safe Schools Policy, and the School Health, Nutrition and HIV Policy (2009) which reportedly do not address the specific vulnerabilities of key affected populations
- Education and sensitization of the Department of Labour and the labour unions in relation to the HIV in the Workplace Regulations, legal recourse and access to justice for employees
- Legislative reform to create an enabling environment for the human rights of key affected populations (amendments to the Prevention of Discrimination Act in Guyana has already been initiated)
- Representation by NAPS in the drafting of a Gender Policy for Guyana in order to ensure that issues specific to key affected populations are included
- Sensitization of PLHIV regarding their rights and the resources available to them in this regard

- Increased focus and assistance provided to the transgender community in Guyana (meetings have since been held with the Guyana Trans United (GTU) organization to explore areas for providing support for their programme)

- Involvement of municipalities in the reduction of stigma and discrimination against key populations through engagement with the various sectors - health, civil society, security services, social services, local government, and private sector entities

At the level of the healthcare workers, during 2016 and 2017 there were a number of training programmes promoting human rights, the rights of clients, and the legal frameworks that are applicable to HIV. At the level of PLHIV and key populations, some amount of Human Rights training has been provided to empower them to challenge and to prevent violation of their rights. Aspects of human rights in relation to HIV are occasionally discussed during PLHIV support group meetings held at health care facilities and NGO locations. In the attempt to promote the rights of PLHIV and key populations, one partner agency developed a case-based reporting system for incidents of stigma and discrimination (S&D) experienced by PLHIV and key populations. NGOs providing support to PLHIV and key populations were trained in the use of the system and in addition, received training in the standard operating procedures and tools for combating S&D. This tool kit was also used to sensitize 20 members of the community on the enablers and effects of S&D. In an effort to further sensitize persons in the workplace, a number of lunch-time panel discussions were also held to focus on various aspects of human rights and discrimination. These sessions were attended by a total of 46 persons, most of whom attended multiple sessions.

## COMMITMENT 10: Commit to taking AIDS out of isolation through people-centred systems to improve universal health coverage, including treatment for tuberculosis, cervical cancer and hepatitis B and C.

Within recent years, there has been a continuous move towards integration of HIV care and treatment within the primary care services. As such the delivery of HIV services has become integrated to varying extents with other health services offered at the different health care facilities. These health services include: VCT at general outpatient care; chronic non communicable diseases; sexual and reproductive health; screening and treatment for tuberculosis; screening and treatment for cervical cancer and; maternal and child health care.

## 10.1 Co-managing TB and HIV treatment

During 2018 there were 96 registered patients that were living with both with TB and HIV of which 92% (88/96), which represents new and retreated patients were receiving both ARV and TB medication. This achievement of 92% represents an improvement in the ART coverage of active TB patients from 2017, which was 83% (115/138). Eighty-eight percent (88%) (74/84) represented new and relapse patients that were receiving both ARV and TB medication during 2018. The National AIDS Program Secretariat and the National TB Program worked closely during the reporting period in the areas of capacity building and service delivery which included home visits, as well as monitoring the use of IPT. During the last quarter (Oct-Dec), an exchange program was set up to strengthen the clinical skills of the medical practitioners by having those employed at the HIV services, provide care at the TB clinics and vice versa. This approach will be continued in 2019, and further cemented by monthly clinical case discussions which was first restarted in April 2018. TB-HIV Collaborative meetings were also held quarterly and this forum was utilized to share updates and plan for implementation of activities. The NAPS and NTP will continue to work in tandem for the improvement of the quality of healthcare services provided to TB-HIV co-infected individuals.

## 10.2 Proportion of people living with HIV newly enrolled in HIV care with active TB disease

Of the 554 patients that were newly enrollment into the HIV Care & Treatment programme in 2018, 14% (76/554) were reported as having active TB disease. Males and Females represented 69.7% and 30.3% respectively of those new enrollments that had active TB.

## 10.3 Proportion of people living with HIV newly enrolled in HIV care started on TB preventive therapy

Of the 554 patients that were newly enrollment into the HIV Care & Treatment programme in 2018, 42.6% (236/554) were started on TB preventive therapy. Males and Females represented 43.2% and 56.8% respectively. This was a noticeable increase of 28.8% from 2017 which reported only 14.4% (92/641) for this indicator. This increase can be attributed to the approach and deliberate decision by the two programs to work closely to address both diseases and the willingness and enthusiasm of the clinical team to ensure that new initiatives were rapidly implemented.

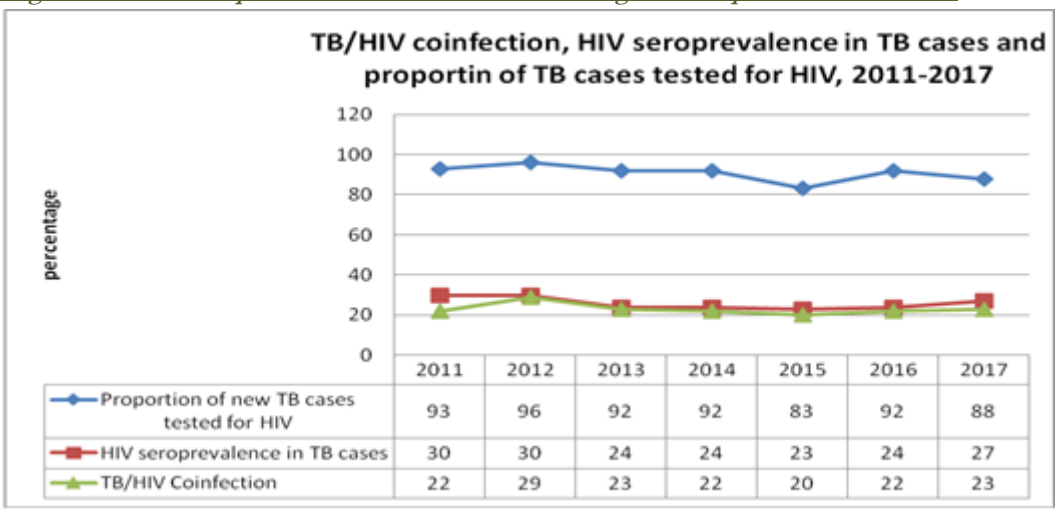
The integration of tuberculin skin testing (TST) into the package of services provided at health care facilities during 2016 and 2017 was further strengthened with a total of 19 and 15 healthcare workers respectively being trained in the administration of TST. This further enhanced the referral process between HIV treatment sites and TB treatment sites. The status of key indicators relating to the management of TB/HIV co-infection during the period 2015 – 2018 is shown in the table 17 below.

*Table 17: Key Indicators for the National TB Programme: 2015 – 2018*

| Indicators | 2015 | 2016 | 2017 | 2018 |
|---|---|---|---|---|
| Tuberculosis incidence rate (per 100,000) | 75 | 77 | 72 | 69 |
| Tuberculosis prevalence rate (per 100,000) | 90 | 87 | 79 | 78 |
| Percentage of new TB cases tested for HIV | 83% | 88% (459/506) | 88% (408/467) | 88% (413/468) |
| Percentage of retreated TB cases tested for HIV | | 92 (131/142) | 77% (95/123) | 83% (97/117) |
| Co-infection rate | 20% | 22% | 23% | 16% |
| Percentage of PLHIV with active TB newly enrolled in HIV care | | 4.67% (25/535) | 4.2% (27/641) | 13.7% (76/554) |
| The proportion of PLHIV newly enrolled in HIV care who started treatment for latent TB infection | | 8.2% (44/535) | 14.2% (91/641) | 43% (236/554) |
| Percentage of new TB HIV-positive patients who start on or continue previously initiated ARV therapy | 74% | 82% | 81.8 | 89% |
| Treatment success rate of HIV positive TB cases | 68% | 48% | 79% | 85% |
| TB mortality rate (per 100,000) | 9 | Not Available | Not Available | 4.8 |
| TB/HIV mortality rate (per 100,000) | 4 | Not available | Not available | 25 |

The TB/HIV co-infection rate of 23% found during 2017 represents a further increase when compared to 20% occurring in 2015 and 22% in 2016. Data for the period 2011 – 2017 indicated that HIV sero prevalence in TB patients fluctuated between 30% and 27% during the period as shown in figure 23 below.

*Figure 23: HIV sero prevalence and co infection among new TB patients: 2011 – 2017*



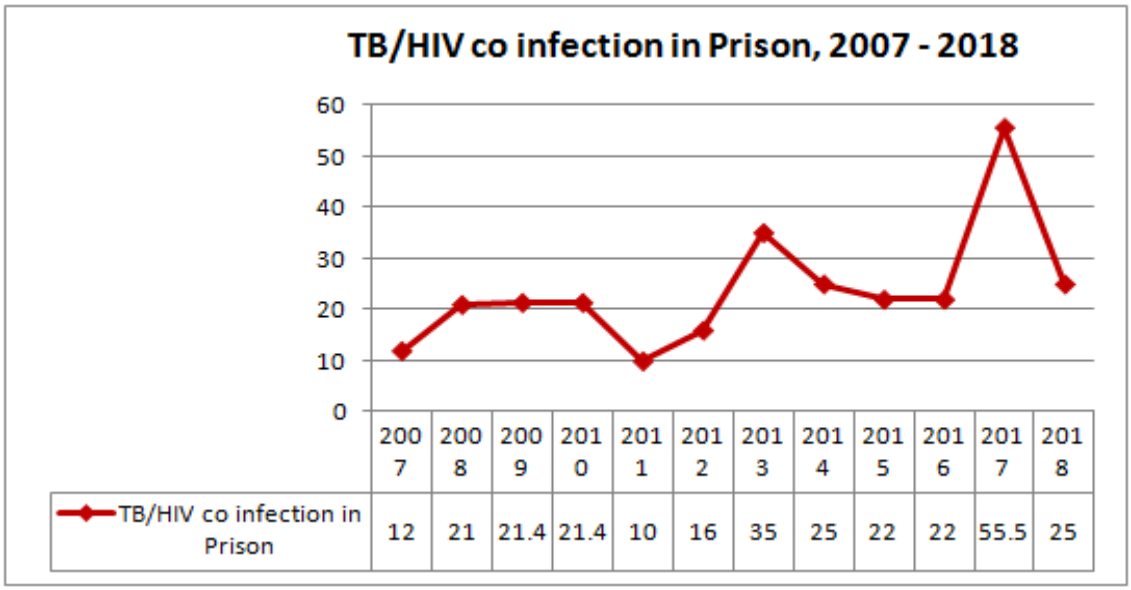

| | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 |
|---|---|---|---|---|---|---|---|
| Proportion of new TB cases tested for HIV | 93 | 96 | 92 | 92 | 83 | 92 | 88 |
| HIV seroprevalence in TB cases | 30 | 30 | 24 | 24 | 23 | 24 | 27 |
| TB/HIV Coinfection | 22 | 29 | 23 | 22 | 20 | 22 | 23 |

***Source: NTP Programme records***

The percentage of TB HIV co-infected patients who received ART was 74%, 82% and 81.8% in 2015, 2016, and 2017 respectively. One hundred percent (100%) of co-infected patients received Cotrimoxazole. The NAPS and NTP are currently collaborating to improve the uptake of IPT in co-infected patients. During 2016 and 2017, enabler support was also provided to co-infected patients in the form of nutritious drinks (5,608 units in 2016 and 11,825 in 2017), food vouchers (58 in 2016 and 155 in 2017) and public assistance (12 patients in 2016 and 18 in 2017).

As part of the package of services provided to prisoners, TB and TB/HIV co-infected patients are routinely monitored by the TB/DOTS prison supervisor 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 2016, 371 prisoners taken from 6 prisons were screened for TB and TST and 10 new TB cases (2.6%) were detected. During 2017, 660 prisoners from these prisons were screened and 9 new TB cases (1.4%) detected. Of the prisoners diagnosed with TB, 2 (22%) and 5 (55.5%) were found to be co-infected with HIV in 2016 and 2017 respectively. Of those screened, 49 and 80 were placed on IPT in 2016 and 2017 respectively. Figure 31 shows TB/HIV co-infection rates among prisoners during the period 2007 - 2018.

*Figure 24: TB/HIV co-infection rate in prison during the period 2007 – 2018*



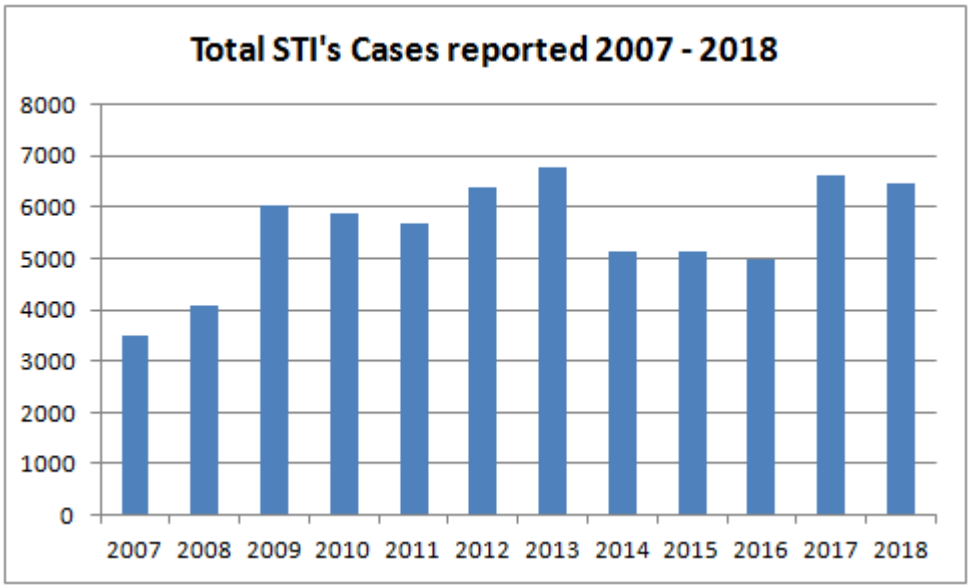

| | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| TB/HIV co infection in Prison | 12 | 21 | 21.4 | 21.4 | 10 | 16 | 35 | 25 | 22 | 22 | 55.5 | 25 |

## 10.4 Men with urethral discharge

During 2016 and 2017, efforts to prevent and control STIs continued in accordance with the National STI Treatment Guidelines which was last updated in 2015. Guyana's STI Strategic and Monitoring and Evaluation Plan 2011-2020 also guided the control of STIs in conjunction with the HIVision 2020 which was launched in 2013.

During 2016, the percentage of men reporting urethral discharge was 0.44% (922 of the 207,028 men aged 15 years and over in the general population). Figure 32 below shows the fluctuation in the number of reported STI cases during 2007 – 2018.

*Figure 25: Total reported STI cases from 2007 – 2018*




There were 4,969 STI cases reported in 2016 and 6,626 in 2017 when compared with 6447 reported cases in 2018. During 2018, there was a 2.7% decrease (179 cases) in cases when compared with 2017. This also represented a marked decrease in STI cases since from 2015 - 2016 period of which was 3.4%. Genital discharge syndrome (GDS) remained the most frequently reported STI during the period 2013-2017 (ranging between 90 and 95%) as shown in table 25 below, while genital ulcer disease (GUD) remained the second highest occurring STI (ranging between 3.3 and 6%).

*Table 18: STI by type 2013 – 2018*

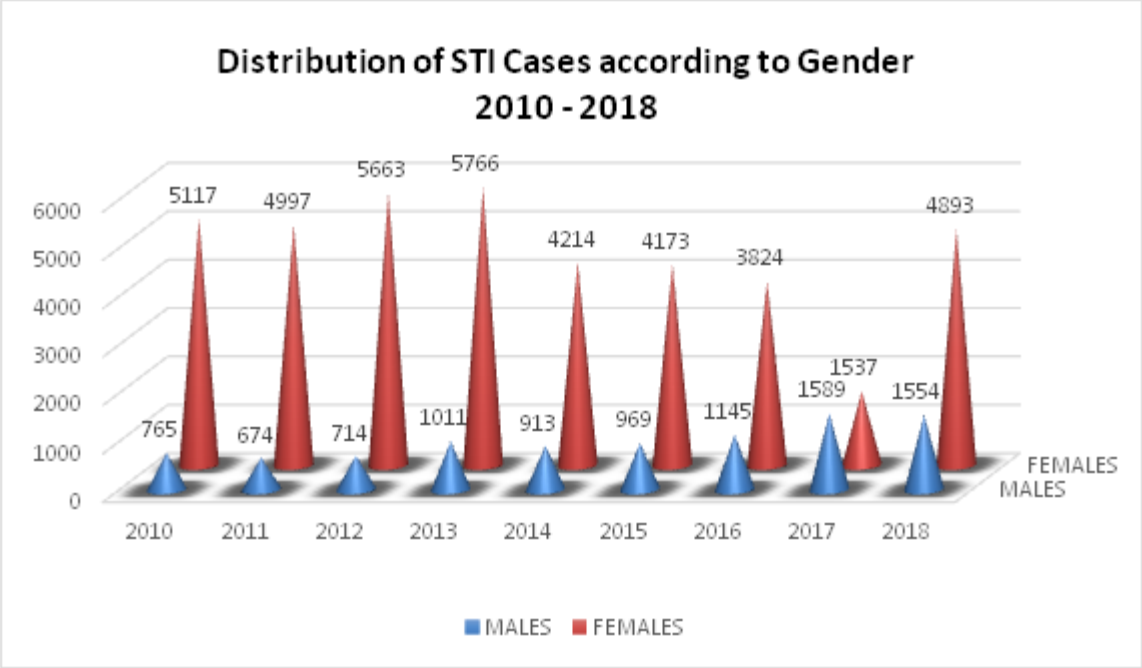
| STI | 2013 | | 2014 | | 2015 | | 2016 | | 2017 | | 2018 | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | No. | % | No. | % | No. | % | No. | % | No. | % | No. | % |
| GDS | 6421 | 94.7 | 4863 | 94.9 | 4787 | 93.1 | 4443 | 89.4 | 5795 | 90 | 5987 | 86 |
| GUD | 260 | 3.8 | 167 | 3.3 | 225 | 4.4 | 314 | 6.3 | 399 | 6 | 460 | 6.6 |
| Gonorrhea | 30 | 0.4 | 30 | 0.6 | 46 | 0.9 | 87 | 1.7 | 97 | 2 | 167 | 2.4 |
| Chlamydia | 8 | 0.1 | 5 | 0.1 | 23 | 0.4 | 28 | 0.6 | 0 | 0 | 113 | 1.6 |
| Syphilis | 26 | 0.4 | 23 | 0.4 | 17 | 0.3 | 46 | 0.9 | 58 | 1 | 183 | 2.6 |

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Trichomoniasis | 11 | 0.2 | 16 | 0.3 | 29 | 0.6 | 33 | 0.7 | 44 | 1 | 31 | 0.4 |
| LGV | 1 | 0.0 | 0.0 | 0.0 | 4 | 0.1 | 0 | 0 | 0 | 0 | 0 | 0 |
| Herpes Simplex | 20 | 0.3 | 23 | 0.4 | 11 | 0.2 | 18 | 0.4 | 22 | 0 | 18 | 0.3 |
| **Total** | 6777 | 99.9 | 5127 | 100 | 5142 | 100 | 4969 | 100 | *6415 | 100 | 6447 | 100 |

*Accounts for over 15 years age group. The remaining 211 cases occurred in the younger age groups.

The majority of the STI cases reported continued to be among females as seen in figure 33 below: 77% in 2016 and 76% in 2017 compared with 75.9% in 2018 (MoPH Surveillance data).

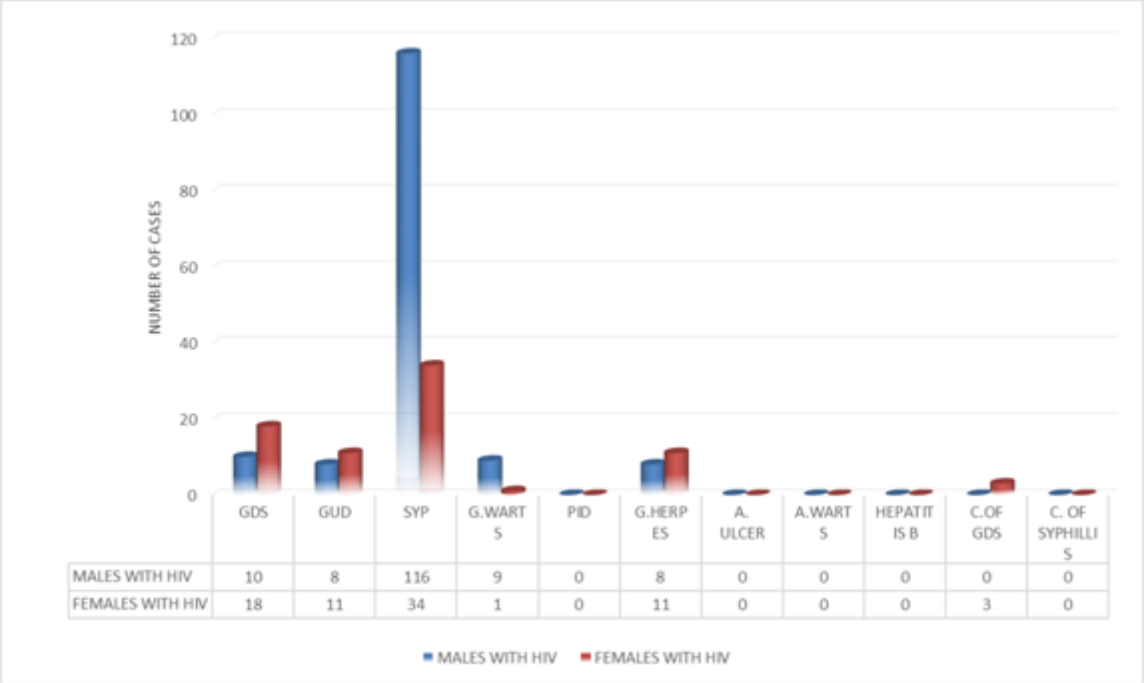
***Figure 26: Distribution of STI Cases According to Gender 2010 – 2018***




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 may not have been fully captured within the public reporting system.

**Figure 27** below shows STI data from the National Care and Treatment Center (NCTC) in Region 4, which is the main sentinel site for monitoring STIs.

***Figure 27: Comparison of HIV and other STI Co-infection at NCTC***




| | GDS | GUD | SYP | G.WARTS | PID | G.HERPES | A. ULCER | A.WARTS | HEPATITIS B | C.OF GDS | C. OF SYPHILLIS |
|---|---|---|---|---|---|---|---|---|---|---|---|
| MALES WITH HIV | 10 | 8 | 116 | 9 | 0 | 8 | 0 | 0 | 0 | 0 | 0 |
| FEMALES WITH HIV | 18 | 11 | 34 | 1 | 0 | 11 | 0 | 0 | 0 | 3 | 0 |

Gonorrhea, chlamydia and syphilis are known STIs that increases the likelihood as much as five-fold for the contraction of HIV. The NCTC in 2018 recorded a total of two hundred and thirty-seven (237) new cases of HIV co-infection which accounts for sixty-two (62) more new cases of co-infection when compared to 2016. A higher prevalence of HIV co-infection was noted in males with syphilis and HIV accounting for the highest recorded cases of HIV co-infection.

Comparing 2016 and 2018 data, it was noted that there was a mentionable increase in males with HIV and co-infected, (103 cases v 151 cases), while there was also a slight increase in women (66 v 78 cases) during the same time period. It was also evident that they were much more cases of HIV co-infection with syphilis in men (49 v 116 cases) as well as an increase in women with this similar co-infection (8 v 34 cases) during the aforementioned time period.

Over the years NCTC continues to record the most frequent cases of HIV co-infection in GDS, GUD, syphilis, and herpes in both males and females. Even though this statistic remains the same for 2018 there has been significant decreases recorded in females with HIV and co-infected with GDS, GUD

and herpes. Men also recorded a slight decrease in these co-infections, but syphilis continues to record the highest rate of HIV co-infection.

## 10.5 Gonorrhea among men, Hepatitis B and C

During 2016, the percentage of gonorrhoea cases diagnosed among men as a percentage of the general male population was 0.03% (60 positives within the population of 207,028 men 15 years and older). There is no information for 2017 and 2018. The percentage of adults reported with genital ulcer disease during 2015 was 0.1% (80 males, 173 females.

## 10.6-10.8 Hepatitis B and C testing

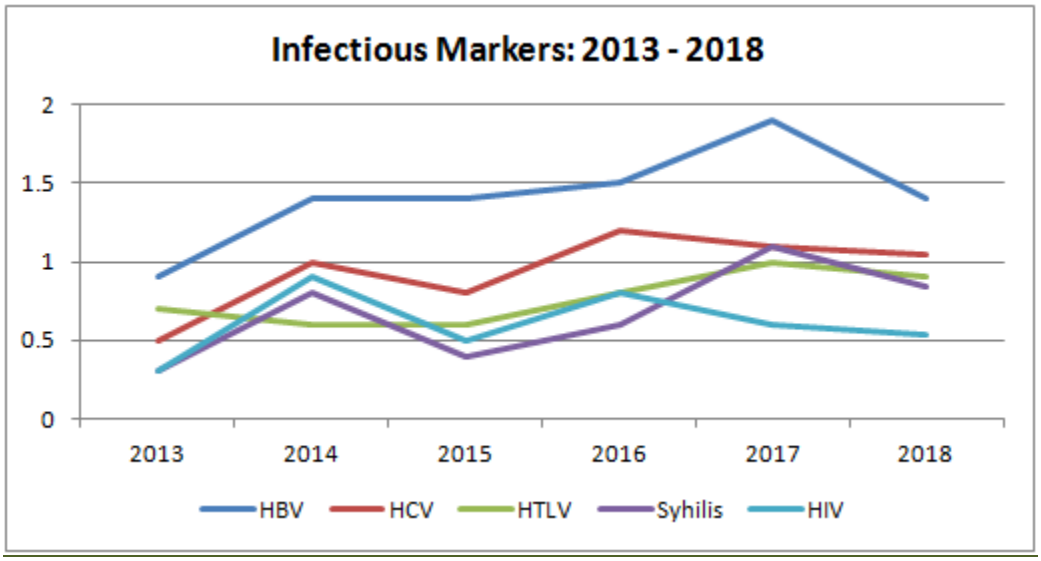
During 2015, the proportion of persons in HIV care who were tested for hepatitis B was 30.2% (1565/5176). During 2016, the proportion of persons starting antiretroviral therapy who were tested for hepatitis B was 3.57% (21/587) while those tested for hepatitis C was 0.34% (2/587). Persons tested were females over 15 years. There is no data for 2017.

During 2016 and 2017 all blood donors were screened for STIs as part of the National Blood Transfusion Protocol. Table 19 below shows the infectious markers for blood screened during 2016 to 2018. Figure 35 shows the trend in infectious markers for blood screened during 2013 – 2018.

***Table 19: Infectious markers for blood screened during 2016 - 2018***

| Marker | 2016 | | | 2017 | | | 2018 | | |
|---|---|---|---|---|---|---|---|---|---|
| | Total screened | Reactive | % reactive | Total screened | Reactive | % reactive | Total screened | Reactive | % reactive |
| HIV | 10,200 | 87 | 0.85 | 9,755 | 61 | 0.64 | 9687 | 51 | 0.53 |
| HBsAg | 10,200 | 156 | 1.53 | 9,755 | 183 | 1.88 | 9687 | 137 | 1.14 |
| HCV | 10,200 | 118 | 1.16 | 9,755 | 103 | 1.06 | 9687 | 101 | 1.04 |
| Syphilis | 10,200 | 61 | 0.59 | 9,755 | 109 | 1.12 | 9687 | 81 | 0.84 |
| T. Cruzi | 10,200 | 46 | 0.45 | 9,755 | 155 | 1.59 | 9687 | 102 | 1.05 |
| HTLV I - II | 10,200 | 84 | 0.82 | 9,755 | 99 | 1.02 | 9687 | 88 | 0.91 |

*Figure 28: Infectious markers for blood screened: 2013 – 2018*




The percentage of screened blood that tested positive for STIs was 5.41% (552/10,200) in 2016 and 7.28% (710/9,755) in 2017 compared with 8.7% (560/6447) in 2018.

The NAPS in an effort to successfully fulfil our mandate to effectively mitigate and control the spread of sexually transmitted infections has actively increased its focus on the sensitization, prevention and treatment of such. It is with this in mind, we at the NAPS provided trainings for doctors, nurses and counsellor testers in the use of rapid diagnostic kits for some of the most common STIs. These include gonorrhoea, chlamydia, trichomoniasis, syphilis and hepatitis B. A total of 66 persons throughout regions 2, 3,4,5,6 and 10 inclusive of both public and private institutions were trained. The introduction and use of the rapid kits is in its pilot phase, to test the efficacy of moving in the direction of etiologic management. While the treatment of STIs syndromically has proven effective over the years, there is still the issue of over-diagnosis when treating of patients. Ten laboratory technicians were also trained in WET Preparation of slides for STIs

## 10.7 Proportion of people co-infected with HIV and HBV receiving combined treatment

There is no information currently available on the proportion of persons co-infected with HIV and HBV who started treatment for HBV. However, all persons diagnosed with HBV are eligible for treatment and more so with the full implementation of the "Treat all" policy.

## 10.9 Proportion of people co-infected with HIV and HCV starting HCV treatment

There is no national guidelines and treatment established for Hepatitis C Infection. HCV testing is done as part of the baseline panel of tests. Moving forward the country will begin and plan for the diagnosis and treatment of HCV and hopes to be able to access the same in a cost effective manner to ensure sustainability.

## 10.10 Cervical cancer screening among women living with HIV

With clear association between cervical cancer and HIV, screening for cervical cancer is being provided at 17 sites in the different regions of Guyana. Visual Inspection with Acetic Acid (VIA) screening continued at these sites – including 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 at work places and other organizations.

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. Table 20 below shows the VIA services provided during the period 2012 – 2017.

***Table 20: VIA services provided: 2012 – 2018***

| | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 |
|---|---|---|---|---|---|---|---|
| Total receiving VIA | 6,937 | 5,363 | 4,993 | 4,742 | 4,032 | 3,817 | 512 |
| Total of all clients with Positive VIA | 639 | 466 | 392 | 420 | 313 | 241 | 35 |
| Percent with positive VIA findings | 9.2% | 8.7% | 10.7% | 11% | 7.8% | 6.3% | 6.8 |
| # of HIV positive clients who received VIA | 969 | 648 | 505 | 283 | 407 | 528 | n/a |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| # of HIV positive clients who received VIA and had a positive VIA | 74 | 33 | 32 | 33 | 35 | 46 | n/a |
| Percentage of HIV positive clients with positive VIA findings | 9.6% | 5.1% | 6.3% | 11.7% | 8.6% | 8.7% | n/a |
| Received cryotherapy | 522 | 353 | 310 | 355 | 252 | 313 | n/a |
| Received LEEP | 26 | 55 | 51 | 14 | 20 | 36 | n/a |
| Referred to Oncology | 48 | 45 | 14 | 13 | 14 | 14 | n/a |

During 2016, of the 4,032 clients who received VIA, 407 were HIV positive females of whom 8.6% (35) had a positive VIA. During 2017, of the 3,817 clients who received VIA, 528 were HIV positive females of whom 8.7% (46) had a positive VIA. The data for 2018 is unavailable on the HIV positive females screened, as well as had a positive VIA. Table 20 shows that the percentage of HIV positive females with a positive VIA fluctuated between 9.6% and 8.7% during the period 2012 and 2017.

During 2016 and 2017, ten health care providers from two regions were trained and certified in each year to provide VIA testing and cryotherapy. The participants received both practical and theoretical knowledge. In addition, during 2017, there was heightened public awareness and promotion of the Human Papilloma Virus vaccine as part of the national campaign to offer the vaccine to school age girls in the effort to reduce the number of cases of cervical cancer.

## MONITORING AND EVALUATION

The Monitoring and Evaluation Plan for the National HIV Programme 2018-2020 guides the operations of the Monitoring and Evaluation (M & E) Unit of the National AIDS Programme Secretariat (NAPS). The M&E Plan has its basis in the HIV Strategic Plan 2013-20 (HIVision 2020). The main task of the M & E Unit is to manage a central integrated database to support the analysis of the indicators outlined in the HIV M&E Plan. It is also responsible for coordinating regular analyses and reporting on the effectiveness of the national response to all aspects of the HIV epidemic.
A list of Monitoring and Evaluation activities implemented during 2018 in table 28 below.

*Table 21: Monitoring and evaluation activities: 2018*

| Name of Training | Date | Target Population | Topic | # of People Trained |
|---|---|---|---|---|
| **Data Entry Training** | April 12th, 2018 | Data Entry clerks, Nurses, Social Workers, and Outreach workers | Monitoring Evaluation Fundamental | 25 |
| **Regional Data Analysis, Dissemination & Use** | September 12-15, 2018 | NAP Managers, Strategic Information and Monitoring & Evaluation Officers | To strengthen capacity in data analysis and use of data to improve programming and policy<br>To strengthen mechanisms for regional information sharing<br>▪ To the increase the availability of strategic information to inform and guide policy and program development. | 2 |

## BEST PRACTICES/SUCCESS STORIES

### When Passion Collides with Purpose

Michelle is a feisty woman who sometimes wears her dreadlocks like a crown. She is one of the Client Advocate Associates (CAA) hired by Advancing Partners and Communities (APC) in Guyana. She works tirelessly to help link newly diagnosed HIV positive persons to care and treatment services, and assist with getting defaulting HIV+ clients re linked into the national health care system.

On any given day she can be seen hunched over a telephone, her voice soothing and strong with an intense undertone. Her gaze is sharp and focused on a faraway place. Today, she is engrossed in her conversation with 'Minerva', one of the newly diagnosed clients who was put on an ART regimen but is experiencing challenges.

*"From day to day it differs"*, she later says. *"This one was tough...the client is having a reaction to the ART medication and cannot sleep"*. Michelle explains because of physical isolation of the client, it was impossible to see her face-to-face in a timely manner. As a stop-gap, via a telephone call, she walked 'Minerva' through a number of possible options with the hope one would help with the upset stomach and tingling feelings being explained. A few hours later the client calls to let Michelle know one of the remedies worked - ginger tea to soothe the stomach. The client was able to sleep for a solid few hours.

These are the little things that makes a difference, Michelle notes, taking the time to develop a relationship with the clients she works with is essential. *"Now Minerva trusts that I do care and that I will have her best interest at heart. I hope she will continue to see me as a resource and not only take my calls but continues to call me when she needs help"*.

The intensive and proactive client engagement approach used by Michelle is the same as is used by five other Client Advocate Associates on board with APC who support HIV positive members of the key populations – sex workers, men who have sex with men, and transgender persons – along UNAIDS 90/90/90 HIV continuum of care.

This pilot initiative which commenced in July 2017 and continued during 2018, has shown very encouraging results. At the end of September 2017, after six months, data showed CAAs were able to test 90 KP members, diagnose fourteen as HIV positive and link 79% of these individuals to national HIV care and treatment services.

APC will continue to support this and other emerging innovative strategies in order to make progress along UNAIDS 90/90/90 HIV continuum and ultimately contribute to Guyana's HIV goals.

### Differentiated Service Delivery Model

Equally important to the National response was the establishment of the "Extended hours" Clinic in June 2018 at the National Care and Treatment Centre, the country's premier treatment facility. This initiative saw HIV and STI testing services as well as treatment being provided to persons of both general and key population. HIV testing was conducted for 356 person during the period June to December 2018, 177 males and 179 females. Among the individuals tested 127 were MSM, 40 were FSW and 3 were miners. There were 12 persons testing positive.

…….

## Let's Talk SOGI and Stigma and Discrimination

***Background***

Stigma & discrimination and the lack of understanding of issues related to sexual orientation and gender identity (SOGI) are major socio-structural barriers to HIV prevention efforts. Discrimination perpetrated towards HIV positive key populations impedes national and global efforts against the epidemic, prevents access to health services, and intensifies the spread of HIV. In order to address these challenges, Advancing Partners and Communities (APC) conducted quarterly SOGI and S&D sensitization sessions at national HIV care and treatment sites. Content sought to increase knowledge of SOGI and the effects of S&D on HIV+ KPs. Moreover, efforts also contributed to UNAIDS' 90/90/9 goal: a stigma-free, non-discriminatory, gender sensitive health care system.

## MAJOR CHALLENGES AND REMEDIAL ACTIONS

Whilst acknowledging the major progress made by the Government of the Cooperative Republic of Guyana in its response to HIV during the last three years, the following challenges were identified as being critical in needing to be addressed moving forward. Cross cutting these challenges was the issue of staff attrition. Remedial action was taken to address some of the challenges below while measures to address some challenges are currently being considered.

Challenges and remedial actions relating to 2018 were as follows:

**Voluntary Counseling and Testing:** While the country made significant progress towards the first 90, there were challenges with human resources to provide the services and in some instances adequate

furnishing of the testing sites. Monitoring visits were conducted to some sites and supplies such as thermometers, timers and job aides were provided. This will be continued in 2019 utilizing a more systematic approach.

**Social Support Services:** Clients continued to experience difficulties commuting to clinic due to financial constraints which resulted in missed appointments and poor adherence to medications. Adherence to medications was also impacted by lack of disclosure, poor nutrition, domestic violence and the emergence of mental health issues. Efforts are ongoing to encourage disclosure with the support of social workers and the use of the 'buddy system" is being explored among the adolescent group, among whom adherence was found to be a special challenge.

Some NGOs also discontinued their support group meetings due to the reduction in donor support and members of these NGO support groups were encouraged to join the MoPH groups. Support group membership however decreased during the period when compared with 2017 due both to the reduction in financial support and decreasing commitment among group leaders. To address the decreasing group membership, social workers were encouraged to inform new clients of the availability of support groups, signs were posted up at treatment sites informing of the dates of meetings, and calls were made to clients to remind them of meetings. The range of discussion topics was also expanded and in addition, the NAPS collaborated with the Guyana Community of Positive women and girls to attract more females to the sessions.

Unemployment continued to be an issue among PLHIV since a number of these persons were single parents and were relatively reluctant (due to parental responsibilities) to accept the security guard jobs being offered through the Central Recruitment and Manpower Agency, since these jobs required working after-hours in most cases. In addition, the provision of nutritional support to PLHIV by the Food Bank was interrupted by shortages of basic items due to the lengthy procurement process, withdrawal of a number of private sector contributors, reduced funding from the Global Fund, and the time taken for the partial transitioning of this programme to government funding. During the period, logistical challenges also persisted with regard to the dispatch of food supplies to PLHIV within the hinterland regions. In the attempt to address these challenges, efforts continue to secure additional sponsorship for the Food Bank from within the local business community.

**Prevention:** BCC and IEC efforts were impacted during the period by the absence of the Prevention Coordinator who resigned in March 2016. As a result, the support of CSOs was sought in targeting the most at-risk groups and in distributing information, education and communication (IEC) materials.

Prevention efforts were also incorporated into the various components of the national HIV programme.

With regard to STIs, there was limited availability of certain STI drugs (particularly to treat genital warts) during 2018. The etiologic diagnosis of STIs via wet prep and gram stain needed to be strengthened at STI sites and there were delays in the introduction of point-of-care rapid testing for common STIs e.g. syphilis, hepatitis B, gonorrhea and chlamydia which was eventually accomplished in July 2018, during which period 65 service providers from 8 public sites, 1 private site and 3 NGOs were trained. There was also inadequate documentation in the patient charts with regard to the performance of these tests among HIV patients.

**Prevention of Mother to Child Transmission:** During the period the PMTCT programme experienced challenges with regard to the supply of reagents and test kits for Hb testing and also for screening mothers for Hepatitis B and Syphilis. While for most of the period there was no national stock out of HIV test kits at PMTCT sites, there were reported facility level stock outs, especially within the hinterland regions, due to delays in the filling of requisitions. To address these issues, the procurement process for reagents and kits is currently being reviewed.

During the period, there was inadequate documentation in the antenatal registers with regard to syphilis testing, treatment for reactive results and contact tracing/partner notification. There was also inadequate documentation with regard to HIV testing and ART in relation to HIV-exposed infants. To address this issue, the PMTCT data collection system was reviewed and updated in 2017. Training in surveillance was also provided to 38 HCWs in the hinterland region 9, as part of eMTCT Initiative.

**Care and Treatment:** During the period, the availability of 2 ARVs was impacted by delays in delivery and the initial procurement process. This situation continues to be reviewed. The unavailability of data entry personnel to update the Pre-ART and ART registers also affected the submission of Monthly Summary and Cohorts Analysis reports - within the hinterland regions. In addition, the completeness of the data collected was also impacted by the non-inclusion of important information such as functional status/clinical staging of clients, TB status/TB prophylaxis, expected date of delivery of pregnant women, family planning methods, etc. To address these issues, five data entry clerks were hired to provide services at high volume sites.

With regard to the care and treatment of prisoners, this service was impacted due to: missed appointments resulting inadequate laboratory support; lack of on-site care and treatment services and facilities within the prisons and; inadequate coordination between the TB programme and HIV programme in providing prison services. In order to address the quality of HIV services provided to

prisoners, collaborative meetings for prisons continued to be held during the period with key stakeholders from MoPH and representatives from the correctional facilities.

**Key Populations**: During 2018, the national programme was impacted by delays in contracting CSOs to provide the prevention package of service. The absence of a Social Worker within the Key Populations programme to address the specific psychosocial needs of key populations e.g. gender-based violence, substance abuse, etc., also impacted the quality of service provided by the national programme.

Included among the challenges during the period was also suspiciousness among some brothel/bar owners in having outreach personnel provide services to the sex workers associated with their entities - due to the perception that these Associates were conducting investigations in relation to trafficking in persons. Some female sex workers were also reluctant to be tested. The fears of the brothel/bar owners and sex workers were however alleviated by the Associates who reassured them of the maintenance of confidentiality with regard to their interactions. To increase the number of persons providing VCT to key populations, new batches of 15 female commercial sex workers and 24 MSM were also trained in 2018 to provide VCT to their peers.