2012

COUNTRY PROGRESS REPORT

Republic of Guyana

GLOBAL AIDS RESPONSE PROGRESS REPORT

Reporting Period: January 2010- December 2011

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Presidential Commission on HIV and AIDS

FOREWORD

This Country Progress Report 2010-2011 provides us with an opportunity to assess the progress made towards achieving the bold targets set in June 2011 Political Declaration on HIV and AIDS and its new targets - by 2015 to reduce sexual transmission of HIV and HIV infection among people who inject drugs by half, to increase the number of people on treatment to 15 million, to halve TB-related deaths in people living with HIV, and to eliminate new infections among children. The Government of Guyana had, in 2010, outlined several of these targets at a NASA preparatory meeting where the direction of the HIVision 2020 was articulated.

The body of this report provides a preponderance of evidence that point to the further stabilizing of the HIV epidemic. There is a steady decline in the number of new reported cases of HIV infection among a significantly higher number of persons who are coming forward to be tested for HIV. Compared to 2010 when there were 1,039 new reported cases of HIV infection, we have seen a decrease to 972 new reported cases in 2011. A similar trend has been observed in the number of new reported AIDS cases, from 146 in 2010 to 62 in 2011. In 2010, 5.8 percent of babies born to HIV-positive mothers were infected with HIV and this declined to 1.9 percent in 2011. The number of TB patients testing positive for HIV also declined from 26.0 percent in 2010 to 23.4 percent in 2011. Voluntary blood donation increased from 79.0 percent in 2010 to 89.0 percent in 2011 and prevalence among blood donors decreased from 0.2 percent in 2010 to 0.1 percent in 2011.

We continue to identify and place more persons on treatment. There were 3,432 persons actively receiving antiretroviral therapy (ART) at the end of 2011, compared to 3,059 in 2010, representing a 12.3 percent increase. We have also expanded the number of fixed care and treatment sites from 16 in 2010 to 18 in 2011 thereby providing increased national coverage. We have kept our commitment to tackle other sexually transmitted infections that have been overshadowed by HIV by developing Guyana's first Sexually Transmitted Infections Strategy and Monitoring and Evaluation Plan 2011-2020.

Our laboratory capacity has increased to support accurate diagnosis and treatment. We are placing greater emphasis on quality improvements in our prevention and treatment programmes. The launch of the Guyana National Principles, Standards and Guidelines for HIV Prevention in 2010 is a demonstration of our commitment to improve the quality of our activities to achieved prevention. This commitment to quality services is also demonstrated in our treatment programme with the robust monitoring of quality care through a series of quality programmes including HEATLHQUAL and HIV Drug Resistance Monitoring, and the monitoring of the Early Warning Indicators which form part of the HIVDR prevention strategy. We have completed a second revision of the National Guidelines for the Management of HIV Exposed Infants and Infected Adults and Children to ensure that the people living with HIV in our country are receiving the best care possible.

We have partnered with the business community, non-governmental organizations, faith-based organizations, line ministries, discipline services, youth, sex workers, men who have

sex with men and donor agencies to bring together human, financial and material resources to mount a truly multi-sectoral response.

Despite our achievements, we must remain vigilant and must harness the collective energy of our people to aggressively tackle barriers to universal access, such as stigma and discrimination, archaic laws, geography and attrition of highly qualified staff. It is imperative that we fully implement the Principles, Standards and Guidelines for HIV prevention to ensure that we develop 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 challenging issues of gender base violence. We must improve adherence to treatment through ongoing monitoring and support to persons living with HIV.

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

We must adopt these measures if we are to preserve the gains of the last 10 years and increase the country's social progress. I believe that together we can.

Honorable Dr. Bheri Ramsaran
Minister of Health

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ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
AIS	AIDS Indicator Survey
ANC	Antenatal Clinic
ART	Antiretroviral Therapy
ARV	Antiretroviral
BCC	Behavior Change Communication
BSS	Behavioral Surveillance Survey
BBSS	Biologic and Behavioral Surveillance Survey
CBOs	Community-based Organizations
CCM	Country Coordinating Mechanism
CDC	US Centers for Disease Control and Prevention
CIDA	Canadian International Development Agency
CHAT	Country Harmonization and Alignment Tool
CRIS	Country Response Information System
CRS	Catholic Relief Services
CSO	Civil Society Organization
DHS	Demographic Household Survey
DNA	Deoxyribonucleic Acid
FBO	Faith-based Organization
FSWs	Female Sex Workers
FXB	Francois Xavier Bagnaud
GBoS PHC	Guyana Bureau of Statistics, Population and Housing Census
GDP	Gross Domestic Product
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GHARP	Guyana HIV/AIDS Reduction and Prevention Project
GIZ	Deutsche Gesellschaft fur Internationale Zusammenarbeit
GoG	Government of Guyana
GSIP	Guyana Safer Injection Project
GUM	Genito-Urinary Medicine
HFLE	Health and Family Life Education
HBC	Home-Based Care
HIV	Human Immuno-deficiency Virus
HSDU	Health Sector Development Unit
HTLV	Human T-Lymphotropic Virus
IEC	Information, Education, Communication
MARPs	Most At-Risk Populations
M&E	Monitoring and Evaluation
MoLHS&SS	Ministry of Labor, Human Services and Social Security
MoH	Ministry of Health
MSM	Men Who Have Sex with Men
MTCT	Mother-to-Child-Transmission
NAC	National AIDS Committee
NAP	National AIDS Programme
NAPS	National AIDS Programme Secretariat
NCTC	National Care and Treatment Centre

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

I. STATUS AT A GLANCE

I.1 Inclusiveness of stakeholders in report preparation

The National Commitments and Policy Instrument (NCPI) interviews provided a unique opportunity for key stakeholders to contribute to writing this report. Stakeholders provided candid feedback on the progress towards the development and implementation of national HIV policies and strategies, and remained engaged throughout the review process. Additionally, Civil Society was represented on the Guyana Country Progress Report Preparation Team throughout the preparation and review processes. Key stakeholders were invited to a participatory workshop to ensure consensus on the content of the report. Decisions on which data the country can report on were made by the Monitoring and Evaluation Reference Group which also provided oversight to the report preparation process.

1.2 Status of the Epidemic

According to epidemiological data available in 2011, the prevalence of HIV among the general population has steadily reduced since 2004, when it was 2.4 percent to 1.07 percent in 2011 (Based on most recent modeling done in Spectrum 4.47). The proportion of all deaths attributable to AIDS has also steadily declined by 56 percent since 2002, when it was 9.5 percent to 4.2 percent in 2009 (MoH Statistics Unit).

HIV prevalence among pregnant women was 0.88 percent in 2010 and 1.08 percent in 2011 (PMTCT programme data). In 2010, 5.8 percent of babies born to HIV-positive mothers were infected with HIV and 1.9 percent in 2011 (PMTCT programme reports and National Public Health Reference Laboratory report). HIV prevalence among blood donors was 0.2 percent in 2010 and 0.1 percent in 2011 (Blood Bank Programme data).

The Biologic Behavioral Surveillance Survey (BBSS) 2009 showed a sharp decrease (38%) in the HIV prevalence among female sex workers (FSWs), from 26.6 percent (BBSS, 2005) to 16.6 percent (BBSS, 2009). In contrast only a slight decrease was observed among MSM, from 21.2 percent (BBSS, 2005) to 19.4 percent (BBSS, 2009). Notwithstanding these encouraging signs female sex workers and men who have sex with men are disproportionately affected by the epidemic.

Data on HIV cases revealed that main coastal region which comprises 41.3 percent of the total population of Guyana accounted for 71.5 percent (743/1039) of all HIV cases in 2010 and 70.8 percent (688/972) in 2011.(NAPS Annual Report).

The sex ratio (male to female) for HIV cases has been fluctuating over the last four years. For the first time since 2000 when the sex ratio was 1.16 there was an observed change, to 0.91 in 2008, then to 1.05 in 2009. This situation reversed in 2010 and 2011, dropping to 0.8 percent in both years (MOH Surveillance data).

The 30-34 age-group was the most affected accounting for 18.58 percent of all cases of HIV in 2010 and 18.10 percent of all HIV cases in 2011. Children aged 0-4 accounted for 0.49% in 2010 and 2.77 percent in 2011. Persons 50 years and above accounted for 8.66 percent of all cases of HIV in 2010 and 11.94 percent in 2011 (MOH Statistics Unit).

1.3 Policy Response

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

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

An adequate and safe blood supply is a crucial element of a national strategy to control HIV. In light of this a National Blood Policy was developed and approved.

A Orphan and Vulnerable Children (OVC) Policy was prepared and approved by the Ministry of Labor, Human Services and Social Security (MOLHS&SS).

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

The Ministry of Health (MOH) with support from USAID developed a policy against Stigma and Discrimination in 2011 with the objective of protecting all persons accessing health care from the effects of discrimination.

1.4 Programmatic Response

"Guyana's social progress made over the last decade has begun to erode significantly because of the high percentage of HIV/AIDS in its population." This was the sobering message conveyed to the United Nations General Assembly Special Session (UNGASS) on HIV/AIDS, held in June 2001, by the then Minister of Health, Dr Leslie Ramsammy. The programmatic response of the Government of Guyana over the last decade has therefore been grounded in a desire to preserve and increase the country's social progress.

The period under review was characterized by increased coverage of HIV-related services, particularly in the areas of prevention of mother-to-child transmission of HIV, voluntary

counseling and testing, and treatment, care and support. The period also saw greater emphasis being placed on strengthening monitoring and evaluation and surveillance systems, and increased use of strategic information to inform programming and quality improvements.

The development and launch of the Guyana National Prevention Principles, Standards and Guidelines was a significant achievement. Prevention efforts sought to maximize the use of national events such as Mashramani (Guyana equivalent to Carnival) and GUYEXPO (Guyana's Premier Exhibition) which provide unique opportunities to increase HIV awareness among the general public and promote healthy lifestyles. Special attention was given to the most-at-risk populations, particularly the involvement of youth.

Both the PMTCT and VCT programmes were expanded to increase coverage through 75 VCT sites and 165 PMTCT sites in 2010 and 78 VCT sites and 181 PMTCT sites in 2011 respectively, and individuals' access to PMTCT and HIV counseling and testing services. The three mobile VCT facilities remained an invaluable approach to reaching persons from distant hinterland regions with services.

The proportion of units collected by the blood bank from voluntary blood donors over the last two years has increased from 79.0 percent (6,000/7,595) of all units collected in 2010 to 89.0 percent (7,052/7,930) of all units collected in 2011 (Blood Bank Reports). All units collected are screened for infectious markers.

Fifty-nine (59) health care workers were trained in 2010 and 203 in 2011 to provide timely delivery of post-exposure prophylaxis (PEP). There were 22 reported cases requiring PEP in 2010 and 9 reported cases in 2011.

A total of 4,443,282 pieces of male and female condoms were distributed free and 460,759 pieces sold at a reduced cost through non traditional condom outlets in 2010, a result of the collaborative efforts of the public and private sectors. In 2011 a total of 2,761,981 condoms were distributed by the public and private sectors.

For the first time life skills education was delivered as a timetabled subject in 30 secondary schools in 2010 and an additional 40 secondary schools in 2011. Previously this was done using the Infusion Method. This was complemented by the School Health Clubs set up by the Ministry of Health to deliver life skills education and information on health issues.

A total of 10,021 individuals from most-at-risk populations including MSM, SWs, youth and drug users were reached with an appropriate package of HIV prevention services in 2010 and 12,000 reached in 2011. In addition, through strategic collaboration with stakeholders such as the Gold and Diamond Miners Association and the Guyana Forestry Commission outreach and other activities increased reach to over 2,500 miners and loggers in 2011.

An estimated 14,716 employees were reached with HIV and AIDS programme within the workplace in 2011. Almost 2,000 male workers were sensitized on gender issues in relation to HIV and AIDS in 2011.

A total of 4,213 persons were enrolled in the Care and Treatment programme at the end of 2010, with 1,154 of those persons in care and 3,059 actively receiving antiretroviral therapy (ART) (NAPS programme reports). In 2011 3,432 persons were on ART. These services were delivered through 18 fixed sites and a mobile clinic servicing the four hinterland regions in 2011.

The diagnostic capacity of the treatment and care programme has been significantly enhance with the establishment of a National Public Health Reference Laboratory (NPHRL) in 2008. The NPHRL provides CD4 testing for the national treatment programme and began providing early infant diagnosis and viral load monitoring for the national programme in and TB identification and drug sensitivity testing in 2010 and 2011 respectively.

The provision of support to persons living with and affected by HIV was intensified. A total of 918 new persons were enrolled into the Home Based Care (HBC) programme in 2010 and 1,189 new persons were enrolled in 2011 (NAPS programme reports). The Home Based Care and the Orphans and Vulnerable Children programmes contributed to improving the well being of 1,629 children who were provided with a minimum of one care service in 2010 and 1,853 in 2011. A total of 1,328 children in children's homes and those at treatment sites benefitted from school amenities, recreation activities and furnishings in 2010 while 373 benefited from school amenities in 2011. Additionally, 1,629 eligible children were provided with a minimum of one (1) care service by non governmental organizations (NGOs) in 2010 and 1,853 in 2011. Psychological, social and nutritional needs of persons living with HIV were addressed through monthly support group activities and the distribution of food hampers.

The Ministry of Health developed and launched Guyana's first Comprehensive Sexually Transmitted Infections (STIs) Strategic and Monitoring and Evaluation Plan 2011-2020 as a means of responding to the challenge posed by other STIs. The main goal of the plan is to 'reduce the transmission and morbidity and mortality caused by STIs and to minimize the personal and social impact of the infections.'

For the first time since its establishment the National AIDS Programme Secretariat's (NAPS) Monitoring and Evaluation Unit was fully staffed. This has significantly improved the NAPS' ability to meet internal and external reporting requirements and utilize strategic information to inform programming and quality improvements**.**

Table 1: Overview of Indicator Data

Targets	Indicator	Data origin	Period	Value	Remarks
Target 1: Reduce sexual transmission of HIV by 50 percent by 2015 General Population	**1.1** Percentage of young women and men aged 15-24 who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconception about HIV transmission	DHS	2009	51.4%	
	1.2 Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15	DHS	2009	13.6%	
	1.3 Percentage of adults aged 15-49 who have had sexual intercourse with more than one partner in the last 12 months	DHS	2009	4.9%	
	1.4 Percentage of adults aged 15-49 who have had more than one sexual partner in the past 12 months who report the use of a condom during their last intercourse	DHS	2009	Males 15-49 65.5%	There was a low level of response among women to this question in the DHS. Only 14 women reported having intercourse with a partner other than their husband in past 12 months. Of these only 7 answered the question of 'having used a condom at last intercourse".
	1.5 Percentage of women and men aged 15-49 who received an HIV test in the past 12 months and know their results	DHS	2009	24.8%	
	1.6 Percentage of young people aged 15-24 who are living with HIV *Note: Data not disaggregated by sex*	ANC Programme data	2010 2011	0.88% 1.08%	There is no disaggregation for this indicator. Data represents all women testing positive within the total ANC population
Sex Workers	**1.7** Percentage of sex workers reached with HIV prevention programmes	BBSS	2009	21.4%	This indicator is measured by two questions: 1. Percentage of SW who know where to go if you wish to receive an HIV test. 2. Percentage who received condoms in the last 12 months.

Targets	Indicator	Data origin	Period	Value	Remarks
					This was not asked in either of the BBSS. Percentage reached by a Peer educator is used as a proxy The Peer Educator Programme entails distribution of condoms, IEC materials and referral to HIV testing sites.
	1.8 Percentage of sex workers reporting the use of a condom with their most recent client	BBSS	2009	94.2%	
	1.9 Percentage of sex workers who have received an HIV test in the past 12 months and know their results	BBSS	2009	83.9%	
	1.10 Percentage of sex workers who are living with HIV	BBSS	2009	16.6%	
Men who have sex with men	**1.11** Percentage of men who have sex with men reached with HIV prevention programmes				This indicator is measured by two questions: 1. Percentage of MSM who know where to go if you wish to receive an HIV test- This was only asked in the BBSS 2004/05 (17.2%) 2. Percentage who received condoms in the last 12 months. This was not asked in either of the BBSS. Percentage reached by a Peer educator is used as a proxy (68.7% 90/131) The Peer Educator Programme entails distribution of condoms, IEC materials and referral to HIV testing sites.
	1.12 Percentage of men reporting				*The BBSS indicator is*

Targets	Indicator	Data origin	Period	Value	Remarks
	the use of a condom the last time they had anal sex with a male partner				*the same, except that it distinguishes between 3 classes of partners as specified below.*
	Regular partner	BBSS	2009	79.7%	
	Non-regular partner	BBSS	2009	75.0%	
	Commercial partner	BBSS	2009	84.2%	
	1.13 Percentage of men who have sex with men that have received an HIV test in the past 12 months and know their results	BBSS	2009	72.3%	
	1.14 Percentage of men who have sex with men who are living with HIV	BBSS	2009	19.4%	
Target 2: Reduced transmission of HIV among people who inject drugs by 50 percent by 2015	**2.1** Number of syringes distributed per person who injects drugs per year by needle and syringes programmes	-	-		Surveillance data suggests that this is not a major population
	2.2 Percentage of people who inject drugs who reported the use of a condom at last sexual intercourse	-	-		
	2.3 Percentage of people who inject drugs who reported using sterile injecting equipment the last time they injected	-	-		
	2.4 Percentage of people who inject drugs that received an HIV test in the past 12 months and know their results	-	-		
	2.5 Percentage of people who inject drugs who are living with HIV	-	-		
Target 3: Eliminate mother-to-child transmission of HIV by 2015 and substantially reduce AIDS-related maternal deaths	**3.1** Percentage of HIV-positive pregnant women who received antiretrovirals to reduce the risk of mother-to-child transmission	Most recent Modeling in Spectrum 4.47 ANC Programme Report	2010 2011	110.5% 132.6%	*Denominator from Estimates:* Number of HIV+ pregnant women is 143 (2010) and 129 (2011) *Numerator from programme data:* 158 (2010) and 171(2011) Using programme data for Denominator HIV+ pregnant women:

Targets	Indicator	Data origin	Period	Value	Remarks
					82.7% (158/191) in 2010 and 64.8% (171/264) in 2011
	3.2 Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth	NPHRL data	2011	34.1%	Numerator: 90 infants were tested within 2 months; 50 tested between 2 to 12 months. 73 tested 12 to 18 months. Denominator: 264 positive pregnant women giving birth in 2011
	3.3 Mother-to-child transmission of HIV modeled	Most recent Modeling in Spectrum 4.47	2011	4.5%	From the Estimates: Numerator: new infections 0-14 (5) denominator: women needing PMTCT (110) According to programme data, there were 5 babies testing positive out of 264 positive women giving birth (1.9% transmission)
Target 4: Have 15 million people living with HIV on antiretroviral treatment by 2015	**4.1** Percentage of eligible adults and children currently receiving antiretroviral therapy	Most recent Modeling in Spectrum 4.47 NAPS Programme Reports	2010 2011	71.0% 77.2%	*Denominator from the Estimates:* Children and adults in need of ART 4,307 (2010) and 4,444 (2011) Numerator from programme data: Number of adults & children receiving ART: 3059 (2010) and 3,432 (2011)
	4.2 Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	Patient Monitoring System (NAPS)	2010 2011	80.7% 80.4%	
Target 5. Reduce tuberculosis deaths in people living with HIV by 50 percent by 2015	**5.1** Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV	Chest Clinic Programme Reports WHO Estimates	2010 2011	41% 65%	*Denominator from the 2010 WHO Estimates*: HIV/TB co-infected cases is 200 *Numerator from*

Targets	Indicator	Data origin	Period	Value	Remarks
		2010			*programme data:* 82 (2010) and 130 (2011) *Using Programme data for Denominator* TB/HIV co-infected cases: 50.9% (82/161) in 2010 and 88.4 % (130/147) in 2011
Target 6: Reach a significant level of annual global expenditure (US22-24 billion) in low and middle-income countries	**6.1** Domestic and international AIDS spending by categories and financing sources	-	-		Information not available
Target 7: Critical Enablers and Synergies with Development Sectors	**7.1** National Commitments and Policy Instruments (prevention, treatment, care and support, human rights, civil society involvement, gender, workplace programmes, stigma and discrimination and monitoring and evaluation)	Key informant interviews	2011		See Annex 2
	7.2 Proportion of ever-married or partnered women aged 15-49 who experienced physical violence from a male intimate partner in the past 12 months				Data not available. The DHS 2009 asked about women's attitude towards wife beating: 16.3% of women 15-49 agree with at least one specified reason.
	7.3 Current school attendance among orphans and non-orphans aged 10-14	-	-		Indicator relevant but data not available
	7.4 Proportion of the poorest households who received external economic support in the last 3 months	-	-		Indicator relevant but data not available

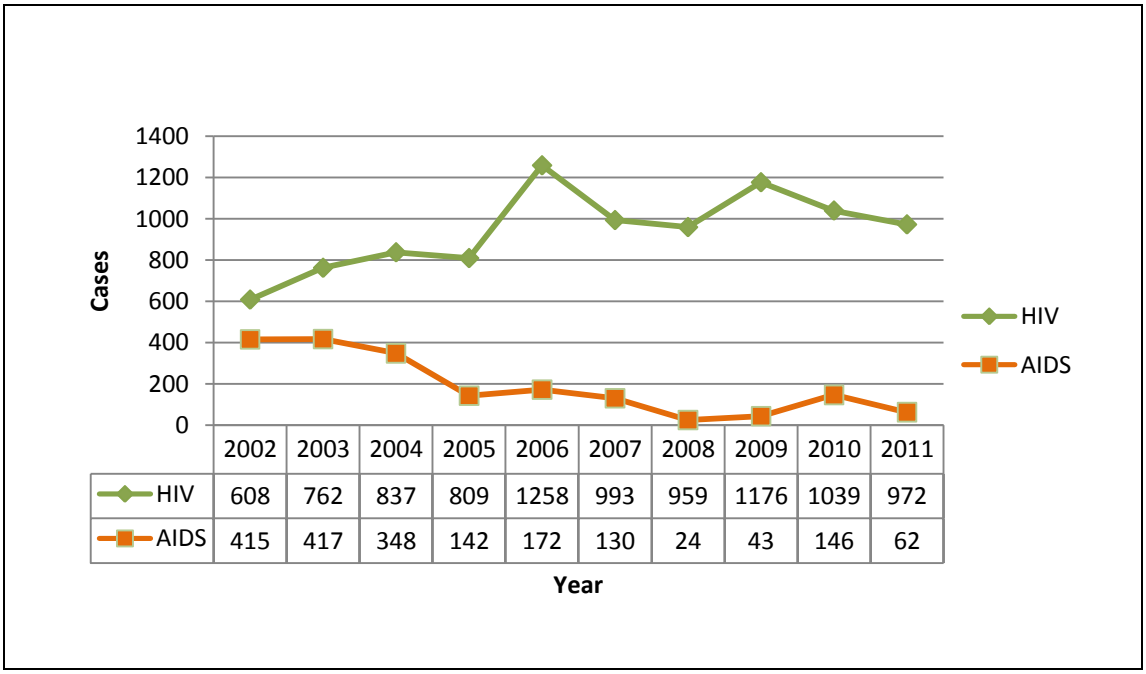
II. OVERVIEW OF THE AIDS EPIDEMIC

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

Guyana is divided into 10 administrative regions, with four coastal regions (Three, Four, Five and Six) collectively accounting for 72.0 percent of the total household population. Per capita GDP is US$2,501.70 (GBoS, 2010 rebased series) and the country is ranked as a medium development country moving up two points from the 2010 report on the Human Development Index (HDI) scale to 117 of 187 countries in 2011 (HDI Report).

The first case of AIDS was reported in a male homosexual in 1987 and there has been a progressive increase in the number of reported cases. The epidemic in Guyana is considered generalized, as an HIV prevalence of greater than 1.0 percent has been consistently found among pregnant women attending antenatal care clinics. A cumulative total of 9473 cases of HIV and 1899 cases of AIDS were reported to the Ministry of Health for the period 2002-2011 (Ministry of Health Statistics Unit). The number of new AIDS cases has progressively decreased since 2004. There were 1,039 reported cases of HIV and 146 reported cases of AIDS in 2010 and 972 cases of HIV and 62 cases of AIDS reported in 2011. These are illustrated in Figure 1.

Figure 1: ***Annual Cases of HIV and AIDS, 2002-2011***



	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
HIV	608	762	837	809	1258	993	959	1176	1039	972
AIDS	415	417	348	142	172	130	24	43	146	62

Source: Ministry of Health Statistics Unit and NAP

TRENDS IN THE HIV EPIDEMIC

Sex Distribution HIV and AIDS Cases

The male to female ratio for HIV cases have been fluctuating over the past four years. While HIV appears to have initially been most prevalent among males, the infection has been transmitted to increasing numbers of women. By 2003, the annual number of reported cases of HIV was higher among females and remained so until 2008 when the male female ratio was 0.91. The situation was again reversed in 2010 and 2011 when more females were diagnosed with HIV, with a male to female ratio of 0.8 in both years (MOH Statistics Unit). This trend is illustrated in Table 2.

Table 2: *Trends in Reported Cases of HIV and AIDS by Sex, 2002 – 2011*

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

Source: Ministry of Health Statistics Unit and NAPS

Age Distribution of HIV Cases

Notable increases were observed among the age-groups 15-19 and 20-24 (in and out of school youth) in 2010 but there was a marked reduction in cases within these age groups in 2011.

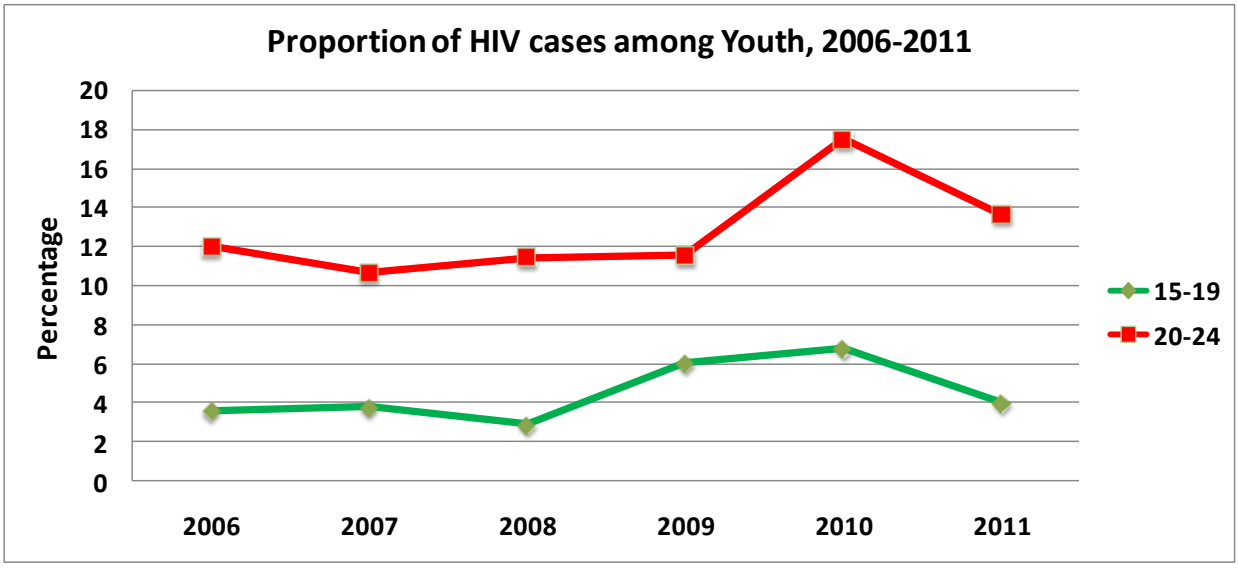
There was also an increase in cases in the 30-34 in 2010 and 2011. The highest proportion of reported cases of HIV has been occurring in the 30-34 age-group, as shown in Table 3.

Whilst there are variations within the specific age groups, consistently more than three quarters of HIV cases are reported in the combined age group of 20-49, clearly the productive workforce.

Table 3: *Distribution of HIV Cases by Age-group 2006 – 2011*

PROPORTION OF HIV CASES BY AGE GROUP 2006-2011						
Age group in years	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**
0-1	1.75	0.10	0.00	0.09	0.01	2.26
1-4 years	0.00	1.60	0.52	0.76	0.48	0.51
5 yrs -14 yrs	1.66	2.50	1.56	1.19	0.87	0.93
15-19	3.60	3.80	2.91	6.04	6.83	4.01
20-24	12.00	10.70	11.47	11.56	17.52	13.68
25-29	17.00	16.30	17.30	13.69	12.80	13.27
30-34	19.60	19.60	18.03	17.35	18.58	18.10
35-39	15.34	15.70	16.37	16.83	13.67	15.23
40-44	11.00	11.40	11.05	12.15	11.93	11.52
45-49	7.00	6.00	7.30	8.93	6.54	8.54
50-54	4.50	3.70	5.01	4.08	4.04	5.66
55-59	2.25	2.70	2.19	2.55	2.60	4.12
60+	1.03	2.60	3.44	2.12	2.02	2.16
Unknown	3.34	3.10	2.81	2.63	2.02	0.00

Figure 2: ***Proportion of HIV Cases among Youth, 2006 – 2011***



Spatial Distribution of HIV and AIDS

Region 4 continues to account for the largest proportion of notified HIV cases; 71.5 percent and 70.8 percent in 2010 and 2011 respectively. The spatial distribution of HIV cases is illustrated in Table 4.

Table 4: *Proportion of HIV Cases by Region 2006 – 2011*

Region	Total Population	% of population	2006	2007	2008	2009	2010	*2011*
1	24,275	3.2	0.2	0.1	0.5	0.9	0.6	*0.8*
2	49,253	6.6	4.6	3.8	3.9	2.6	1.3	*4.1*
3	103,061	13.7	6.8	7.4	8.2	10.6	10.7	*2.7*
4	310,320	41.3	65.2	66.2	59.1	56.3	71.5	*70.8*
5	52,428	7.0	2.3	3.7	1.7	2.7	2.6	*9.0*
6	123,695	16.6	10.5	7.6	9.7	9.9	7.4	*2.8*
7	17,597	2.3	2.5	1.8	1.6	2.4	1.6	*4.9*
8	10,095	1.3	0.1	0.4	0.1	0.5	0.3	*1.1*
9	19,387	2.6	0.3	0.4	0.3	0.0	0.3	*0.4*
10	41,112	5.5	4.0	4.3	3.7	3.1	2.5	*0.1*
Unknown	0	0	3.7	4.2	11.1	10.8	1.3	*3.3*
Total	*751,223*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100*

AIDS-Related Mortality

The proportion of all deaths attributable to AIDS has declined from 9.5 percent in 2002 to 4.7 percent in 2008 and 4.2 percent in 2009 (Ministry of Health Statistics Unit). The actual number of AIDS-related deaths has also generally declined as illustrated in Table 5.

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

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

Source: Ministry of Health Statistics Unit

A pattern of decreasing prevalence among key populations is illustrated in Table 6. The significant increase in the proportion of voluntary blood donors and improved screening of potential donors would have contributed to the decreasing pattern observed among blood donors. The trend over the last eight years shows that the co-infection prevalence among TB-HIV patients is decreasing as illustrated in Table 6.

Table 6: *HIV Prevalence among Key Populations in Guyana*

POPULATION	SEX	YEAR	PREVALENCE	REMARKS
Pregnant Women	Female	2004	2.3	ANC Survey
		2006	1.55	ANC Survey
		2003	3.1	PMTCT Programme Report
		2004	2.5	
		2005	2.2	
		2006	1.6	
		2007	1.35	
		2008	1.15	
		2009	1.11	
		2010	0.88	
		2011	1.0	
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	
Sex Workers	Female	1997	45.0	Special Survey
		2005	26.6	BBSS
		2009	16.6	BBSS
MSM	Male	2005	21.25	BBSS
		2009	19.4	BBSS
TB Patients	All	1997	14.5	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	
Miners	Male	2000	6.5	Special Survey One mine study
		2003	3.9	Special Survey 22 mines study
Security Guards	All	2008	2.7	BBSS
Prisoners	All	2008	5.24	BBSS

Source: National AIDS Programme Secretariat, 2011

III. NATIONAL RESPONSE TO THE AIDS EPIDEMIC

3.1 POLITICAL COMMITMENT

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

In 1989, the Government of Guyana established the National AIDS Programme (NAP) under the Ministry of Health (MoH), which resulted in the development of the Genito-Urinary Medicine (GUM) Clinic, the National Laboratory for Infectious Diseases (NLID) and the National Blood Transfusion Service (NBTS). In 1992, the National AIDS Programme Secretariat (NAPS) was established and charged with the role of coordinating the national response to the AIDS epidemic. The National AIDS Committee (NAC) was also established in 1992 with responsibility for developing and promoting HIV and AIDS policy and advocacy issues, advising the Minister of Health and assessing the work of the National AIDS Programme Secretariat. The NAC also encourages the formulation of Regional AIDS Committees (RACs) and networking amongst NGOs involved in the HIV response. The government's response is complemented by the activities of various civil society organizations, whose approach focused primarily on prevention (disseminating information, education and communication initiatives).

There has been significant legislative development in the area child protection in the last three years. The following legislation was passed by Parliament:

1. The Sexual Offenses Act 2010

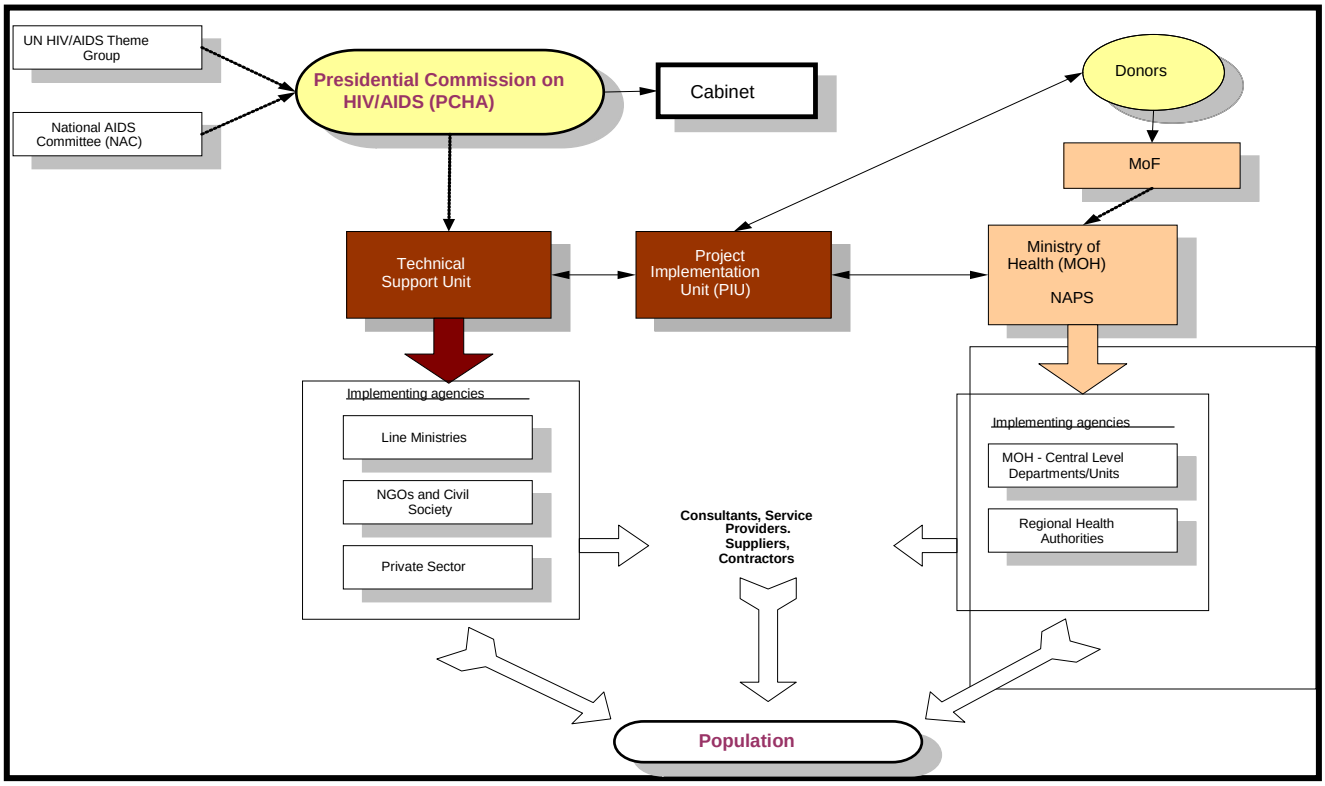
2. Child Care and Development Services Act 2011

3. Custody, Access, Guardianship & Maintenance Act 2011

In the area strategic planning, a National Sexually Transmitted Infections Strategy and Monitoring and Evaluation Plan 2011-2020 was developed.

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

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



Institutional Roles and Responsibilities

HIV coordination is done through an institutional structure that permits the wide participation of all public and private sector actors, civil society, and the international donor community (Country Harmonization and Alignment Tool Report, 2010).

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

The National AIDS Programme Secretariat (NAPS), operating from within the Ministry of Health (MOH), is technical agency responsible for coordination, implementation and the monitoring and evaluation of the national response. The National AIDS Programme Secretariat provides support to the PCHA on technical issues and works closely in providing technical directional guidance to donors. The NAPS also provides technical support to Line Ministries and Civil Society organizations implementing HIV programmes.

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

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

society including NGOs and faith-based organizations, private sector, donor agencies, academia, most-at-risk-populations and persons living with HIV.

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

National Commitment and Policy Instrument (NCPI)

Thirty-five (35) key informants representing government (15), civil society organizations (15), and UN organizations and bilateral partners (5), drawn from Regions Two, Three, Four, Seven and Ten were interviewed for the National Commitment Policy Instrument (NCPI) survey, compared to 42 key informants interviewed in 2009. The main objective of the NCPI is to evaluate and note Guyana's progress in relation to the National Strategic Planning process and to garner stakeholders' feedback on the extent to which progress has been made in achieving national commitments on HIV and AIDS. The questionnaire comprised two parts. Part A was administered to government officials and covers:

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

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

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

I. Strategic Plan

Four (4) representatives from government were interviewed for this section. Results suggest that several major sectors were included in the strategy, with a specific HIV budget for their activities. Three (3) representatives reported that Labor, the Military / Police and Young People were included in the strategy with an earmarked budget, while two (2) representatives reported that women were included and one (1) representative reported that Transportation, Housing and Water were included in the budget with an earmarked budget for their activities. Two (2) representatives reported that Home Affairs (Prisons) were not included in the budget, and one (1) reported that it did have a budget.

Three (3) representatives reported that the key target populations identified within the strategy were in the greatest need for HIV interventions, and one (1) representative reported that the identification of these groups was done through various studies, focus group

discussions, and through the use of programmatic data. Two (2) representatives agreed that persons with disabilities were included in the strategy. In addition three (3) representatives reported that the specific needs of Transgender people and the elderly were not addressed in the strategy, and cited that Transgender issues were not as prominent when the National Strategy was developed in 2007 compared to the current needs. It was pointed out that since the Biologic Behavioral Surveillance Survey (2009) did not identify injecting drug use as an issue hence this was not included in the strategy.

All representatives agreed that cross cutting issues such as stigma and discrimination, HIV and Poverty, Human Rights protection and the involvement of people living with HIV were addressed in the strategy. Two (2) representatives reported that Gender Empowerment / or Gender Equality was addressed.

With regard to the inclusion of an operational plan, all representatives reported that the strategy has an operational plan and three representatives agreed that there is inclusion of: formal programme goals, an indication of funding sources and a Monitoring and Evaluation Framework. Two (2) representatives reported that clear targets or milestones and detailed costs for each programmatic area were included in the operational plan.

In relation to full and active participation or involvement of civil society in the development of the strategy all representatives agreed that Guyana has ensured this. As part of its strategy, Guyana has developed plans to strengthen its health systems, including infrastructure, human resources and capacities, logistical systems to deliver and procure drugs and its Health Information System.

With regard to the endorsement of the strategy by most development bi-laterals and multi-laterals, all representatives said that this was done. However in relation to whether partners had aligned and harmonized their HIV-related programmes to the National Strategy, two representatives reported that only some partners had done so.

HIV and AIDS and the General Development Plans

One (1) representative reported that the negative socio-economic impact on national development was evaluated; however comparison with the results of the NCPI 2009 suggests that it remains unchanged.

With regard to HIV integration in the Common Country Assessment UN Development Assistance Framework (UNDAF), three (3) representatives reported that there is support for integration into the UNDAF and two (2) representatives reported that there is support for HIV integration into the Poverty Reduction Strategy, the National Development Strategy and the National Health Plan and one (1) representatives reported that there was support for HIV integration in the sector-wide approach.

All representatives reported that HIV impact alleviation, reduction of stigma and discrimination, and treatment, care and support (including social security and other schemes) were included in the General Development Plans. Two (2) representatives reported that there was inclusion of reduction for gender inequalities as it relates to HIV prevention, treatment, care and support and for women's economic empowerment while one (1)

representative reported that the reduction of income equalities in relation to HIV prevention, treatment , care and support were not included in the strategy.

Respondents identified several key achievements since 2009 including the development of a National Public Health Reference Laboratory and the development of a National STI Strategy and accompanying Monitoring and Evaluation Plan 2011 – 2020 and work plan. However they reported that some challenges remained including sustainability within an environment of dwindling resources, inability to reach all of the populations due to Guyana's geographical make up and information systems remaining largely paper based.

HIV and AIDS issues among national uniformed services

All respondents reported that there is a strategy for addressing the HIV issues of Guyana's uniform services. It was pointed out that these groups are beneficiaries of targeted interventions and they are becoming increasingly involved in the efforts to stop the spread of HIV.

Commitment and Monitoring

Two (2) respondents reported that Guyana has followed up on commitments made in the 2011 with regards to the political declaration on HIV and AIDS. All respondents reported that the HIV programme coverage is being monitored by sex and geographical area. Most respondents reported that monitoring was done by population, such as prisoners and sex workers, and the data are being utilized for policy and programme decisions.

II. Political Support

Six (6) representatives from government were interviewed for this section. Respondents noted that Guyana has continued the distinctive steps it has taken in ensuring leadership at the highest level in the response to HIV and AIDS. In keeping with the Three Ones Principle, Guyana has developed the Presidential Commission on HIV and AIDS under the chairmanship of President since 2004. All representatives agreed that the Minister of Health as well as other Government Ministers demonstrated public leadership in rolling out the national response to retarding HIV and AIDS.

National AIDS Programme Secretariat (NAPS)

Compared to 2009 when only half of the respondents agreed, all respondents agreed that the National AIDS Programme Secretariat (NAPS) is the national mechanism that promotes interaction among government, people living with HIV, civil society and the private sector as well as implements HIV and AIDS strategies or programmes in Guyana.

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

- Interactions in the form of updates from each sector or agency;
- Better monitoring and evaluation; and
- Review of the policies and laws to determine those that are inconsistent with the national AIDS control policies with regard to Human Rights for Children and the Sexual Offenders Act.

Remaining challenges include but are not limited to:

- The ongoing review of the policies and laws to determine which are inconsistent with the national AIDS control policies;
- Implementation of existing policies, laws, or regulations for the promotion and protection of persons living with HIV and other vulnerable sub-populations;
- Bringing on board more policy makers in the national response to retard HIV and AIDS; and
- Helping more policy makers to understand the impact that HIV and AIDS could make in relation to sector development, provision of goods and services and its impact on human resources for the country at large.

All representatives reported that the NAPS supports Civil Society for the implementation of HIV-related activities by providing information on priority needs. Five (5) representatives reported that capacity building and technical guidance were provided and four (4) representatives agreed that there was coordination with other implementation partners in relation to procurement and distribution of medications and other supplies.

A total of 16 representatives from civil society, bilateral agencies and UN organizations were interviewed regarding civil society involvement in the national response. Nine (9) representatives reported that the government, through political and financial support, had involved key populations and or other vulnerable sub-populations in Governmental HIV policy design and programme implementation. The development of the HIV policy and the Ministry of Health Policy Statement against Stigma and Discrimination as well as subventions granted to the Regional AIDS Committee were cited as examples.

III. Human Rights

A total of 11 respondents were interviewed regarding human rights. All respondents reported that Guyana has non-discrimination laws or regulations which specify protections for specific key populations and other vulnerable subpopulations including: Orphans and other vulnerable children, People with Disabilities, Women and Girls.

Of the four (4) government representatives interviewed, three (3) reported that there was specific protection for persons living with HIV. On the other hand, four (4) representatives from civil society, bilateral agencies and UN organizations reported that there was no specific protection for persons living with HIV and that there was no specific protection for young women and young men. In contrast three (3) government representatives reported that there was no specific protection for this population.

All respondents agreed that there was no specific protection for Transgendered people. Three (3) government representatives agreed that men who have sex with men, migrants/ mobile populations and sex workers were not specifically protected. This view was shared by six (6) representatives from civil society, bilateral agencies and UN organizations who also held this view in relation to sex workers and migrant /mobile populations. Additionally, five (5) of them held this view regarding prison inmates and all held this view in relation to men who have sex with men. Four (4) agreed that Guyana has a general not specific HIV-related discrimination law. Respondents cited the Constitution of Guyana which contains a section on non-discrimination on the grounds of age, sex, gender, ethnicity, religion and the

inclusion of non discrimination on the grounds of sexual orientation in the Ministry of Health Policy on Stigma and Discrimination.

Respondents from Government reported that the Ministry of Labor, Human Services and Social Security has mechanisms in place to ensure that these laws are implemented. Conversely respondents from civil society, bilateral agencies and UN organizations stated that there is limited enforcement of these laws since women are constantly harassed and people are discriminated against based on their ethnicity.

Nine (9) respondents reported that there are laws that present obstacles to effective HIV prevention, treatment, care and support, in particular for MSM, migrants / mobile populations, prison inmates, sex workers and transgendered people, compared to more than half of those interviewed in 2009 who agreed. The following examples were provided:

- The buggery laws and the Gross Indecency Act, which affect gay men and other Men who have Sex with Men.
- There are specific laws against prostitution and loitering which affect sex workers.
- There are specific laws against cross dressing which affect transgendered people.
- There is policy that stipulates that prisoners cannot have condoms.

Respondents also noted that there are laws that criminalize and discriminate against those vulnerable populations and contribute to driving high risk behaviors under the ground and away from prevention efforts.

Seven (7) representatives from civil society, bilateral agencies and UN organizations reported that Guyana has a policy, law or regulation to reduce violence against women which is covered under the Domestic Violence Act. Five (5) representatives reported that the promotion of human rights is explicitly mentioned in the National HIV/AIDS policy document as well as the Guyana National HIV Prevention, Principles, Standards and Guidelines as a cross cutting issue, in comparison to only two-thirds of the respondents in 2009 who reported that it was explicitly mentioned.

As in 2009, most respondents (5) from civil society, bilateral agencies and UN organizations society agreed that there was no mechanism to record, document and address cases of discrimination experienced by persons living with HIV, key populations and other vulnerable sub populations. All representatives reported that Guyana has a policy of free services for HIV prevention services, antiretroviral treatment and HIV-related care and support interventions, compared to a majority who agreed in 2009. Six (6) reported that Guyana has a policy to ensure equal access for women and men to HIV prevention, treatment and support services, with coverage for women outside the context of childbirth, in comparison to more than half in 2009 who agreed that there was a policy to ensure equal access.

Five (5) respondents agreed that Guyana has a policy to ensure equal access for key populations and /or vulnerable sub-populations to HIV prevention, treatment, care and support services. However they also stated that attitudes and behaviors of security guards, cleaners and clerks are barriers to access and that such individuals are not held accountable.

As in 2009 more than half (4) respondents reported that Guyana has a policy prohibiting HIV screening for general employment. However, respondents also reported that the policy was not enforced as screening for employment is still being done. Similar to 2009, more than half (4) respondents reported that there is an independent national institution for the promotion and protection of human rights, which considers HIV-related issues within their work.

Three (3) respondents reported that there were no performance indicators or benchmarks for compliance with human rights standards in the context of HIV efforts, compared to a majority that held this view in 2009. Three (3) respondents reported that members of the judiciary and law enforcement have not been trained on HIV and human rights issues that may come up within the context of their work, compared to a majority of the respondents who held this view in 2009. However six (6) respondents reported that there were programmes to educate and raise awareness among persons living with HIV and key populations concerning their rights in the context of HIV, compared to little more than half of those interviewed in 2009 who agreed.

With regard to legal aid, five (5) respondents reported that there is no legal aid system for HIV case work or private sector law firms or university- based centres to provide free or low cost legal services to persons living with HIV. In 2009 the majority reported that there was no legal aid for HIV case work, while noting that although there was legal aid it was not specific to HIV. In 2009 respondents also agreed that private sector law firms or university based centres did not provide free or reduced cost legal services for persons living with HIV.

Six (6) respondents reported that there are programmes in place to reduce HIV-related stigma and discrimination for the media, work place and health care workers.

Respondents reported that since 2009 there were several key achievements, in policy, laws and regulations in place to promote and protect Human Rights in relation to HIV. Respondents from civil society, bilateral agencies and UN organizations noted the following key achievements:

- Ministry of Health Policy on Stigma and Discrimination
- Code of Ethics
- Implementation of the suggestion box at clinics
- There was more Human Rights training
- Friends across Differences (Group of Transgendered people), Guyana Sex Work Coalition, SASOD and GUYBOW have become more vocal.

Respondents identified several challenges that remain including: reform of the punitive laws that criminalize sexual minorities and other vulnerable groups; stigmatization and ridicule of the marginalized populations perpetuated by some religious groups.

Respondents from civil society, bilateral agencies and UN organizations cited key achievements in the effort to implement human rights related policies, laws and regulations including: non criminalization of HIV and increased training and enforcement as part of the efforts to implement human rights related policies, laws and regulations. Remaining

challenges identified by respondents include: selective application of laws, sensational reporting by the media, and the discriminatory laws and the stigma perpetuated by some religious group.

3.2 PREVENTION

The Prevention Reference Group on HIV/AIDS monitors the implementation of activities to achieve prevention.

A major achievement in the national HIV prevention programme has been the development and launch of the Guyana National Prevention Principles, Standards and Guidelines in 2010. The document serves as a tool to ensure that minimum standards to achieve HIV prevention are met and maintained. A cadre of 35 key persons from both governmental and non governmental agencies was trained as trainers and facilitators in the use of the prevention tool to facilitate the full application and further nationwide roll-out of the principles, standards and guidelines.

Behavior Change Communication (BCC)

During the period under review the NAPS continued to intensify its prevention programme with the development of new Behavior Change Communication campaigns for the purpose of increasing awareness in specific targeted populations as well as the general population. The campaigns covered many aspects of prevention ranging from increasing condom use, encouraging early HIV testing to reiterating the importance of adherence to medication.
Areas of focus for new campaigns:
1. Prevention with Positives
2. Greater involvement of men in health services
3. Prevention of sexually transmitted infections
4. Prevention of mother-to-child transmission of HIV
5. Prevention of TB/HIV Co-infection
6. Intervention among religious groups, children and young adults

As part of the BCC campaigns for 2011, a campaign on TB-HIV Co-infection was launch on World Tuberculosis (TB) Day to create greater public awareness of the need to adopt health seeking behaviors crucial for increasing individuals' access to earlier screening and treatment for TB. The campaign also demonstrated increased collaboration between the National TB Control Programme and the National AIDS Programme of the Ministry of Health.

Ride For Life

The Annual Five Stage Cycle saw the participation of 58 riders from host country Guyana, and Suriname, Trinidad, United States of America and Canada in 2010 and 61 riders from host country Guyana, Suriname, Trinidad, Barbados, The United States of America, England and Germany in 2011. This event is staged to increase awareness and knowledge about HIV and AIDS among participants and the general public, encouraging HIV and AIDS activism and volunteerism among the participants, and inspiring them to become ambassadors in the

response to HIV. During the races, peer educators distributed a total of 5,500 (3,000 male condoms, 200 female condoms in 2010 and 2,500 male condoms in 2011) as well as 900 brochures (600 in 2010 and 300 in 2011) to onlookers (NAPS Annual Report and Programme Report).

Information, Education and Communication (IEC)

Using a mix of three (3) major communication channels-mass media, interpersonal and community channels, BCC programmes were used to create greater awareness of common health problems, influence societal attitudes and norms, and promote healthy behaviors. In 2010 advertisements were placed television stations and radio stations nationally which aired 138,469 spots. In 2011, stronger partnerships between the National AIDS Programme and television and radio stations resulted in increased allocation of free airtime for television and radio advertisements and HIV programming.

Box 1: Distribution of IEC Materials

Some 170,338 pieces of IEC materials; posters, brochures and books with HIV-related themes were distributed in 2010 and 186,074 were distributed in 2011.
The materials addressed:

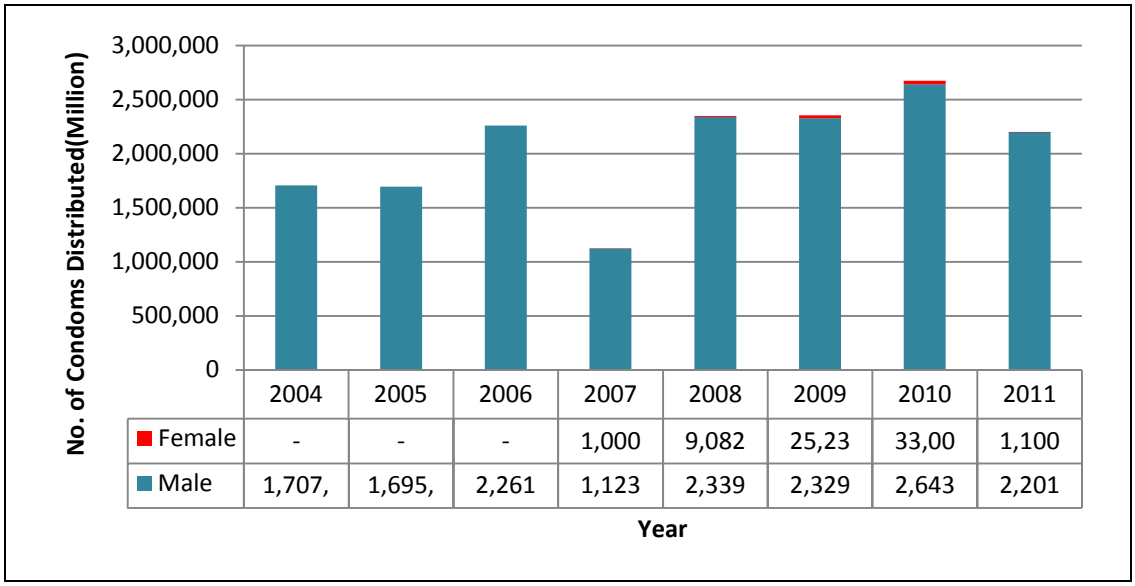
- *Stigma and Discrimination*
- *Early HIV Testing*
- *Condom Social Marketing*
- *Treatment and Care.*

Condom Distribution

As a means of facilitating universal access to condoms, 4,433,228 condoms (4,410,228 male condoms and 33,000 female condoms) were distributed in the public sector in 2010 (NAPS Annual Report). A total 460,759 male condoms were sold by large and small scale distributors and condom sales promoters in 2010. A total of 10,000 free single use lubricants were also distributed. A total of 2,263,422 condoms (2,262,322 male and 1,100 female condoms) were distributed in 2011 nationally by the NAPS while 498,559 pieces were sold by the private sector at a low cost through non-traditional retail outlets (NAPS programme report).

Female condoms made available initially by UNFPA in 2007 were provided primarily for the Female Commercial Sex Workers. This small pilot revealed that the use of the female condoms by FCSW was acceptable and in high demand. This led to concerted efforts by the Government to increase the availability of the female condoms.

Figure 4: Types of Condoms Distributed by NAPS, 2004-2011



Prevention of Mother-to-Child Transmission (PMTCT)

HIV prevalence among women attending antenatal clinics was 0.88 percent in 2010 and 1.08 percent in 2011 (PMTCT programme data). In 2011 there were 181 primary sites including antenatal clinics, delivery wards and private hospitals providing PMTCT services compared to 165 in 2010.

Uptake of VCT services among pregnant women increased from 93.7 percent in 2010 to 94.8 percent in 2011(PMTCT programme data). The percentage of HIV-positive pregnant women who received ART to prevent mother-to-child transmission decreased from 87.3 percent to 85.1 percent in 2011 (PMTCT Programme data).

Babies born to HIV-positive mothers were provided with early HIV diagnosis through DNA PCR testing at the Guyana National Public Health Reference Laboratory (NPHRL) which began DNA for Polymerase Chain Reaction (PCR) testing in 2010. Prior to 2010 such testing was conducted in South Africa with support from The Clinton Foundation. In 2010 5.8 percent babies born to HIV-positive mothers were infected with HIV compared to 1.9 percent in 2011(5 out of 264 HIV positive women giving birth). (PMTCT programme data and NPHRL Reports). Exposed infant are currently being tracked at the national care and treatment sites through use of the Exposed Infants Register. A summary of achievements and status of the PMTCT programme is shown in Table 7.

Box 2: Dry Blood Spot Testing

Reports from the National Public Health Reference Laboratory (NPHRL) indicate the following:

	2010	2011
DBS specimens received	211	229
Samples rejected	27	16
Samples processed	184	213
Number of positive samples	11	5
% positive	6%	2.3%
Babies tested before 2 months	87	102

Table 7: *Summary of Achievements and the Status of the PMTCT Programme, 2003-2011*

Category	2003	2004	2005	2006	2007	2008	2009	2010	2011
No. of Sites with PMTCT	23	37	57	92	110	135	157	165	181
Annual No. of live Births	16,993	16,391	14,885	12,817	15,114	15,076	14,584	14,528	NA
ANC mothers counseled and tested for HIV	3,279	4,741	9,675	13,041	12,004	15,702	11,776	11,441	13,490
Mothers tested who received their results	-	-	-	-	-	14,337	10,046	9,829	11,641
Uptake of VCT among pregnant women (%)*	84.9	86.3	93.8	97.8	97.6	95.5	*89.8	93.7	94.8
No. of HIV positive mothers	103	118	212	215	176	180	130	101	147
Prevalence of HIV (%) (*programme data*)	3.1	2.5	2.2	1.6	1.3	1.15	1.1	0.88	1.08
Exposed live infants who received ARVs	71	99	148	174	210	222	**206	188	196
Percentage of babies tested Positive	-	-	-	-	6.0	3.8	8.9	5.8	1.9
Percentage of Positive women receiving a complete course of ART	-	-	-	-	85.10	90.9	95.8	87.3	85.1
Number of Health Care Workers Trained in PMTCT according to National Guidelines	-	-	-	-	-	234	132	98	306
Number of babies born to HIV Positive women who are tested before 18 months	-	-	-	-	-		89	159	213

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

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

***** Note*** *Between 2007 and 2009 the number of exposed live infants who received ARVs exceeded the number of HIV positive mothers due to some women having multiple births.*

Male partner involvement

Male partner involvement is measured at the national level through male partner testing. Some 627 (5.5%) of male partners of pregnant women (11,441) were tested through ANC settings in 2010. Of those males, 21 (3.3%) were found to be HIV-positive. In 2011, a total of 1,272 (10.1%) male partners of pregnant women (12,635) were tested of which 11 (8.6%) were HIV positive. National PMTCT data do not reveal whether male partners of positive women are more likely to get tested.

Voluntary Counseling and Testing (VCT) for HIV

Using 2006 as a baseline, it is evident that the Voluntary Counseling and Testing (VCT) programme continued to expand in both coverage and reach. There are currently 78 fixed VCT sites spread across all ten administrative regions which are complimented by three mobile serving the hinterland communities.

A total of 93,532 and 106,491 tests were performed in 2010 and 2011 respectively. Figure 5 shows the sex breakdown in 2010 and 2011.

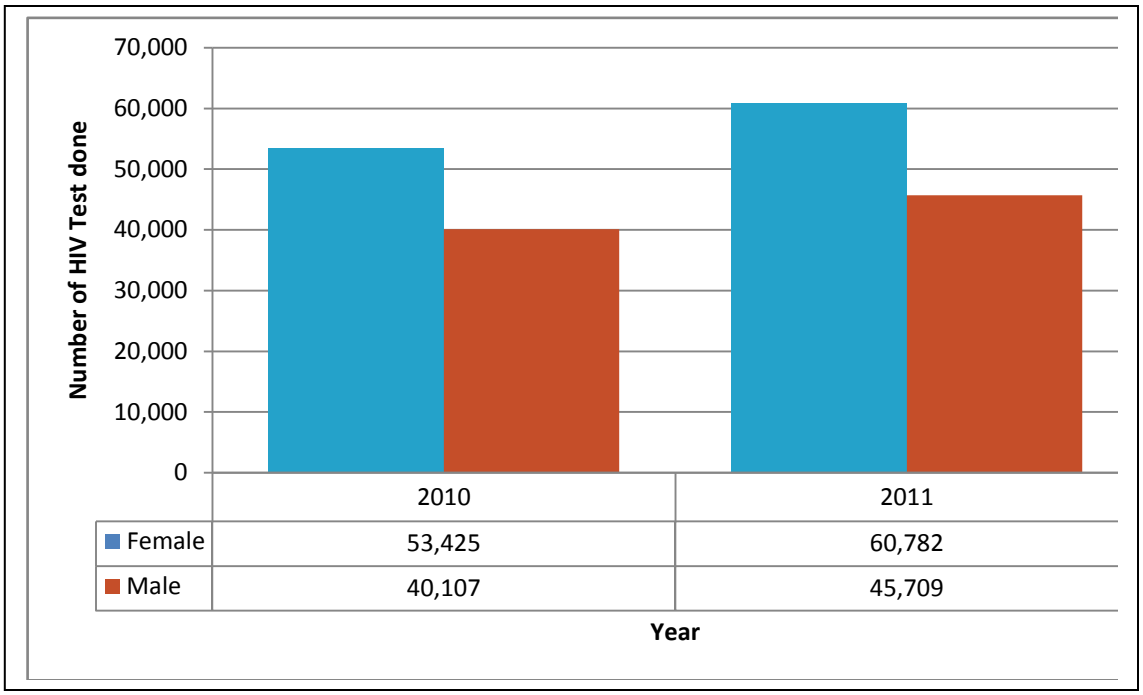
More females continue to access VCT services across the country. The proportion to males was maintained at 57% in 2010 and 2011. The number and proportion of persons testing HIV positive by sex for the period 2006 – 2011 is illustrated in Table 10.

Box 3: Expansion in VCT Services

The following indicators contributed to the expansion of the national VCT programme

	2006 (Baseline)	2010	2011
Number of fixed testing sites	38	75	78
Number of mobile units providing VCT	2	3	3
Number of counselor/testers implementing the programme nationally	58	101	104

Figure 5: *HIV Testing and Counseling by Sex, 2010-2011*



Source: NAPS VCT Programme report 2011

Testing for HIV also occurs in PMTCT programme and is mandatory as part of the screening protocol for all blood and blood products through the National Blood Bank. There has been a progressive increase in the number of persons being tested annually in these settings as shown in Table 8.

Table 8: ***HIV Testing in Various Settings for the period 2005-2011***

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

Training of Counselor/testers

A total of 45 persons were trained as new VCT counselor-testers in 2010 and an additional 40 were trained in 2011. VCT Refreshers trainings were conducted for a total of 287 counselor-testers in 2010 and 293 in 2011.

Quality assurance visits were conducted at all sites to monitor services delivery and data quality against the VCT standards established by the Ministry of Health. Clients exit surveys were randomly administered to ascertain their level of satisfaction with the quality of services received. Case Navigators navigated 181 (68.6%) of 264 newly diagnosed persons from four (4) VCT sites to the treatment programme in 2010 and 299 (80.6%) persons from the same sites were navigated in 2011.

National Week of Testing

The National Week of Testing has seen significant increases in the number of persons being tested in 2010 and 2011. This very successful event involves the collaboration of partners from all sectors and is implemented nationally.

Box 4: National Week of testing, 2010-2011

Indicators	2010	2011
Target for the No. of persons tested	30,000	35,000
Actual No. of Persons tested	35,771	45,198
No. of males tested	17,024	21,428
No. of females tested	18,747	23,770
% testing positive	0.8	0.5

Blood Safety Programme

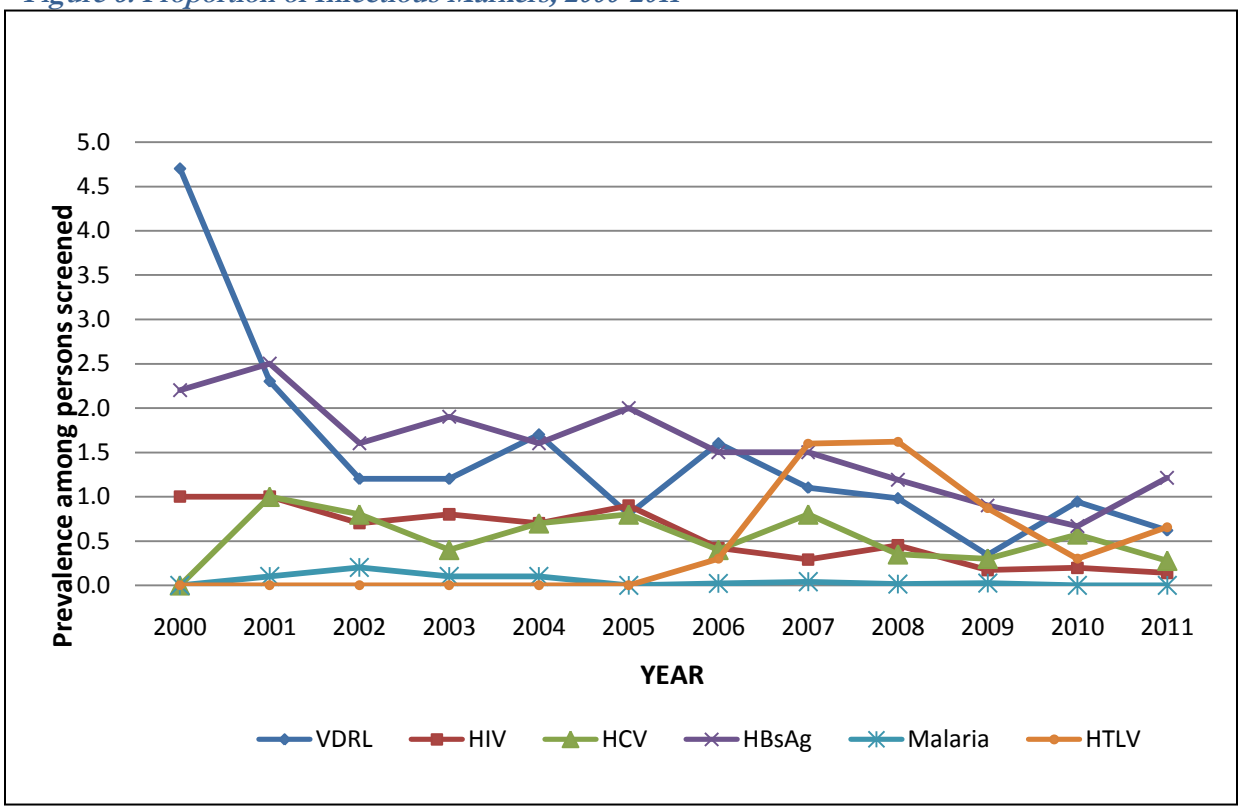
In line with the national Blood Safety Policy, all donated blood is screened for infectious markers. There has been an increasing trend with regard to the proportion of units collected by the blood bank from voluntary blood donors over the recent years with each unit being screened for infections.

In 2010 the proportion of persons testing positive for HIV among all persons screened was 0.2 percent (15/7,654) and 0.1 percent (11/7,929) in 2011. As illustrated in Figure 8 there has been an increase in HBsAg and HTLV among blood screened over the last two years.

Box 5: Expansion in Voluntary Blood Donation

	2008	2009	2010	2011
Total Units Screened	7,500	7,700	7,595	7,930
Total Units donated	4,021	5,236	6,000	7,052
Percent donation	55	68	79	89

Figure 6: Proportion of Infectious Markers, 2000-2011



Provision of Post Exposure Prophylaxis (PEP) Services

The aggressive promotion of the use of safe injections, with special emphasis on using a new syringe and needle for each new patient, as well as disposing used syringes and needles in a safety disposal box resulted in a total of 17 public health facilities and four private hospitals

providing PEP services during 2010. Fifty-nine health care workers were trained in to facilitate the effective delivery of post-exposure prophylaxis. All PEP sites are fully equipped with a special PEP kit which includes the ARVS, medications for emergency contraception and for treatment of other sexually transmitted infections (gonorrhea and Chlamydia). The sites are supported with standard operating procedures and quick references.

Whilst Post Exposure Prophylaxis addresses occupational exposure in the health care setting, sexual exposure primarily through sexual assault is also key to this intervention. To this end, police officers were trained in responding in an adequate and timely fashion. Police stations and outposts were mapped to specific PEP sites to further facilitate the timely access to PEP. In 2011, there were 203 health care workers trained in PEP. A total of 22 and 9 cases respectively were notified to the NAPS for 2010 and 2011 respectively.

Prevention and Control of Other Sexually Transmitted Infections (STIs)

To respond to the challenge posed by other STIs, the Ministry of Health developed and launched Guyana's first Comprehensive STI Strategic and Monitoring and Evaluation Plan 2011-2020. The main goal of the plan is to "reduce the transmission and morbidity and mortality caused by STIs and to minimize the personal and social impact of the infections."

Box 6: STI Strategic Plan 2011-20

The plan has identified five (5) priority areas:

- Strengthening of STI programme management and coordination;
- Promoting healthy sexual behaviors to reduce the transmission of STIs;
- Expanding access to STI prevention, care and treatment in the health sector;
- Increasing access to medicines, vaccines, diagnostics and laboratory support;
- Improving the availability of strategic information.

The plan recognizes that high quality and effective STI programmes and services are critical to the provision of comprehensive sexual and reproductive health services. The plan will serve as a reference framework for the development and implementation of sexual and reproductive health interventions in Guyana and is being implemented in conjunction with the Guyana National HIV/AIDS Strategy 2007- 2011, the National Health Sector Strategy 2008-2012 and the new Guyana National HIV/AIDS Strategy 2012-2020 which is being developed. It places more focus on diseases that have been overshadowed by HIV and will bring together all of the ministry's efforts in this area and coordinate one standard of care across the health sector in close collaboration with the private sector and non-governmental organizations.

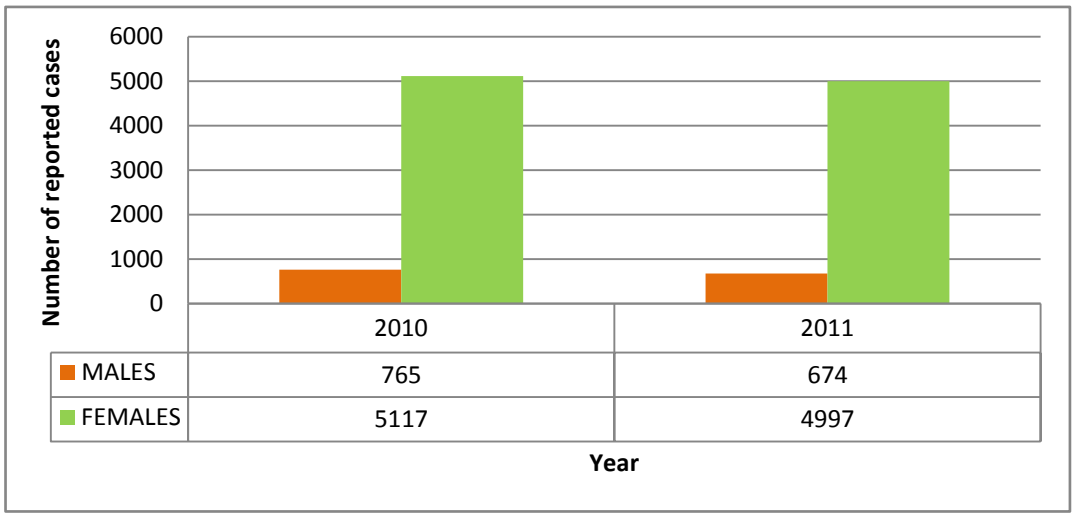
There were 5,671 STI cases reported in 2011 representing a slight decrease from the 5,882 cases reported in 2010 (MOH Surveillance Unit). Genital discharge syndrome (GDS) remains the most frequently reported syndrome while cases of genital ulcer disease (GUD) have been decreasing over the past three years as illustrated in Table 9.

Table 9: *STI by Type 2007 – 2011*

STI	2007		2008		2009		2010		2011	
	No.	%	No.	%	No.	%	No.	%	No.	%
GDS	3,233	92.9	3,388	95.2	5,569	92.5	5,419	92.1	5,231	92.2
GUD	142	4.1	94	2.3	372	6.2	385	6.5	344	6.1
Gonorrhea	8	0.2	8	0.2	15	0.2	19	0.3	35	0.6
Chlamydia	5	0.1	19	0.5	10	0.2	6	0.1	6	0.1
Syphilis	25	0.7	17	0.4	17	0.3	7	0.1	22	0.4
Trichonomiasis	64	1.8	41	1.0	26	0.4	30	0.5	14	0.2
LGV	0	0	1	0.0	1	0.0	0	0	0	0.0
Herpes Simplex	4	0.1	17	0.4	11	0.2	16	0.3	19	0.3
Total	**3,481**	**99.9**	**4,079**	**100.0**	**6,021**	**100.0**	**5,882**	**100.0**	**5671**	**100.0**

The majority of the STI cases reported were among females; 87 percent in 2010 and 88 percent in 2011 (MoH Surveillance data). This might be partly due to the increased vulnerability of women to STIs as compared to men. Also, this may be a reflection of the health-seeking behaviors of men cited in the Canadian Society for International Health (CSIH) STIs Study, 2001, which found that men were four times more likely to self-medicate than women with regards to STIs.

Figure 7: ***STI*** *reported cases, 2010 – 2011*



An STI outreach worker manual was developed to provide the standard operating procedures, guidelines and forms to be utilized in conducting STI outreach work. Essential STI drugs, reagents and consumables have been procured to ensure that health facilities and laboratories will be adequately equipped to provide the required STI services. National STI guidelines and handbooks were reprinted and redistributed to health facilities throughout Guyana. STI prevention activities continued with the development of an STI advertisement and STI posters.

Screening for cervical cancer

Screening for cervical cancer has scaled up with the establishment of 16 active sites during the period 2010 and 2011. Visual Inspection with Acetic Acid (VIA) screening was initiated at the Maternity Unit of the National Referral Hospital as part of the Ministry of Health's national cervical cancer management programme which seeks to identify women with a higher risk for cervical cancer. Through programme outreach, screening is being done at work places that have the requisite privacy. Precancerous cells are removed using cryotherapy. Large lesions are removed using Electrosurgical Excision Procedure at the National Referral Hospital. Clients with suspected cancer cells undergo biopsy and are referred to the Gynecology Clinic at the referral hospital for management.

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

Guyanese girls, aged 11 to 13 years old will be able to benefit from the introduction and free distribution of the Human Papiloma Virus (HPV) vaccine which was introduced in the first quarter of 201. The HPV vaccine has demonstrated high levels of protection against the development of cervical cancer linked to the HPV virus subtypes 16 and 18. Cervical cancer currently affects women globally and kills an estimated 80 Guyanese women annually (MOH Surveillance Unit). The vaccination programme aims to arrest the potential impact on women contracting cervical cancer and also to prevent other health issues such as genital warts and cancers of the anus, vagina and vulva.

Community Mobilization

The thrust of the community mobilization programme during 2010 and 2011 was training and sensitization of in and out of school youth across Guyana on HIV and AIDS and stigma and discrimination. A total of 290 youth (128 males and 162 females) were trained in 2010 and 152 (65 males and 87 females) were trained in 2011. The training was aimed at helping participants identify ways of transmission and prevention strategies including the ABC, the role that stigma and discrimination play in preventing individuals' access to services and increasing their risk to HIV, and facilitating the development of peer education skills.

As an intended benefit, a network of young peer educator has been established and continue to lead HIV prevention activities in their communities and beyond primarily through volunteerism.

A total of 50 community leaders were trained in the use of strategies for community mobilization through sharing of experiences on adult teaching methodologies, moral leadership, community management and the use of the community mirror.

Interventions with Most-at-Risk-Populations (MARPs)

Men who have sex with men and sex workers

The Ministry of Health continues to coordinate the MARPS response in close collaboration with its partners. Interventions have focused on preventing the spread of HIV and other STIs among female sex workers (FSWs) and men who have sex with men (MSM) populations. Seven (7) NGOs are currently implementing HIV education and other prevention programmes that target these two populations. NGOs implementing these programmes received significant capacity building in addressing the issues affecting these specific populations and also in the monitoring and evaluation of their programmes.

Linking these populations with the clinical services ensures that they receive voluntary counseling and testing, screening and treatment for sexually transmitted infections and referral and treatment for HIV as appropriate. Anectodal evidence suggested that discrimination from health care workers presented as an obstacle to accessing these services. In addressing this, 140 health care workers were trained to serve these populations in a non judgemental and non discriminatory manner. Building on this, a stigma and discrimination policy was developed and approved for health care facilities.

A total of 10,021 individuals from most-at-risk populations including MSM, SWs, youth and drug users were reached with an appropriate package of HIV prevention services in 2010 and 12,000 reached with in 2011.

An initiative which commenced in 2009 to increase FSWs and MSM access to condoms at hotels, brothels and bars expanded in 2010. A total of 31 such businesses are partnering with the Ministry of Health on this initiative. The owners of these businesses have been sensitized to HIV, AIDS and other STIs. Some 114,219 pieces of condoms and 34,407 IEC materials were distributed to FSWs and MSM through these businesses in 2010.

A total of 125 FSWs and 143 MSM were trained as peer educators in 2010. Many FCSW and MSM were encouraged to seek alternative sources of income. To facilitate this training was done in literacy, computer skills, art and craft and possible income generating activities. MSM were trained to deliver counseling and testing for HIV at one NGO.

In 2010, UNFPA Guyana collaborated with an NGO, Artistes In Direct Support (AIDS) to work with male and female sex workers with a specific focus on the urban communities. In 2011 UNFPA also collaborated with Guyana Sex Work Coalition (GSWC) to expand the initiative to rural communities where sex work has been increasing.

In 2010 AIDS identified male and female sex workers from their support group to participate in training courses conducted by educational institutions in foundation computer studies and food preparation. In 2011, an additional organization, the GSWC, was brought on board to expand the initiative to rural regions in Guyana. Courses conducted were advanced computer studies, cosmetology, costume designing and craft. Additional to the training, the sex workers received Sexual and Reproductive Health (SRH) awareness sessions and VCT services.

Under this programme, 100 male and female sex workers gained additional income earning skills and access to SRH information in 2010 and 2011. Further, in 2011, 156 male and female sex workers were tested as part of the mobilization exercise for VCT of which 10 tested positive and were referred to treatment and follow up care.

Prevention among Youth

HIV prevention among youth remains a priority as whilst knowledge on HIV is reported as high, behavior change remains a challenge. The two rounds of BSS conducted among the in school youth clearly demonstrates this as knowledge of HIV was reported at over 95% and all major misconceptions were rejected. Further findings however did not bring to bear parallel appropriate behavior as comparatively the age of sexual debut decreased from 15 years to 14 years (2004, 2009). Further as it relates to sexual practices, 66% of the ISY who reported having sex were sexually active within the past 12 months, 7.6% were involved in transactional sex and almost one quarter were forced to have sex. Importantly low levels of consistent condom use were reported, lower for transactional partners compared to regular partners (39.3% vs. 48.7%). One tenth (10%) of the In school youth self reported genital discharge and 8.5% self reported genital ulcer. Considering these practices, there seemed to be a disconnect between the perception of the levels of risk as 66% of the in school youth felt that they were at no risk or low risk for HIV and only 6.9% felt that they were at a moderate to high risk.

Further programmatic data lends to the importance of maintaining the focus on the youth population. The National Care and Treatment Center reports in 2009 that almost half (45.6%) of persons diagnosed with a sexually transmitted infection and accessed treatment was within the age group of 15-24.

With this evidence, a National Youth Reference Group was established at the NAPS. Complementing this is the committee established by the Adolescent Health Unit of the Ministry of Health jointly with the Ministry of Education to target the in school youth population.

Several initiatives were also undertaken to work with this population. NGOs were funded through different projects in conducting sensitization in school, in working with the Ministry of Education in support of the in school youth programmes. The Adolescent Health Unit of the MoH established school health clubs in secondary schools and worked with Parent Teacher Associations. Youth friendly health services are provided through 19 youth friendly health centers and include HIV and STI education, access to voluntary counseling and testing, STI screening.

For the first time health and family life education (HFLE) was delivered as a timetabled subject in 30 secondary schools in 2010 and an additional 40 secondary schools in 2011. Previously this was done using the Infusion Method. Approximately 6,300 students are being reached with life skills education. A total of 104 teachers have been retrained to deliver the curriculum in 104 primary schools which is now reaching 9,360 primary school students with

life skills education. Life skills education is complemented by School Health Clubs that deliver information on health issues in addition to the life skills.

In addition to the findings of the two rounds of BSS (forms 4,5, and 6), the GSHS conducted in 2010 reported on similar findings for the lower classes of forms 2,3 and 4.

The 2010 Guyana Global School-based Student Health Survey (GSHS) was conducted among students in Forms 2, 3, 4, and other. A two-stage cluster sample design was used to produce data representative of all students in Forms 2, 3, 4, in Guyana. A total of 2,392 students participated in survey which was self reported.

Table 10: *Key Results from the Global School-based Student Health Survey, 2010*

Results for students aged 13 – 15 years	Total	Boys	Girls
ALCOHOL USE			
Percentage of students who drank at least one drink containing alcohol on one or more occasion of the past 30 days	39.2 (35.6-42.9)	44.1 (39.1-49.2)	34.3 (30.2-38.6)
Among students who ever had a drink of alcohol (other than a few sips), the percentage who had their first drink of alcohol before age 14 years	79.0 (75.7-82.0)	80.5 (75.3-84.8)	77.1 (71.5-81.9)
Percentage of students who drank so much alcohol that they were really drunk one or more times during their life	29.3 (25.7-33.1)	34.7 (29.4-40.4)	24.5 (21.4-27.9)
MENTAL HEALTH			
Percentage of students who ever seriously considered attempting suicide during the past 12 months	23.2 (20.8-25.9)	16.8 (13.6-20.5)	29.1 (25.5-33.0)
Percentage of students who had no close friends	10.2 (8.1-12.7)	9.6 (7.0-13.0)	10.6 (8.2-13.6)
SEXUAL BEHAVIORS			
Percentage of students who ever had sexual intercourse	29.3 (24.6-34.5)	41.3 (34.4-48.5)	18.5 (15.0-22.5)
Among students who ever had sexual intercourse, the percentage who had sexual intercourse for the first time before age 14 years	71.0 (64.3-76.8)	75.7 (67.3-82.5)	57.5 (47.1-67.2)
Among students who ever had sexual intercourse, the percentage who used a condom the last time they had sexual intercourse	62.7 57.8-67.3)	61.1 (56.7-65.4)	66.3 (54.8-76.2)
TOBACCO USE			
Percentage of students who smoked cigarettes on one or more days during the past 30 days	12.0 (9.3-15.4)	17.4 (13.6-22.1)	6.8 (4.8-9.6)
Among students who ever smoked cigarettes, the percentage who first tried a cigarette before age 14 years	89.5 (85.0-92.7)	88.6 (81.8-93.0)	90.8 (85.0-94.5)
Percentage of students who reported people smoked in their presence on one or more days during the past seven days	58.9 (54.5-63.2)	58.2 (53.6-62.8)	59.6 (54.4-64.6)
VIOLENCE AND UNINTENTIONAL INJURY			
Percentage of students who were in a physical fight one or	37.9	51.3	25.0

Results for students aged 13 – 15 years	Total	Boys	Girls
more times during the past 12 months	(34.6-41.4)	(47.2-55.3)	(21.3-29.2)
Percentage of students who were seriously injured one or more times during the past 12 months	37.6 (34.5-40.9)	41.6 (37.5-45.9)	33.8 (29.8-38.0)
Percentage of students who were bullied on one or more days during the past 30 days	38.4 (33.5-43.6)	40.2 (33.8-46.9)	36.6 (32.0-41.6)

In 2010 also the Guyana Global Youth Tobacco Survey (GYTS) was conducted among students in forms 2 to 4. A total of 1,751 students aged 13-15 participated in the survey.

Box 7: Key findings of the Global Youth Tobacco Survey

More than one in five students currently use any form of tobacco; 9.5% currently smoke cigarettes; 14.8% currently use some other form of tobacco.

• Second had smoking exposure is high – over three in 10 students live in homes where others smoke, and more than one-half of the students are exposed to smoke around others outside of the home; more than three in 10 students have at least one parent who smokes.

• Nearly seven in 10 students think smoke from others is harmful to them.

• Almost three-quarters of the students think smoking in public places should be banned.

•Four in five current smokers want to stop smoking.

• More than one in 10 students have an object with a cigarette brand logo on it.

• Over three-quarters of the students saw anti-smoking media messages in the past 30 days; almost three in five students saw pro-cigarette ads on billboards and pro-tobacco ads in newspapers or magazines in the past 30 days.

In an effort to promote knowledge among youth on HIV/AIDS as well as the work done by the national programme, two batches of students (21) were hosted at the National AIDS Programme Secretariat for four weeks as part of the Annual Work Study Programme in 2011. This placement exposed students to the world of work and enabled them to contribute to the development of four (4) brochures on condoms and STIs. They also visited and interact with children on the pediatric ward of the National Referral Hospital, supervised children of the orphanages during the field visits to the museum and zoo. These students also benefitted from SPSS training, provided recommendations for the revision of Post Exposure Prophylaxis posters and participated in two debates. The students were involved in training on adolescent development in relation to their interaction with their parents, and adolescents' roles and responsibilities.

In 2010 of 93 in-school youth were reached through the listen and discussion groups, school drama and forum theatre by Merundoi, an NGO that draws attention to HIV-related issues through a twice-weekly radio serial drama and which works at the level of the community to encourage and reinforce behavior changes among the target population. As a result of the discontinuation of funding for HIV-related work the organization shifted its focus away from HIV in 2011.

Prevention of Gender Based Violence

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

There has been accompanying legislation to strengthen the institutional framework established to address gender based violence. In 2010 a Sexual Offenses Bill that broadened the definition of rape to include spousal rape and coercion was passed in Parliament. Section III of the legislation states that a person commits the offence of rape if that person engages in sexual penetration with another person (the complainant) or causes the complainant to engage in sexual penetration with a third person. It is also rape if the complainant does not consent to the penetration, and if the accused does not reasonably believe that the complainant consents. The law also states that a husband can be accused of sexually assaulting his wife because she is now recognized as having to consent. Apart from the offences associated with rape, and marital rape exemption, the new law creates an offence whereby a person is made to perform a sexual act in coercive circumstances.

To facilitate implementation of the Domestic Violence Legislation and the Sexual Offences Legislation the Government launched a public awareness campaign in 2010 and continued in 2011. The Guyana Police Force introduced a mandatory 8-module programme which forms part of the curriculum for recruits at the Felix Austin Police College as well as ranks and officers participating in continuing education courses offered by the College to effectively enhance the Police response to domestic violence reports and cases. Nine (9) instructors been trained to deliver the course. Guyana law enforcement benefitted from a two-week internship programme with the Ottawa (Canada) Police Services Department in 2011 on the Management of Sexual Offences and Domestic Violence which sought to address the gaps and strengthen police and prosecutorial management of sexual offences and domestic violence cases.

During the period under review a wide range of programmes and services were available for women who are victims of domestic violence, including counseling, legal aid, and temporary refuge. The Guyana Legal Aid Clinic gave priority to women who were in abusive relationships. The Women Affairs Bureau launched two (2) free emergency 24 hrs hotlines in

2010 for victims or survivors of domestic violence. The hotlines are publicized in the local media and through brochures and posters.

A Men Affairs Bureau was also established in 2010. The establishment of the Bureau was born out of the recognition that the effort to address violence against women required the involvement of men as part of a holistic response. Among the Bureau's objectives is to concentrate on public education and outreach programmes to promote awareness of gender based violence and other gender issues. A network of male advocates against gender based violence is also being supported by UNFPA.

A priority of the workplace programme during 2010 and 2011 was the integration of gender based-violence and male norms and behaviors into the training curricula given their relation to HIV. Almost 2,000 male workers were sensitized on gender issues in relation to HIV and AIDS in 2011. The Federation of Independent Trade Unions of Guyana (FITUG) trained 72 union members on male norms and gender-based violence. The Guyana Trades Union Congress (GTUC) also trained 156 members (106 males and 50 females) on male norms and gender-based violence.

Other key initiatives implemented under the national prevention programme

Interventions targeting Migrant/mobile Populations: The Government of Guyana with support from a donor partner began implementing a Migrant Population Project to enhance the accessibility and the quality of HIV prevention, care and treatment services for migrant and mobile populations in 2011. A Technical Working Group was established with focal persons from the following: NAPS, Health Sector Development Unit, Ministry of Amerindian Affairs, International Labor Organization, National Malaria Programme, National Tuberculosis Programme, Ministry of Health, PAHO-WHO, Guyana Bureau of Statistics, Guyana Geology & Mines Commission, Guyana Forestry Commission, Institute of Migration and GHARP II, PEPFAR implementing agency.

Faith based programme: The Guyana Faith and HIV Coalition continued its focus on the reduction of stigma and discrimination among members of the faith-based community. The body comprise representatives from five Faiths - Hindu, Muslim, Christian, Rastafarian and Bahai. The coalition has conducted a series of community life competence visits throughout Guyana and a total of 22 faith-based members trained in VCT in 2011.

Workplace Programme: The thrust of the workplace programme has been to propel enterprises towards sustaining their own programmes through the implementation of comprehensive health and wellness programmes which address issues beyond HIV and which include the promotion of human rights and social security. A priority of the programme is the integration of gender based-violence and male norms and behaviors into the training curricula given their relation to HIV. An estimated 14,716 employees were reached with HIV and AIDS programme within the workplace in 2011. Almost 2,000 male

workers were sensitized on gender issues in relation to HIV and AIDS in 2011 (PEPFAR FY 2010 and 2011 Reports).

The Guyana Business Coalition on HIV and AIDS (GBCHA) has been a key agency that supported the workplace programme over the past two years. Its membership increased to 46 companies in 2011 from 43 in 2010 and simultaneously increased its capacity for multi-sectoral partnerships and approaches for addressing HIV and AIDS in Guyana. A total of 19 persons from GBCHA member companies were trained as peer educators and 30 persons from other member companies underwent refresher trainings in 2010. In 2011, 24 persons from member companies were trained as peer educators. A total of 800 workers and 1,034 workers of member companies were reached with HIV prevention information and resources in 2010 and 2011 respectively.

A total of 660 employees (364 males; 296 females) from 17 workplaces were reached with HIV and AIDS information through the Ministry of Labor's general occupational safety and health outreach activities in 2010. Some 14 Labor, Occupational Safety and Health (LOSH) officers were trained as master trainers in 2010. The Federation of Independent Trade Unions of Guyana (FITUG) trained 75 of its members 2010. These sessions among other things sought to sensitize members to the National HIV and AIDS Workplace Policy which was launched in 2009. A total of 45 loggers were also trained.

In 2011 the Consultative Association of Guyanese Industry (CAGI) continued to integrate HIV prevention education into their curricula of training for business enterprises, making it a regular feature of training in most of its activities. A total of 44 persons were trained through CAGI management development training courses and The Federation of Independent Trade Unions of Guyana (FITUG) trained 72 union members on male norms and gender-based violence. The Guyana Trades Union Congress (GTUC) also trained 156 members on male norms and gender-based violence.

As part of its community outreach a total of 858 persons (560 males and 298 females) including workers and community members were reached with prevention services in mining communities in 2011.

A Supermarket Initiative was launched in October 2010 with the signing of a Memorandum of Understanding (MOU) between NAPS and participating supermarkets. This initiative is aimed at aggressively promoting awareness of HIV and AIDS and general health and wellness through 10 participating supermarkets. HIV and general health sensitization sessions for employees of the supermarkets, condoms and IEC health materials are provided to supermarkets for free distribution to the public. VCT services, random blood sugar testing, and blood pressure testing for staff are also provided. The 10 participating supermarkets also identify and assign an employee as a popular opinion leader as a focal point with responsibility for training staff and reinforcing health prevention information. A total of 27 managerial and non managerial staff were trained in 2010.

Reducing Stigma and Discrimination: Like many other countries, stigma related to HIV continues to affect the National Programme in reaching persons who most need prevention, treatment, care and support services. Stigma and discrimination have been revealed as significant factors that impede the prevention of the spread of HIV particularly among

sexual and gender minorities specifically MSM. The Sexual and Gender Minorities Baseline Report: The Situation in Guyana by Magda Wills in 2010 revealed that health workers, religious opposition, cultural traditions, and legal constraints form the basis for the discrimination that exists. Further, even though an increasing number of PLHIV have disclosed their status and publicly speak out against discrimination, a significant number are still reluctant to do so. In light of this, Guyana has worked assiduously in combating stigma and discrimination using a multipronged approach.

The high level of political support to the HIV programme and the proactiveness and involvement of leaders in making statements on HIV stigma and discrimination and on accessing services for HIV have been ongoing. During the National Week of HIV testing, political leaders (parliamentarians, opposition members, Ministers of Government) were tested publicly though out the country which served as an example of an initiative that has contributed to the de -stigmatization of the VCT services and HIV/AIDS by extension.

Moreover, there are other ongoing efforts within the health sector to incorporate stigma and discrimination modules in all pre-service training curricula. Health care staff who work with some of the most at risk populations, specifically the men who have sex with men and female sex worker populations, have been trained in stigma and discrimination. A stigma and discrimination policy on HIV was developed for the health facilities and is currently being rolled out through training of the health staff. A number of clinical sites display on a daily basis a plaque which identifies the clinic's policy of non stigmatization and non discrimination.

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

At the community level, the National AIDS Programme Secretariat has conducted training on reducing stigma and discrimination among young persons and among community opinion leaders. Civil Society Organizations also continue with efforts among the Most at Risk Populations and specifically in dealing with issues of self stigma.

Targeting the general population, several mass media campaigns were developed and disseminated including public service announcement for Television and Radio, posters, brochures and billboards. The PSAs were strategically timed for airing, billboards were placed at points of maximum impact and posters, brochures and other print materials were widely distributed.

The results of a qualitative assessment among the faith community led to the formation of the Guyana National Faith Coalition on HIV and AIDS (GFCHA), whose mandate is dealing primarily with the family as a unit. With this, disclosure and sharing is facilitated at that level. The GFCHA has trained its core leadership in addressing stigma and discrimination among its constituents.

Several assessments were conducted to understand the levels of stigma and discrimination that exist among various groups including two qualitative assessments among health care workers and two rounds of BBSS/BSS among several key populations (ISY, OSY, MSM, FSW, Military, and Police). Comparatively the BBSS rounds indicate progress in the reduction of stigma and discrimination. The findings were significant for almost every question asked. The ISY population reported improvement in all areas explored.

Table 11: ISY- Comparison of the 2003/4 and 2008/9 BBSS in the reduction of Stigma & Discrimination

ISY	2003/04	2008/09
Would you be willing to share a meal with someone who is HIV positive?	59.9%	66.2%
Would you be willing to care for a male relative who has AIDS	68.4%	79.2%
Would you be willing to care for a female relative who becomes sick with AIDS	70.1%	82.3%
Would you allow a healthy looking teacher who was not sick to continue working	66.0%	78.1%
Would you continue to buy from a shop keeper or a vendor with HIV	17.3%	24.2%
Would not keep secret that a family member has HIV	28.8%	46.4%

Similarly progress was noted among the other populations. The police and military for example, in 2003/2004, 73.7% and 80.1% respectively believed that persons with HIV/AIDS should be isolated from the rest of the society. This significantly reduced in 2008/2009, reporting at 17.9% and 6.6% respectively. There were seemingly more accepting attitudes among the men who have sex with men compared to the FSW.

Table 12: MSM & FSWs- *Comparison of the 2003/4 and 2008/9 BBSS in the reduction of Stigma & Discrimination*

	MSM		FSW	
	2003/04	2008/09	2003/04	2008/09
Would you be willing to share a meal with someone who is HIV positive?	80.1%	79.4%	75.7%	72.2%
Would you be willing to care for a male relative who has AIDS	91.5%	87%	86.4%	81.8%
Would you be willing to care for a female relative who becomes sick with AIDS	91.8%	86.3%	86.6%	82.8%
Would you allow a healthy looking teacher who was not sick to continue working	62.9%	82.4%	29.2%	-
Would you continue to buy from a shop keeper or a vendor with HIV	37.2%	55%	30.5%	41.4%
Would not keep secret that a family member has HIV	40.2%	67.9%	47%	45%

In mid 2011 a cross-sectional survey was conducted among a random sample of health care and support service providers working at public and private health care facilities in seven of

the ten Regions of Guyana (2, 3, 4, 5, 6, 7, and 10). The medical health care workers are defined as staff members who come into direct contact with patients these include physicians, nurses, pharmacists, and medical technologists. The support providers include the registration clerks, porters, guards, cleaners, social workers and providers of home based care. Data for this assessment was collected using a structured pre-tested questionnaire. Seven hundred and ninety seven subjects of were interviewed and all data collected were entered on an excel spreadsheet and will be exported to EPI-info 7 and analyzed by mid 2012.

Response by routine programme implementation also serves as indirect indication to the reduction of stigma and Discrimination. The National Week of HIV testing serves as a best practice, where persons from across the Guyana openly participate without any fear of stigmatization or discrimination.

NCPI Prevention Results

Ten respondents from Government and civil society, bilateral agencies and UN organizations were interviewed for this section. Six (6) respondents reported that Guyana has identified the specific needs for HIV prevention programmes through the Biologic Behavior Surveillance Survey (BBSS), Demographic Health Survey (DHS) and from analysis of programmatic data. Two (2) respondents reported that HIV prevention programmes are being scaled through AIDS Competence and can be further scaled up through the full implementation of the Health and Family Life Education (HFLE).

Perception of the extent to which HIV prevention has been implemented varied significantly among respondents from government and civil society, bilateral agencies and UN organizations, where five (5) of the latter disagreed that there is risk reduction for intimate partners of key populations including, MSM, out-of-school youth as opposed to five (5) respondents from Government who agreed that there is risk reduction for intimate partners of key populations.

Three (3) respondents from civil society, bilateral agencies and UN organization and two (2) among Government disagreed that there is IEC on Stigma and discrimination and School based HIV education for young people.

National IEC Strategy

Six (6) respondents representing civil society, donor partners and UN agencies were interviewed on the section. All respondents compared, to a majority in 2009, agreed that Guyana has a policy or strategy that promotes information, education and communication on HIV to the general population. Five (5) respondents reported that key messages were explicitly promoted, with the exception of:

- Abstain from injecting drugs
- Avoid commercial sex
- Avoid intergenerational sex
- Male circumcision under medical supervision

All respondents agreed that Guyana has a policy or strategy promoting life skills based HIV education for young people. Five (5) respondents reported that life skills are delivered in primary and secondary schools and four (4) respondents agreed that it is included in teacher training. Five (5) respondents also agreed that the strategy includes age appropriate, gender sensitive sexual and reproductive health elements.

All respondents, compared to more than half in 2009, reported that there was an HIV education strategy for out-of-school youth.

All respondents reported that Guyana has a policy or strategy to promote IEC and other preventative health interventions for key or other vulnerable sub-populations, further detailing that it is built into several strategies but primarily covered in the Behavior Change Communication Strategy.

Respondents reported that since 2009, there were many key achievements in the policy efforts in support of HIV prevention. Respondents from Government shared the following key achievements:

- Development of Guyana National Prevention Principles, Standards and Guidelines which was launched in March of 2010;
- Launch of the Ministry of Health Policy on Stigma and Discrimination in 2011; and
- Expansion of prevention campaigns to include women and girls empowerment.

Remaining challenges includes:

- Enforcement of the existing policies, laws and regulations; and
- Access to services for HIV prevention is centralized.

National Coverage of IEC Services

All respondents were in agreement that specific messages were developed for prevention components such as condom use and HIV testing and counseling. Five (5) respondents reported that prisoners' needs with regard to condom promotion are neglected. Four (4), respondents, compared to less than half in 2009, reported that messages are suitably tailored to reduce vulnerability of customers of sex workers, prison inmates and men who have sex with men.

HIV Prevention and the Media

Of the six (6) respondents from among Government, five (5) reported that there was an activity or programme to promote accurate reporting on HIV by the media. Respondents identified several key achievements since 2009 in the efforts to implement activities to achieve prevention. Respondents from civil society, bilateral agencies and UN organizations reported the following key achievements:

- Decrease in HIV prevalence
- Sustained success of PMTCT
- Scaling up of VCT
- Involvement of the Ministry of Education in HIV prevention programmes
- Massive testing exercise to "KNOW YOUR STATUS"

Challenges remaining include:

- Continued external funding and sustainability of programmes and strategies to reduce HIV and AIDS;
- Adequate access to Information, Education and Communication by hinterland communities;
- Limited implementation of HFLE in schools;
- Limited capacity of teachers to deliver sexuality education;
- Gender based domestic violence and its impact on HIV; and

3.3 TREATMENT AND CARE

The National Care and Treatment Reference Group as well as a Special Tuberculosis and HIV Sub Group provide oversight to the implementation of the care and treatment programme.

The HIV treatment and care programme expanded during the period under review, increasing from 16 to 18 fixed sites in 2011.

In 2011 there were 3,432 persons receiving antiretroviral therapy compared to 3,059 in 2010. Table 13 shows the number persons on ARV during the period 2003 – 2011.

Table 13: *Persons on ARV for the Period 2003-2011*

	2003	2004	2005	2006	2007	2008	2009	2010	2011
Number of persons on ARVs	123	497	1,002	1,611	1,965	2,473	2,832	3,059	3,432
Total increase over previous year	NA	374	505	609	354	508	359	227	373
Percentage (%) increase	NA	304	101	60.7	21.9	25.8	14.5	8.0	12.2

Source: NAPS Care and Treatment Reports

National Cohort – Survival

The national cohort report revealed 580 persons were initiated on ART in 2009. Some 80.7 percent (468/580) were known to be on treatment and alive 12 months later in 2010. There as 80.4 percent (426/530) twelve month survivability for persons initiating treatment in 2010.

Box 8: Twelve month Survivability among the National Cohort

Indicators	*2010*	*2011*
Adult Male	*77.3%*	*76.9%*
Adult Female	*83.4%*	*83.8%*
Children- Male	*90.0%*	*80.0%*
Children- Female	*78.6%*	*85.7%*

There has been a steady increase in the proportion of patients on second line therapy, rising from 3.6 percent (58/1,611) in 2006 to 9.7 percent (296/3,059) in 2010 and dropping a little to 8.9 percent (305/3432) in 2011.

Management of TB-HIV Co-infection

The TB/HIV committee providing oversight for the management of persons with TB/HIV comprises of representatives for the NAPS, NTP, clinicians from HIV and TB programmes and representatives of technical agencies such as PAHO and CDC.

Efforts have been directed at improving the management of TB-HIV co-infected persons. National guidelines for the management of TB and HIV co-infections are clearly established in the guidelines of the HIV programme as well as those of the TB programme. The most

recent revised guidelines (2010/2011) recommend early initiation of ARVs for patients being managed for TB. To this end, the programme reports that for 2011, 88.4% of TB/HIV co-infected patients are managed with ARVS and antiKochs medications.

Health care personnel attached to the NTP are trained in the co-management of TB/HIV infection and outreach staff are equipped to provide DOT-HAART services.

A standard package of care for HIV-TB co-infected persons is provided at 11 care and treatment sites and, universal HIV counseling and testing for TB patients and universal TB screening for HIV-infected patients have been instituted. Referrals between TB treatment sites and ARV treatment sites have been strengthened with the integration of tuberculin skin testing into the package of services provided at the ART sites. This was done by training of nurses, counselor-testers and DOTS workers in placement and reading of Mantoux tests.

A Continuous Quality Improvement programme(HEALTHQUAL) linked to the HIV Quality programme to monitor and document the quality of TB-HIV co-infection care and treatment services have also been implemented.

Laboratory Support

The diagnostic capacity of the treatment and care programme has been significantly enhanced with the establishment of a National Public Health Reference Laboratory (NPHRL) in 2008. The NPHRL provides CD4 testing for the national treatment programme and began providing early infant diagnosis and viral load monitoring for the national programme in 2010. Decentralization of CD4 testing capability was pursued through equipping two regional laboratories (New Amsterdam, Region Six, and Linden, Region Ten) to perform CD4 testing and providing training to staff. These services continue to expand to the peripheral sites in the regions. Additionally TB identification and drug safety testing is being conducted. The NPHRL was accredited by the Guyana Bureau of Standards in 2010 and will be audited in 2012 as a prerequisite for International Accreditation.

Monitoring Quality Care

The national programme continued to monitor quality care during the reporting period through a series of quality programmes. A second revision of the National Guidelines for the Management of HIV Exposed Infants and Infected Adults and Children was conducted during 2010 and 2011 to ensure alignment with the WHO Guidelines.

Patient Monitoring System (PMS)

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

Through collaboration with the Management Information System (MIS) Unit of the Ministry of Health a database for monthly summary report was developed and piloted. There is ongoing collaboration with the MIS Unit for the development of the cohort report database

which has been piloted and is currently being reviewed with a view to expanding to include new modules.

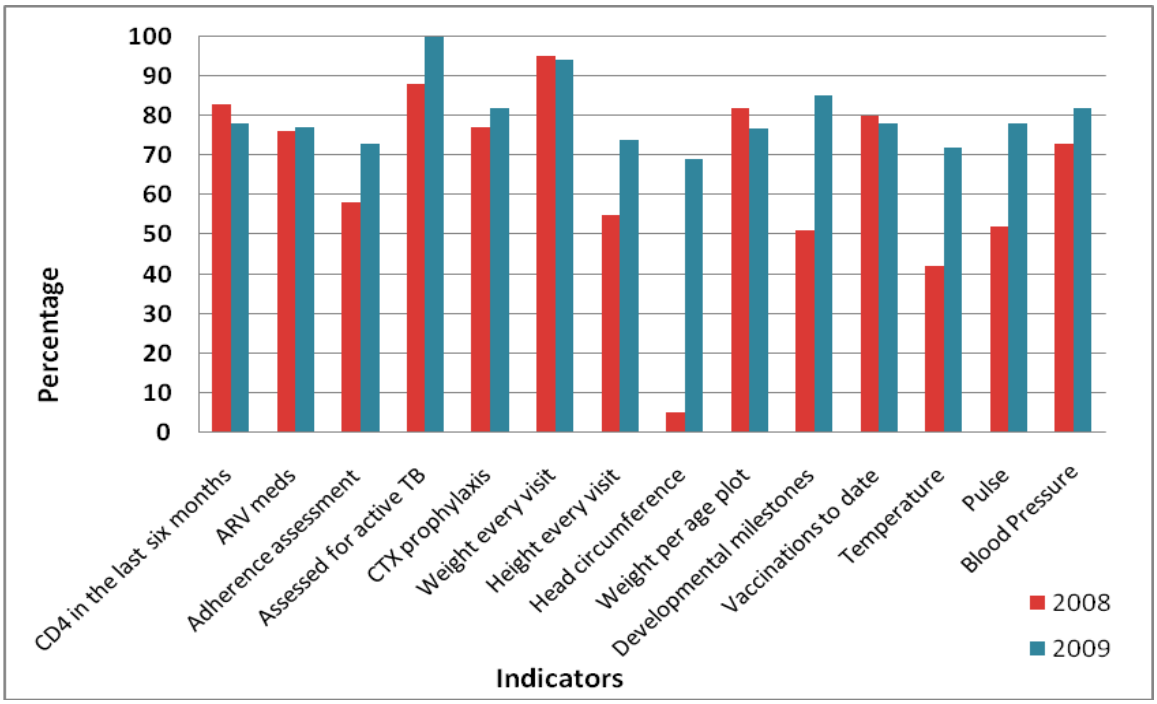
HEALTHQUAL

The HEALTHQUAL programme has extended to 19 pilot sites in 2010, including four (4) sites that provide 'Well Child Care', 10 HIV treatment and care centres and five (5) sites that provide a combination of both services.

The programme successfully completed its second round of data audit during the period 1st July – 31st December, 2009 and presented the results in 2010. The results have shown significant improvement at the various site levels over the first data audit in 2008. There has been movement from 0.0 percent for pulse and temperature to 80.0 percent and 74.0 percent respectively (NAPS Annual Report 2010). The vast majority of the clinical indications such as CD4 testing and ARV medications maintained the high rates reported in 2009 as illustrated in Figure 9.

There was significant improvement in adherence evidenced by an increase from 58.0 percent in 2008 to 73.0 percent reported in 2010. Since adherence is considered a key factor in the reduction of morbidity and reduced risk for the development of drug resistant strains of HIV these results are encouraging. Progress has also been observed in the assessment of HIV-positive patients for active tuberculosis. Significant progress has also been made in the 'Well Child Programme' particularly with regard to monitoring head circumference.

Figure 8: Comparison of HEALTHQUAL Indicators, 2008- 2009



Client Satisfaction Survey

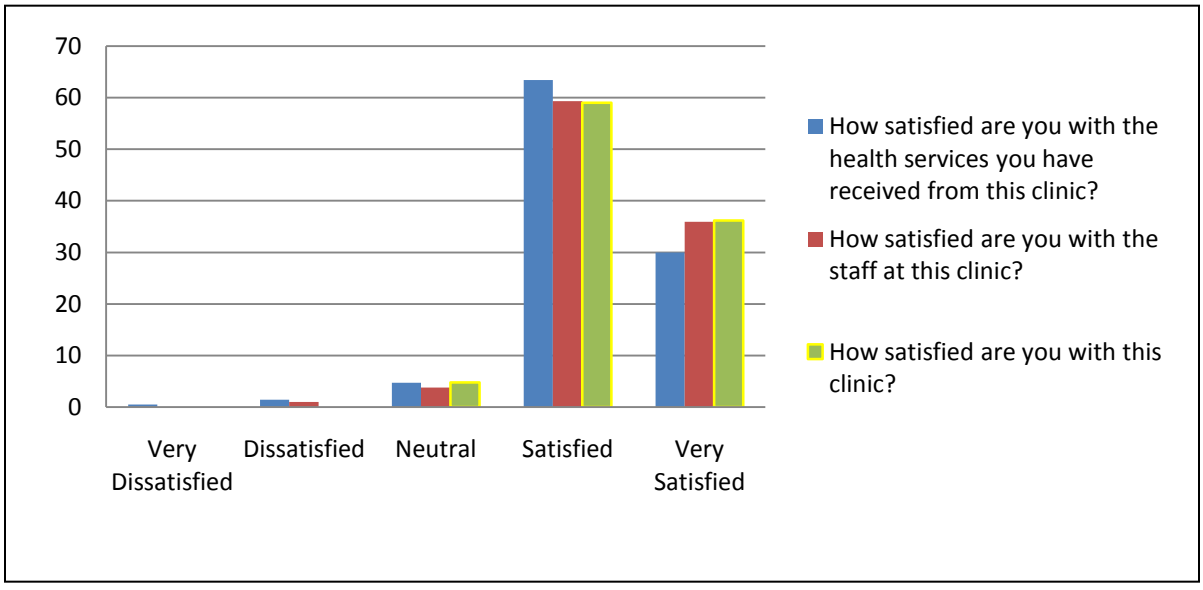
The results of the first client satisfaction survey conducted in 2009 for HIV-positive patients attending HIV and TB clinics were disseminated in 2010. The survey had a two-fold objective; to determine patients' satisfaction with the services provided and to adopt necessary actions for quality improvement.

A total of 262 patients from 13 HIV and TB sites were interviewed using a structured questionnaire. Satisfaction was measured using a five-point Likert scale, with one (1) being least desirable and five (5) being most desirable. To determine the overall level of satisfaction in these areas the following questions were asked:

- How satisfied are you with the health services you have received from this clinic?
- How satisfied are you with the staff at this clinic?
- How satisfied are you with this clinic?

In all three (3) of those areas investigated, the accumulative percentages of satisfied and very satisfied were relatively high. Health services amounted to 93.4 percent, clinic staff with 95.2 percent, and Health facility with the same 95.2 percent. The key findings are illustrated in the Figure 9.

Figure 9: *Client satisfaction level with health service, staff and facility*



While client satisfaction was generally high, the findings also revealed that clients were not as satisfied with reception staff and the content of health information shared and the availability of educational materials. They suggest a need to develop interventions with reception staff, the patients' first point of contact with the health services, improve the content of the health information shared at the facilities and provide more educational materials.

HIV Drug Resistance (HIVDR) Monitoring

The activities of the HIVDR strategy are overseen by a HIVDR Technical Working group, comprising of technical persons from NAPS, NCTC, NPHRL, PAHO, who ensure that all HIVDR activities are completed and reviewed regularly.

The Early Warning Indicators are a part of the HIVDR prevention strategy, and are collected annually for each selected site. The factors that are associated with and may influence preventable emergence HIVDR vary from site to site and therefore results for each site are presented below along with the relevant recommendations.

The Early Warning Indicators for Guyana were selected from the WHO recommended indicators to ensure that the current system can be used to calculate them without the burden of implementing an additional system to capture the relevant information needed for the HIVDR Survey.

Early Warning Indicators
EWI 1a: Percentage of patients prescribed an appropriate ART regimen during a 12 month period.
EWI 1b: Percentage of patients taking a second line ART during a selected time period, who are prescribed, an appropriate second line ART treatment.
EWI 2: Percentage of patients initiating ART at the site in a selected time period who are lost to follow up during the 12 months after starting ART.
EWI 3: Percentage of patients initiating ART at the site during a selected time period who are taking an appropriate first -line ART regimen 12 months later.
EWI 4a: Percentage of patients on first line ART whose regimen was either stopped, substituted, switched or incompletely dispensed at the pharmacy due to stock-outs or shortages during a designated year.
EWI 5b: Percentage of months in a designated year in which there was no ARV drug stock-outs.

Table 14: *Achievement of Early Warning Indicators, 2010*

Care and Treatment Sites	EWI 1a: Target 100%	EWI 1b Target 100%	EWI 2: Target <20%	EWI 3: Target >70%	EWI 4a: Target <2%	EWI 5b: Target 100%
National Care & Treatment Centre	100	100	0	84	0	100
Davis Memorial Hospital	100	100	8	82	0	100
Upper Demerara. Regional Hospital	100	100	0	88	0	100
Campbellville Health Centre	100	100	6	59	0	100
West Demerara Regional Hospital	100	100	17	81	0	100
Suddie Hospital	100	100	0	75	0	100
New Amsterdam Family Health Centre	100	100	0	65	0	100

Care and Treatment Sites	EWI 1a: Target 100%	EWI 1b Target 100%	EWI 2: Target <20%	EWI 3: Target >70%	EWI 4a: Target <2%	EWI 5b: Target 100%
Skeldon Hospital	100	100	0	67	0	100
Bartica Hospital	100	100	25	75	0	100
Rosignol Health Centre	100	NA*	17	50	0	100
Enmore Poly Clinic	100	100	17	83	0	100
Mobile Unit	100	100	17	58	0	100
Beterverwagting Health Centre	100	100	0	83	0	100
St. Joseph's Mercy Hospital	100	100	11	86	0	100
Dorothy Bailey Health Centre	100	100	0	90	0	100

** The Rosignol site did not have any patient on second line*

Source: NAPS Annual Report 2010

Achievement of Early Warning Indicators

Bartica Hospital in Region Seven did not achieve the target of <20% for Indicator EWI 2: *Percent of patients initiating ART at the site in a selected time period who are lost to follow up during the 12 months after starting ART*. Possible reasons for the lost to follow up are; highly mobile population served by this site, cost and availability of transportation from the riverain communities to the site and stigma and discrimination may be barriers to access to services, and the release of prisoners served by the site without appropriate medical referral.

Campbellville Health Centre, Region Four, New Amsterdam Family Health Clinic, Region Six and Rosignol Health Centre, Region Five did not achieve the target of >70% for Indicator EWI 3. *% of patients initiating ART at the site during a selected time period who are taking an appropriate first -line ART regimen 12 months later.*

In relation to EWI 4a, none of the sites reported or documented patients with regimens that were stopped, switched or inaccurately dispensed medication due to stock-out in Guyana

None of the sites could report on EWI 5b since the dates each site experienced ARV shortage was not captured by the Anti-retroviral Dispensing Tool (ADT) nor the Patient Monitoring System (PMS).

In relation to indicators EWI4a and EWI 5b, it is noted that although Guyana experienced some shortages in the last quarter of 2010 the situation was monitored intensively at the National Level with the result that no patient was affected.

The HIVDR Technical working group recommended that the EWIs be modified and additional indicators be collected, bringing the total to seven. This will ensure that additional factors that are related to possible HIV Drug resistance will be considered, and is in accordance with WHO guidelines.

***HIV Drug Resistance Survey*:** Since starting ARV treatment in 2002, Guyana has seen a remarkable scale up from one to 22 care and treatment sites throughout the country (18 fixed and a Mobile Unit servicing two hinterland regions). With the scale up of treatment there is an increased likelihood of HIV drug resistance as persons may not adhere to treatment for a variety of reasons and there may be mutation of the virus.

The monitoring of the HIV Drug Resistance in the National Programme includes the monitoring of key early warning indicators and the measurement of transmission of HIV drug Resistance through the HIVDR survey which commenced in 2011 with an anticipated end date of 2013. The survey is conducted at the NCTC, the largest and most representative care and treatment site in Guyana. All samples will be processed at the NPHRL and will be sent for further processing at a WHO accredited lab in Puerto Rico. Thus far all baselines were collected. Survey participants are followed over time and a comparison of Viral Load and Genotyping results prior to ARV start and that at 12 months later will be conducted to ascertain any HIV resistance to medication. Additionally, relevant information is extracted from each participant's chart and will also be used in the analysis.

Home Based Care

Twenty-two (22) sites provided HBC Services in 2010. These included two private hospitals, nine (9) NGOs, and 11 treatment sites. One site (NGO) stopped providing HBC services in 2011 as a result of funding cuts.

A total of 918 new persons were enrolled into the Home Based Care (HBC) programme in 2010 and 1,189 new persons were enrolled in 2011 (NAPS programme report). More males utilized the services at the treatment sites while more females utilized NGO sites in 2010.

Box 9: Enrolment in HBC

	2010	2011
Enrollment at care & treatment sites	457	456
Enrolment at NGOs	461	733
Total enrolment for HBC	918	1,189

A total of 182 health care providers were trained to improve delivery of efficient and effective HBC services in 2010 and 112 were trained in 2011 (NAPS programme report). Additionally, ten new caregivers were recruited by three NGOs in 2011 to conduct ongoing monitoring of skills and competences of all caregivers.

NCPI Results Treatment and Care

These section summaries the results of the 17 interviews conducted with government and civil society, bilateral agencies and UN agencies. Sixteen respondents reported that Guyana has identified the essential elements of a comprehensive package of HIV treatment, care and support services. Respondents noted that Guyana has prioritized:

- Access for all
    - Treatment for all who needs it
    - Prevention for all including VCT ("Know your Status")

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

- Visual Inspection with Acetic Acid for women
- Training of physicians in HIV management
- Early diagnosis for HIV-exposed infants through DNA PCR at the NPHRL
- The replacement of several drugs with one combination drug (fixed dose combination)

Procurement of critical commodities

Six (6) respondents were interviewed on this issue. Respondents reported that donor agencies provide support for the procurement and management all HIV-related commodities through the Supply Chain Management Systems (SCMS). Four (4) respondents agreed, compared to all respondents in 2009, that Guyana has access to regional procurement and supply management mechanism for critical commodities, in particular, condoms, ARVs, testing kits and reagents. Three (3) respondents reported that Guyana has a policy for using generic medications or parallel importing of medications for HIV, with the caveat that this is dependent on the donor funding. Respondents' responses in relation to national coverage of treatment and care services are summarized in Table 15.

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

	Strongly Disagree	Disagree	Agree	Strongly Agree	Not applicable
ARV Therapy	-	-	10	7	-
ART for TB patients	-	-	13	4	-
Cotrimoxazole prophylaxis in PLHIV	-	-	11	5	1
Early Infant diagnosis	-	-	13	4	-
HIV care and support in the workplace (including alternative working arrangements)	2	8	6	1	-
HIV testing and counseling for people with TB	-	-	10	7	-
HIV treatment services in the workplace or treatment referral systems through the workplace	3	8	5	-	1
Nutritional care	-	6	10	1	-
Paediatric AIDS treatment	-	-	12	5	-
Post delivery ART provisions to women	-	-	10	6	1
PEP for non occupational exposure	-	4	11	2	-
PEP for occupational exposures to HIV	-	4	11	2	-
Psychosocial support for PLHIV	-	7	8	2	-

	Strongly Disagree	Disagree	Agree	Strongly Agree	Not applicable
and their families					
STI management	1	2	12	2	-
TB infection control in HIV treatment and care facilities	-	5	10	2	-
TB preventative therapy for PLHIV	-	1	12	4	-
TB screening for PLHIV	-	-	10	6	1
Treatment of common HIV related infections	-	-	10	6	1
other	**-**	**-**	**-**	**-**	-

Six (6) respondents reported that Guyana has a strategy in place to provide social and economic support to people infected and affected by HIV, indicating that there is:

- Economic support in the form of transportation reimbursement to make clinic appointment at the TB clinic;
- Monthly financial support to persons eligible; and
- Nutritional support.

Respondents identified several key achievements in the implementation of HIV treatment, care and support programmes since 2009 as follows:

- More TB/HIV co-infected patients accessing treatment;
- Availability of DNA PCR testing locally;
- Simplified one day, single pill dosing ;
- Continued blood safety; and
- Sustained success of PMTCT.

Remaining Challenges include:

- Timely movement of procurement of drugs to avoid stock out of ARVs;
- Adequate access to nutritional support;
- Expansion of HIV treatment, care and support systems in the workplace;
- Adequate access to Post Exposure Prophylaxis, particularly in cases of sexual assault, boys and men included;
- Adequate funding; and
- Adequate psychosocial support for persons living with HIV and their families.

3.4 MITIGATION

Support to Orphans and Vulnerable Children (OVC)

The OVC Steering Committee was re-constituted and became functional in 2010 after a two year lapse. This Committee will guide the Ministry of Health's Orphans and Vulnerable Children Programme response in Guyana. The Committee comprises representatives from the Ministry of Health, NAPS, UNICEF, Child Protection Unit, Ministry of Human Services, Youth Division, Ministry of Culture, Youth and Sport, PEPFAR, School Welfare Department, Ministry of Education, Welfare Department, Ministry of Amerindian Affairs, Every Child Guyana NGO.

During the National Elections Campaign of 2011 the leaders of political parties seeking election signed a Declaration of Commitment to making children visible! The Parties have committed to, always, in or outside government, work towards the progressive realization of children's rights including, but not limited to:

- Upholding "the best interest of the child principle" through action which seeks to strengthen the enjoyment of rights of all children.
- Ensuring that children are prioritized in the national development agenda, with a special focus on ensuring equity for all children in all spheres of development.
- Supporting and catalyzing, efforts that are child-focused and child-sensitive, including with regard to laws, policies, plans of action, and budgeting for children.
- Promoting children's rights to survival (health, water and sanitation), development (education, learning and literacy), protection (from violence, abuse and exploitation) and participation (the right to be heard and have their views taken into consideration in decision-making).
- Continuous monitoring and taking action to ensure the respect protection and fulfillment of the rights of all children in Guyana, with attention to equity. to ensure the Rights of the Child including children living with HIV.

A Sexual Offenses Act was passed in Parliament in 2010. The legislation provides for a comprehensive overhaul of the laws and includes a string of new offences that were tabled to expand protection, particularly for young children. Five (5) Bills comprise the Children's

Box 10: Legislation passed for the protection of Guyana's children

1. The Sexual Offenses Act 2010 (2010)
2. Child Care and Development Services Act 2011 (2011)
3. Custody, Access, Guardianship & Maintenance Act (2011)

There are 5 bills that make up the Children's bill which is a comprehensive package of legislation for the protection of children

1. Adoption of Children Act 2009
2. Child Care and Development Services Act 2011
3. Custody, Access, Guardianship & Maintenance Act 2011
4. Status of Children Act 2009
5. Protection of Children Act 2009

Bill, a comprehensive package of legislation for the protection of children that will enhance the promotion of Child Rights and Child Protection. These Bills were passed to ensure compliance with international human rights instruments in relation to the Convention on the Rights of the Child, the Riyadh Guidelines as well as Millennium Development Goals. The package comprises:

The reform is wide-ranging and includes new offences, and at the same time spells out the rights of victims of sexual abuse and raising much needed awareness. It also includes the establishment of a National Task Force for Prevention of Sexual Violence to address implementation. One of the more critical aspects of the bill is that it has made the criminal offence of rape gender-neutral, to include sexual assault on boys and men, bringing the offence of rape in line with reform around the world and therefore maximizing protection by widening the definition. As a result of the Legislation the Ministry of Human Services and Social Security developed a "Tell Campaign geared at empowering children to disclose to teachers when and if their bodies are being violated by an adult. The Legal Aid Clinic provides legal services for children.

Box 11: Other Initiatives implemented in support of OVC in 2010 & 2011

- 25 homes received equipment benefitting 1,026 children
- Children's homes refurbished benefitting 928 children
- Distribution of school amenities & medical supplies to 1,328 children
- 171 children received medical and dental services
- 350 hygiene kits and 250 new born kits were distributed to care & treatment sites
- Assistance towards recreational activities provided to 695 children
- 683 OVC benefitted from HBC services at care & treatment sites and NGOs
- 1,629 eligible children were provided with a minimum of one care service in 2010 and 1,853 in 2011 by NGOs (PEPFAR Report)

Training in support of the OVC programme

Life skills training and capacity building were conducted in 2010 for 153 social workers, caregivers, parents and children. Support was also given to caregivers to enable them to provide optimal service to the OVC. A total of 127 parents from nine (9) ARV treatment sites were trained on how to use effective parenting techniques when dealing with the children in their care.

NCPI Results OVC

Seventeen respondents (6 from government and 11 from the civil society, bilateral partners and UN agencies) were interviewed for this section. Nine respondents from civil society, bilateral agencies and UN organizations and all six (6) respondents representing government reported that they are aware that Guyana has a policy or strategy to address the additional HIV and AIDS related needs of Orphans and Vulnerable Children (OVC) with an operational definition, compared to more than half in 2009. Five (5) from government reported that Guyana has a national action plan specifically for orphans and other vulnerable children, compared to six (6) from civil society, bilateral agencies and UN organizations who indicated that they did not know.

Four (4) respondents from Government agreed that Guyana has an estimate of orphans and vulnerable children being reached by existing interventions, compared four (4) from civil society, bilateral agencies and UN organizations who agreed. One (1) respondent representing Government indicated that 82.0 percent of OVC are reached through existing interventions. The respondent also stated that the Government has continued to provide financial support to six (6) children's homes nationally. The additional 18 children's homes are supported by charitable donations.

Respondents reported that since 2009 there have been many key achievements in the implementation efforts of HIV prevention for OVC and cited the following key achievements:

- Decrease in HIV prevalence among children;
- Most Orphanages have been renovated and equipped to meet the minimum operating standards and regulations for children's homes;
- Continued support for the child protection unit of the Ministry of Human Services and Social Security;
- Continued provision of capacity building to staff of orphanages ;
- Continued economic support for persons living with HIV, including children;
- Capacity building for parents through the development of parenting skills and techniques and skills building for children, particularly those who are not academically inclined;
- School amenity programme continued;
- Introduction of support group for HIV positive adolescents; and
- General support group, including both positive and negative OVC.

Challenges remaining include:

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

Psychosocial Support to persons living with HIV

A Steering Committee, with representation from NGOs NAPS and NGOs oversees support for persons living with HIV. Several initiatives which began in the last reporting period continued in during the current reporting period. These included Economic Support through the Voucher Programme, psychosocial support though support groups at treatment sites, and nutritional support through the Food Bank.

In 2010, 747 new beneficiaries were enrolled on the voucher programme and at the end of the same year 49.0 percent of persons on treatment (1,500/ 3,059) had benefitted from this programme. There was no funding to support the programme in 2011.

Some 661 persons living with HIV were members of the 10 support groups in 2010. Of this total 168 (25.4%) were new members. Some 60.5 percent (400) were females and 39.5 percent (261) were males. This compares with the gender distribution on treatment which shows a higher percentage (55.2% (1,690/3,059)) of females enrolled (1,690/3,059). Issues discussed during support group meetings included adherence to treatment and Care, coping with stigma and discrimination, good nutrition, prevention and treatment of sexually transmitted infections, ethics, confidentiality and disclosure.

A total of 18 persons living with HIV from the support groups found employment through the Ministry of Labor's Central Manpower Recruitment Agency. Three member of support groups enrolled in technical and vocational training in carpentry, plumbing and electrical installation.

Two support groups established Disclosure Committees in 2010 to encourage HIV-positive clients to disclose their status to persons in the home as a means of gaining additional support, including access to treatment and help adhering to treatment. These two support groups also established a Register to document complaints received from persons living with HIV regarding experiences with stigma and discrimination perpetrated by health care workers, peers and family and community members. The data will be analyzed to inform the development of a system of redress for persons living with HIV.

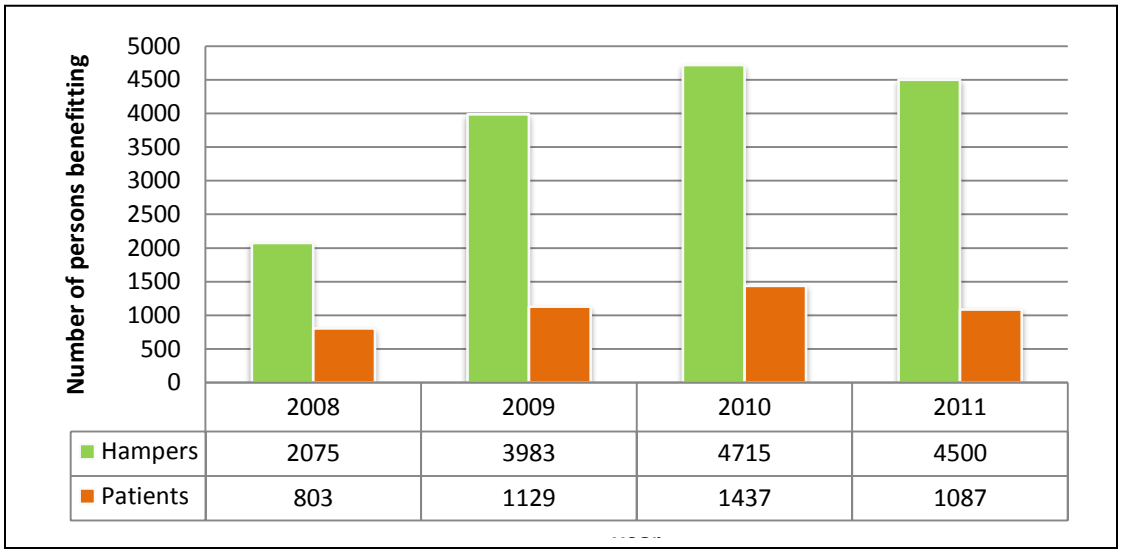
Training

A total of 25 HIV-positive women were trained in human rights and advocacy and an output of the training was a plan that outlines the actions that will be taken to address human rights issues affecting them through advocacy in 2011.

Nutritional Support for Persons living with HIV/AIDS

A total of 4,715 hampers were distributed in 2010 and 4,500 were distributed in 2011 through the Food Bank. The trend in distribution between 2008 and 2011 is illustrated in Figure 10.

Figure 10: *Nutritional Hamper Distribution 2008 - 2011*



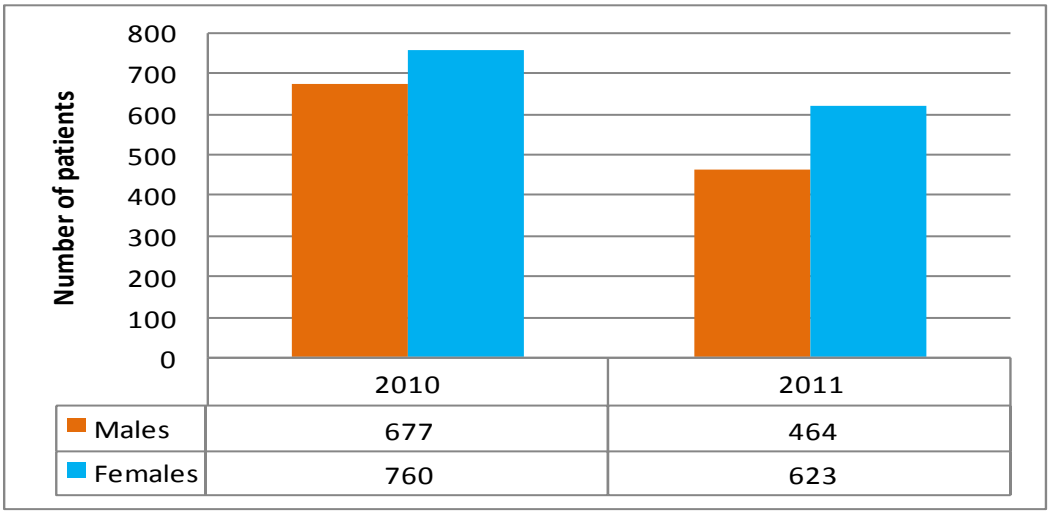
A total of 26 private sector agencies supported the food bank during 2010 and this increased to 30 in 2011. There was a slight increase in the private sector support in 2011 (25.5%) over the support provided in 2010 (23.9%). The procurement and donation trends for the period 2008 – 2010 is shown in Table 16.

***Table 16**: Procurement and Donation for 2008 – 2011*

	2008	2009	2010	2011
	USD			
Total procurement (Donor and GOG)	18531.26	34138.61	40754.14	55584.73
Total Private Sector contribution	9590.84	10134.14	12790.74	19099.37
Total Procurement	28122.11	44272.75	53544.88	74684.11
Annual Private Sector sponsorship	**34.10%**	**22.90%**	**23.90%**	**25.57%**

More females than males continue to access the food bank as illustrated in Figure 11. More persons within the 31-40 age-group continued to access the Food Bank.

Figure 11: *Hamper Distribution by Sex 2010 and 2011*



Other Nutritional Support Initiatives

Collaboration with the Caribbean Food and Nutrition Institute (CFNI) enabled the pretesting of a nutrition algorithm for persons living and affected with HIV and AIDS. Social Workers and nurses from the treatment, and care sites and staff members from the Food Policy Division were trained on the importance of nutrition for persons living with HIV including meal planning and food safety.

Multi-sectoral Collaboration

Civil Society Organizations (CSOs)

Through donor support the Ministry of Health was able to provide financial resources to CSOs to significantly scale-up their contribution to the national response over the last eight years. As a result, the capacity of CSOs was increased and this is reflected in the increasing national coverage of services provided through these entities. The number of CSOs that are active in the HIV national response increased to over 100 in 2011. Key services were provided by CSOs in the areas of prevention (condom distribution, BCC and VCT) as well as care and support for persons living with and OVC. Funding cuts are however negatively impacting CSOs' delivery of services since some have had to stop vital care and support programmes that target OVC and MARPs. As a result CSOs are now placing more emphasis on sustainability through partnerships with the business community and creative resource mobilization ventures.

NCPI Results for CSOs

Respondents from Civil Society, Bilateral Agencies and UN Organization were unanimous that NGOs across Guyana are the main non-clinical service providers as reflected in Table 17.

Table 17: Proportion of HIV services provided by CSOs with support from Bilateral and UN Organizations

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

Progress made in Civil Society Participation since 2009 include:

- Civil Society advocated against the call for the criminalization of HIV;
- Civil Society participation on the CCM has been retained and maintained;
- Civil Society was offered an opportunity to submit funding proposals to the Global Fund;
- Men who have sex with men have been trained as counselor-testers;
- UNAIDS has offered support through community life competence by working for and with communities;
- Partnerships with private sector organization; and

- Implementation of HIV programmes that targeting Sex Workers and men who have sex with men.

Challenges remaining include:

- Sustainability of programmes and services;
- Financial support from the National system;
- Inclusion in the planning, budgeting and monitoring and evaluation of the response;
- Human Resources;
- Private Sector collaboration;
- Civil Society is very docile in Guyana.

Implementation of HIV/AIDS programmes in key Line Ministries

As with Community Services Organizations (CSOs), the Ministry of Health has leveraged external funds to stimulate a broader response among 11 other Line Ministries and six other public corporation and entities.

Focal points facilitate the development of work plans and policies within participating ministries to expand initiatives in accordance with priorities in the National Strategic Plan for HIV and AIDS. Workplace programmes activities focus on achieving prevention of HIV and STIs through training, education and behavior communication, condom distribution, information dissemination, treatment and care for persons living with HIV and their families and workplace policy among other things.

In addition to their staff, focus is also on respective ministries' external clients comprising youth (in-school, and out-of-school including street children), orphans, cultural groups, professional groups such as teachers, associations including parents-teachers associations, trade union groups, farmers, women's groups and other groups identified by line ministries.

The institutional structures which are in place to manage the sub-projects, include a ministerial HIV and AIDS committee chaired by the Minister or his/her designate, who may be a senior official such as the Permanent Secretary, or Director. The committee's function is to coordinate the ministry's programme and perform the follow-up and necessary evaluation activities within the ministry. The ministerial committee also oversees the focal point or coordinator, who is responsible for expediting the coordination of the ministry's response. Ministries are expected to take advantage of their existing departments and divisions already in place, to manage efforts in mainstreaming implementation of HIV activities.

IV. BEST PRACTICES

1. The National Care and Treatment Center- Guyana's Center of Excellence

The National Care and Treatment Centre (NCTC) serves as the premier institution for the management of persons infected with HIV and other sexually transmitted infections. The NCTC formerly known as the GUM Clinic was the first clinical sites established to deal with the HIV epidemic when the first case was diagnosed in 1987.

The NCTC is staffed by a highly qualified multidisciplinary team of practitioners providing holistic management to HIV infected individuals. The center provides comprehensive diagnostic, care and treatment services. All patients are managed according to the National Guidelines; receiving regular CD4 and viral load testing and timely laboratory diagnosis of opportunistic infections. Patients are now initiated earlier on ARVS using the fixed dose combination of Atripla thus improving adherence and compliance. The NCTC in strengthening its adherence efforts, has piloted group adherence counseling and individual adherence case management system. This has shown some success as the loss to follow up and stop rates were relatively low compared to other sites. The NCTC has been integral in providing technical support and leadership in the expansion of the National Cervical Cancer Screening Programme using the low technology of Visual inspection with Acetic Acid. The Center provides a range of supportive services including counseling (disclosure, nutrition, domestic violence and others), provision of nutritional support and economic support and home base care.

The NCTC is the country's largest HIV treatment sites accounting for more than one third (35.5% (1640/4612)) of the patients among all 18 fixed treatment sites and similarly for those on ARV (36.8% (1265/3432)). The Center manages the second largest cohort of pediatric cases and it is the only treatment site that initiates on ARVS more than 100 persons per year. Linked to the high initiation rate, the NCTC is the selected site for the HIV Drug Resistance Surveillance Survey, results for which would be extrapolated to the wider National Programme. This survey is currently ongoing and represents the first such survey in the Caribbean Region.

The center serves as a model for other HIV clinical sites and as a teaching center for physicians, medexes, nurses, pharmacists, social workers and other clinical practitioners. The National HIV Treatment Programme benefits from the experience and expertise of the NCTC clinical team as they provide technical assistance in defining National guidelines for the management of HIV infected adults and children, management of opportunistic infections and TB/HIV co- infection. The team is instrumental in providing supportive supervision and mentoring for other HIV clinical sites and lead the discussion and decision on key clinical issues such as the movement from first to second line therapy.

2. Engaging Most-at-Risk-Populations in Country-led Review

The Government of Guyana had committed to tracking the progress to achieving the national Universal Access targets. In 2010 the government conducted a review that involved the participation of key players in the HIV response, including civil society, particularly people living with HIV, most at risk population groups and caregivers. Six (6) open and inclusive consultations were conducted and brought together stakeholders to review the progress made in reaching Guyana's targets for universal access. Representation came from among most-at-risk-population groups; In-school Youth, Out-of-School Youth, Sex Workers, Men who have Sex with Men, Military, Police and Prisoners. The consultations provided a forum for discussion on the challenges and barriers to achieving the universal access targets in Guyana, and solutions for overcoming the obstacles. The process offered most-at-risk-population groups an opportunity to assess existing approaches to achieve HIV prevention and identify gaps and priorities. Concrete recommendations were provided by the groups and implementing partners to address existing policy and programmatic barriers. The discussions also informed the areas for secondary analysis of the BBSS data on MARP groups and provided recommendations on how to improve the preparation for the next round of the BBSS.

3. Key private sector leaders influence wider private sector response

The Guyana Business Community is cognizant of the importance of their role in ensuring a viable and protected workforce for national development. With the HIV epidemic, strong partnerships were established with the private sector contributing to the multi-sectoral response. Importantly at this critical juncture of the global economy, these partnerships are valued in a profound manner as they are seen as key tools to achieving sustainability of the response.

Guyana's private sector has responded in a variety of ways and through several mechanisms. The Guyana Business Coalition on HIV and AIDS has successfully brought on board some forty six (46) private sector companies to implement workplace training, workplace policy development and implementation, development of in-house communication material and campaigns, peer education, and counseling and testing and care and support services. These companies routinely organize sensitization sessions for their employees which involves showing of infomercial videos and often includes a technical person from the national programme who enlightens employees on up-to-date information as it relates HIV/AIDS.

The visibility of alliances built with the private sector to advance the goals of a sustainable public health response to HIV becomes evident during the national week of testing on

various levels. Many companies designate human resources and allocate an area where testing and counseling services are offered to their employees and their families. The financial and other required resources are borne entirely by the most of the companies during this time. Additionally, other companies commit financial and other resources to the secretariat in support of the week of activities.

On a larger scale, some twenty eight (28) companies unwaveringly support the Secretariat's Food Bank by donating dry food items in large quantities which contribute to a monthly food hamper given to eligible persons living with HIV/AIDS. Support from the private sector also comes from private media houses which commit free air-time to the Secretariat for national week of testing and other public health initiatives. In addition, several companies voluntarily organize blood drives to support the National Blood Transfusion Service target of 100 percent voluntary blood donation.

These cutting-edge public-private partnerships certainly do not go unnoticed and serves as a great example in building a strong, sustainable response to HIV/AIDS.

Hon. Dr. Leslie Ramsammy, Minister of Health (2001-2011) is flanked by Senior Members of the Guyana Business Coalition on HIV/AIDS and Tester/Counselors during the National Week of Testing, 2011

V. MAJOR CHALLENGES AND REMEDIAL ACTIONS

Whilst acknowledging the major progress made by the Government of Guyana in its response to HIV, the Guyana UNGASS Country Progress Report **2008-2009** identified the following challenges to achieving the UNGASS goals/targets and universal access. These include:

- Attracting and retaining suitable staff remain a challenge due to both rural to urban migration and emigration. This challenge is even greater in the regions beyond Region Four.

- Technical capacity to development and implement prevention strategies that target individual behavior.

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

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

- 'Stigma and discrimination' remains a challenge among health workers, the workplace, family, FBOs, and the community and act as barriers to disclosure, adherence to medication, and access to prevention, treatment and care services.

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

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

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

Table 18: Remedial actions and Government actions in response to Challenges

Remedial Actions	Government's Actions
1. Given the spatial disparities in development, attracting and retaining qualified staff will continue to be a challenge for Guyana. The Government will therefore seek to collaborate with development partners to develop a strategy for sustaining human resources.	The National AIDS Programme has been able to retain qualified personnel. The Ministry of Health conducted a human resource assessment to inform the development of a human resource strategy for the health sector. The national Public Health Reference Laboratory has managed to keep attrition very low and morale high. A strategy for sustaining human resources within the sector will be built into the plan during the next two years.
2. Development of technical capacity to development and implement prevention strategies that target individual behavior.	The Government of Guyana developed and launched the Guyana National Prevention Principles, Standards and Guidelines in 2010. The document serves as a tool to ensure that minimum standards to achieve HIV prevention are met and maintained. A cadre of 35 key persons from both governmental and non governmental agencies was trained as trainers and facilitators in the use of the prevention tool to facilitate the full application and further nationwide roll-out of the principles, standards and guidelines.
3. Develop programme aimed at increasing public awareness of the availability and importance of accessing TB screening and TB-HIV co-infection care	As part of the Ministry of Health NAPS Behavior Change Communication campaigns for 2011, a campaign on TB-HIV Co-infection was launch on World Tuberculosis (TB) Day to create greater public awareness of the need to adopt health seeking behaviors crucial for increasing individuals' access to earlier screening and treatment for TB.
4. Increase awareness and of the benefits of early treatment and reduce barriers to access to treatment services.	Linkages between VCT and treatment programmes have been enhanced with the introduction of Case Navigators to navigate newly diagnose persons to treatment programme. Referrals between TB treatment sites and ARV treatment sites were strengthened with the integration of tuberculin skin testing into the package of services provided at the ART sites. This was done by training of nurses, counselor-testers and DOTS workers in

Remedial Actions	Government's Actions
	placement and reading of Mantoux tests. More doctors are being trained and placed in the hinterland to provide services in under-served communities. Health care workers are being provided with anti-stigma training to address the reduction of stigma and discrimination among health care providers. A satellite care and treatment programme is being delivered to the Georgetown Prison by the National Care and Treatment Centre. Additionally a mobile care and treatment service was introduced to the hinterland regions in 2006. First Client satisfaction survey was conducted for HIV-positive patients attending HIV and TB. The survey had a two-fold objective; to determine patients' satisfaction with the services provided and to adopt necessary actions for quality improvement. Clients' level of satisfaction was generally high. Barriers to access included waiting time at reception area and low satisfaction with point of care at reception.
5. Expand and strengthen activities geared towards stigma and discrimination that serve as barriers to universal access to services	Health care workers are being provided with anti-stigma training to address the reduction of stigma and discrimination among health care providers. A policy statement against stigma and discrimination and code of ethics in the health sector was launched in 2011. The statement seeks to protect clients and most-at-risk-populations from the effects of discrimination when accessing health services. It also helps to promote health care provider education and sensitization on the issue of stigma and discrimination and how this reduces access to health services by those most in need of them. A meta-analysis of stigma and discrimination studies conducted in Guyana was done in 2011to examine *Stigma and Discrimination and their Impact on Persons Living with HIV in Guyana -Implications for Universal Access.* The

Remedial Actions	Government's Actions
	meta-analysis suggests that persons living with HIV are highly stigmatized in Guyana, however overt stigma or acts of discrimination are less likely to be experienced by persons living with HIV, particularly within the health sector, general workplace, faith based community. While the fear of being stigmatized may prevent persons living with HIV from disclosing their HIV status, such fear is not likely to deter females living with HIV from accessing care and treatment albeit away from their community. In contrast, however such fear is more likely to deter males and persons with diverse sexual identities from doing so. Efforts are therefore being directed at developing strategies that address covert stigma.
6 Review policies/laws to determine those that contradict national AIDS control policies.	Development of Draft legislation addresses a range of issues including establishing a legal age for accessing HIV and SRH services. A Ministry of Education School Health, Nutrition and HIV (SHN&H) Policy that stipulates that teaches should provide students with information on where to access condoms. In September 2009, the Government committed at the Universal Periodic Review at the United Nations, in Geneva, to hold consultations within two years on current laws which discriminate on the grounds of sexual orientation and gender identity. The Government will conduct national consultations on decriminalizing homosexuality in 2012.

Despite the progress referred to above several challenges were noted **in 2011**. These include:

- ***Reducing Financial Resources and Sustainability-*** Guyana over the years has received significant external support for its HIV response. Over the recent 5 years funding has been decreased with the close out of the World Bank Multi-country AIDS programme. PEPFAR in its second phase has recommitted to Guyana through a similar bilateral arrangement however with reductions in the yearly amount of funds allocated. This new environment has directed the Government of Guyana in placing high on its priority the issue of sustainability of its HIV response. In this regard, Guyana conducted in collaboration of USAID, an HIV sustainability

assessment (HAPSAT). Key areas were explored, including human resources for clinical services (TB, HIV treatment, PMTCT, VCT and others), training and availability of ARVS. Based on the findings, several recommendations were put forward. The Ministry has made significant advances in addressing some of these for examples task shifting among clinical staff and cross training between TB and HIV outreach staff, VCT and PMTCT personnel. Despite these, transitioning staff and other donor funded support from projects to the Public Service and Ministry of Health System still present challenges.

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

- ***Understanding and Reaching the Most at Risk populations:*** Guyana in its BCC strategy has defined priority groups for action including sex workers and men who have sex with men as some of the most at risk populations. There is information available on these populations through two rounds of biological and behavioral surveillance surveys. There is also additional qualitative information on these groups in further addressing stigma and discrimination and access to services. With this, Guyana has been successful in programming for these populations as demonstrated in the reducing HIV prevalence among the female sex worker population and to a lesser extent among men who have sex with men. Despite the progress noted, it is clear that the there remains significant knowledge gaps among these populations. Additionally, information is available for only a few of Guyana's geographic regions and little is known about clients sex workers. Whilst attempts were made to model the size of these populations, a clear estimate is still not available. To be better able to reach these populations with prevention and other services, it is critical to have a comprehensive understanding of their behaviors and that of their clients in all ten regions of Guyana. As Guyana prepares for its third round of BBSS among the MARPS, it is important to conduct a critical examination of the methodology to facilitate this.

  HIV Prevention among Youth has come into sharp focus over the past three years as the Surveillance Department of the Ministry of Health has reported an increase in the proportion of annual HIV cases among the 15-19 age group. Parallel to this, a comparison of the two rounds of the BSS conducted among in and out of school youth showed an increase in high risk behaviors and a decrease in the use of

condoms. The School Health Survey, the Tobacco survey and other related studies have also shown that the levels of undesired behaviors such as alcohol consumption, and tobacco use are high. In intensifying the response to youth, a National Youth Reference Group was established by the NAPS and a School Health Committee was formed jointly between the Ministry of Health and the Ministry of Education. Programming has intensified particularly for in- school youth in a structured manner, however key challenges still exist and would be the focus of the national programme over the medium term. A important component would be the roll out of the Health and Family Life Education programme.

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

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

VI. SUPPORT FROM COUNTRY'S DEVELOPMENT PARTNERS

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

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

- Global Fund for HIV, Tuberculosis and Malaria

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

- The Clinton Foundation

- Pan Caribbean Partnership against HIV/AIDS (PANCAP)

- Deutsche Gesellschaft fur Internationale Zusammenarbeit (GIZ)

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

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

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

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

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

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

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

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

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

VII. MONITORING AND EVALUATION ENVIRONMENT

Monitoring and Evaluation continued to play an integral role in the management of the HIV and AIDS response in order to track and report on the successes and weaknesses of the national programme. Coordination of the HIV M&E agenda in 2010 and 2011 was led by the NAPS M&E Unit with support from technical partners in the local UNAIDS, PAHO-WHO and USAID offices. These efforts were guided by the National HIV M&E Plan 2007-2011 and the M&E Operational Plan 2008-2011.

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

- **Capacity Building:** Training was conducted in the Statistical Package for Social Sciences (SPSS) in order to enhance the skills of the M&E Unit in conducting statistical analyses especially as it relates to the secondary analysis of the BBSS and other studies undertaken by the NAPS/MOH. The training was also extended to MOH Programme heads and staff of the Statistical Unit. A total of 20 persons were trained in the two (2) module programme: Introduction to SPSS & Data Analysis and Presentation. In addition, the M&E Unit along with other staff of the NAPS participated in a capacity building exercise on Leadership. Areas covered in the training included the Leading and Managing Framework and Coaching Principles.

- **Development of an M&E Database:** UNAIDS facilitated a five-day training workshop on the Country Response Information System (CRIS). The M&E Unit and NAPS Coordinators benefited from this transfer of knowledge along with staff of the Ministry's Surveillance, Statistical and Management Information System (MIS) Units. At the end of the training a work plan was developed for the implementation of CRIS and it was decided that the NAPS would conduct the pilot and provide feedback to the Ministry on the results of the Testing phase. It was agreed that CRIS will be used as the central database for HIV M&E data and will later be rolled out to the other disease/programme areas of the MOH.

- **Data Quality Assessment:** A Data Quality Audit was conducted by the Global Fund in 2011 following which a number of recommendations were adopted. The findings and lessons learned from this exercise served to inform the existing verification system for national and programmatic indicators.

- **HIV Prevalence Estimation Exercise:** The M&E staff were provided with training in the SPECTRUM/EPP for the national estimation exercise. A Consensus meeting was held to present the preliminary estimates to the various stakeholders including the broader MOH, donor partners and civil society. Comments were solicited on the assumptions used to generate the draft estimates and these were taken into consideration in finalizing the HIV prevalence. Subsequently, the NAPS M&E Unit worked along with the Programme Manager and experts from UNAIDS in developing the final HIV estimates for publication in the 2010 Global Report.

- **Reports & Surveys:** Staff were integrally involved in the collection, collation and presentation of data for the 2010 Universal Access Report, the 2011 ARV Survey

conducted by PAHO-WHO, The Early Warning Indicators and the Drug Resistance Survey. The NAPS conducted the secondary analysis of the BBSS 2008-2009 among MSM data and prepared and disseminated the results to the wider stakeholder group which included CSOs working with MSM.

NCPI Results for Monitoring and Evaluation

Six (6) respondents representing government were interviewed for this section. Respondents agreed that Guyana has developed one national Monitoring and Evaluation Plan for the period 2007- 2011. Some challenges in the development or implementation of the M&E Plan for HIV cited by the respondents are as follows:

- Consistency of reports
- Lack of Human resources
- Not all indicators of the developmental partners are harmonized.

Five (5) respondents reported that *'most partners'* have harmonized and aligned their M&E requirements, including indicators with the National M&E plan, compared to a minority who reported 'yes' in 2009. Five respondents agreed that the National Plan includes a data collection strategy. As in 2009 all respondents indicated that the data collection strategy addressed:

- Behavioral surveys
- Evaluation / research studies
- HIV surveillance
- Routine programme monitoring
- A well defined standardized set of indicators that includes sex and age disaggregation (where appropriate) compared a majority in 2007.

All respondents agreed that there were guidelines on tools for data collection, compared to a majority in 2009 who agreed. Four (4) respondents reported that there is a data dissemination and use strategy compared to a majority of respondents in 2009 who agreed. Three (3) respondents agreed that there is a data analysis strategy, compared to unanimous agreement among respondents in 2009. Four (4) respondents reported that HIV Drug resistance surveillance was included.

All respondents reported that there is a budget for implementing the M&E Plan, compared to a majority of the respondents in 2009 who reported that there was no budget for implementing the M&E plan. Three (3) respondents estimated that the budget is 1.5 – 10.0 percent of the total HIV programme funding budgeted for M&E activities.

National M&E Unit

All respondents reported that there is a functional national M&E unit, compared to a majority of the respondents who agreed in 2009. The respondents identified the following obstacles:

- Lack of human resources;

- Culture of M&E has not been accepted by staff and stakeholders;
- Data quality;
- Submission of reports to the unit in a timely manner;
- Lack of a central database on HIV; and
- Information manually centralized at testing sites with no electronic link.

Four (4) respondents reported that the M&E Unit is based at the NAPS. There were varying perceptions among respondents as it relates to the number of staff in the unit - three to four permanent staff. In comparison, half of the respondents in 2009 reported that they were not aware that such a unit exists.

Two (2) respondents reported that there is a mechanism in place to ensure all key partners submit their M&E data and reports to the M&E Unit for inclusion in the National M&E System, compared to half in 2009 who disagreed that a mechanism was in place. The data sharing mechanism was described as reports from HIV sites and NGOs being collected by the NAPS to further feed into the M&E System. Some of the major challenges cited in this area include:

- Having no central data base
- Data being stored manually
- Quality of data
- Timeliness of submissions
- Human resource
- Accuracy of data

National M&E Coordination

Five (5) respondents agreed that there is a National M&E Committee or Working Group that meets regularly to coordinate M&E activities, compared to all respondents who agreed in 2009.

Two (2) respondents reported that there is a central national database with HIV-related data. Respondents reported that the national database is located at Health Information and Statistical Unit at the Ministry of Health and consists of:

- Surveillance database for all HIV positives from 1996 to present
- PMTCT database ,which is further broken down by:
    - personal information;
    - geography;
    - demographics; and
    - biology

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

National Health Information System

Two (2) respondents reported that there is a functional Health Information System at the national level and one respondent agreed that it is at the sub national level. In comparison, a minority agreed in 2009. Five (5) respondents agreed that Guyana publishes an M&E report on HIV, including HIV surveillance data at least once a year, compared to 2009 when half agreed.

Culture of Data Use

Five (5) respondents reported that M&E data are used for programme improvement and resource allocation and all reported that data is used to develop and revise the national HIV response. Examples on the use of data include:

- Strengthening current programmes, specifically for TB and HIV co-infection;
- Strengthening adherence by actively following up "those lost to follow up" and bringing them back to clinic;
- Identify gaps, for example during the National week of testing, it was illustrated that services were not adequately accessed in Regions Three and Five. This information was used to plan outreach activities in those Regions;
- In the development of the new strategy for 2012 – 2020, M&E information was used to: -
    - analyze the gaps
    - develop the baseline
- Seen as part of the requirements of international reports.

Main challenges are as follows:

- Perception of M&E needs to change;
- Greater utilization of data in programme planning;
- Human resources to be trained in M&E;
- HIV Surveillance data need to be done yearly, the BBSS is not done regularly and the Demographic Household Survey was done only once in 2009; and
- Verification of programme data.

Three (3) respondents reported that in the last year, M&E training was conducted at the national level, while two (2) respondents reported that training was done at the sub national level and service delivery level including civil society. In contrast, less than half of the respondents in 2009 reported that there is a plan for increasing human capacity at the national level, all agreed that there was none at the sub national level, and less than half agreed that M&E training was conducted at the service delivery levels.

Three (3) respondents reported that other M&E capacity building activities were conducted other than training and cited supportive supervision as an example.

Respondents reported that since 2009 there were many key achievements in the HIV-related monitoring and evaluation as follows:

- Expansion and increase of the number of people on treatment;
- Availability of HAART;
- Collaborative efforts to synchronize HIV / TB prevention and treatment services;

- A staffed and functional National M&E Unit;
- Central database development in progress;
- Development of the core indicators;
- Some accuracy in the routine collection and validation of data; and
- Strengthening of data verification system.

Remaining challenges include but are not limited to:

- Data collection still manual at individual clinics and centres;
- Adequate human resources;
- Coordination with other M&E Units;
- M&E unit functioning as a National M&E Clearing House;
- Data Quality;
- Data Accuracy;
- Timeliness in submission of reports to the Unit;
- Technical support;
- Analysis of data;
- Implementing and rolling out the central database for HIV.

ANNEXES

ANNEX 1: ***Core Indicators for Global AIDS Response Progress Reporting***

Targets	Indicator	Data origin	Period	Value	Numerator	Denominator	Remarks
Target 1: Reduce sexual transmission of HIV by 50 percent by 2015 General Population	**1.1** Percentage of young women and men aged 15-24 who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconception about HIV transmission	DHS	2009	51.1%	1524	2983	
	Males	DHS	2009	46.6%	559	1200	
	Females	DHS	2009	54.1%	965	1783	
	Males 15-19	DHS	2009	44.5%	307	689	
	Males 20-24	DHS	2009	49.4%	252	511	
	Females 15-19	DHS	2009	53.1%	540	1016	
	Females 20-24	DHS	2009	55.4%	425	767	
	1.1.1 Percentage who correctly identify that the risk of HIV transmission is reduced by having sex with one non-infected partner	DHS	2009	81.3%	2425	2983	
	Males	DHS	2009	83.8%	1006	1200	
	Females	DHS	2009	79.6%	1419	1783	
	Males 15-19	DHS	2009	81.4%	561	689	
	Males 20-24	DHS	2009	86.9%	444	511	
	Females 15-19	DHS	2009	78.8%	801	1016	
	Females 20-24	DHS	2009	80.6%	618	767	
	1.1.2 Percentage who correctly reported that consistent condom use reduces the risk of HIV transmission	DHS	2009	83.3%	2485	2983	
	Males	DHS	2009	83.5%	1002	1200	

Targets	Indicator	Data origin	Period	Value	Numerator	Denominator	Remarks
	Females	DHS	2009	83.2%	1483	1783	
	Males 15-19	DHS	2009	84.4%	582	689	
	Males 20-24	DHS	2009	82.4%	421	511	
	Females 15-19	DHS	2009	81.8%	831	1016	
	Females 20-24	DHS	2009	85.0%	652	767	
	1.1.3 Percentage who correctly reported that a healthy looking person can have HIV	DHS	2009	86.3%	2575	2983	
	Males	DHS	2009	86.3%	1036	1200	
	Females	DHS	2009	86.3%	1539	1783	
	Males 15-19	DHS	2009	83.8%	578	689	
	Males 20-24	DHS	2009	89.6%	458	511	
	Females 15-19	DHS	2009	84.9%	863	1016	
	Females 20-24	DHS	2009	88.1%	676	767	
	1.1.4 Percentage with knowledge that mosquitoes cannot transmit HIV	DHS	2009	71.8%	2142	2983	
	Males	DHS	2009	67.5%	810	1200	
	Females	DHS	2009	74.7%	1332	1783	
	Males 15-19	DHS	2009	63.9%	440	689	
	Males 20-24	DHS	2009	72.4%	370	511	
	Females 15-19	DHS	2009	76.0%	772	1016	
	Females 20-24	DHS	2009	73.0%	560	767	
	1.1.5 Percentage with knowledge that sharing a meal cannot transmit HIV	DHS	2009	84.9%	2533	2983	
	Males	DHS	2009	82.0%	984	1200	
	Females	DHS	2009	86.8%	1549	1783	
	Males 15-19	DHS	2009	80.7%	556	689	
	Males 20-24	DHS	2009	83.8%	428	511	
	Females 15-19	DHS	2009	86.9%	883	1016	
	Females 20-24	DHS	2009	86.8%	666	767	
	1.2 Percentage of young women and men aged 15-24 who have had sexual	DHS	2009	13.6%	407	2983	

Targets	Indicator	Data origin	Period	Value	Numerator	Denominator	Remarks
	intercourse before the age of 15						
	All females	DHS	2009	10.1%	180	1783	
	All males	DHS	2009	18.9%	227	1200	
	Females 15-19	DHS	2009	10.3%	105	1016	
	Females 20-24	DHS	2009	9.8%	75	767	
	Males 15-19	DHS	2009	15.7%	108	689	
	Males 20-24	DHS	2009	23.2%	119	511	
	1.3 Percentage of adults aged 15-49 who have had sexual intercourse with more than one partner in the last 12 months	DHS	2009	4.9%	417	8518	
	All Females	DHS	2009	1.3%	65	4996	
	All Males	DHS	2009	9.9%	352	3522	
	Females 15 – 19	DHS	2009	1.1%	11	1016	
	Females 20 – 24	DHS	2009	1.5%	12	767	
	Females 25 - 29	DHS	2009	2.2%	15	658	
	Females 30 - 39	DHS	2009	1.6%	22	1342	
	Females 40 - 49	DHS	2009	0.4%	5	1213	
	Males 15 - 19	DHS	2009	8.00%	55	689	
	Males 20 - 24	DHS	2009	18.40%	94	511	
	Males 25 - 29	DHS	2009	9.5%	44	462	
	Males 30 - 39	DHS	2009	10.1%	100	990	
	Males 40 - 49	DHS	2009	6.4%	56	870	
	1.4 Percentage of adults aged 15-49 who have had more than one sexual partner in the past 12 months who report the use of a condom during their last intercourse ***Note**: There were fewer than 25 unweighted cases for females 15-19 and 20-24, 25-29, 30-39, 40-49, and have been suppressed in DHS report.*	DHS	2009	-	-	-	There was a low level of response among women to this question in the DHS. Only 14 women reported having intercourse with a partner other than their husband in past 12 months. Of these only 7 answered the question of 'having used a condom at last intercourse".

Targets	Indicator	Data origin	Period	Value	Numerator	Denominator	Remarks
	All Females	DHS	2009	-	-	-	
	All Males	DHS	2009	65.5%	228	348	
	Females 15 -19	DHS	2009	-			
	Females 20 – 24	DHS	2009	-			
	Females 25 – 29	DHS	2009	-			
	Females 30-39	DHS	2009	-			
	Females 40-49	DHS	2009	-			
	Males 15-19	DHS	2009	85.8%	47	55	
	Males 20-24	DHS	2009	70.4%	66	94	
	Males 25-29	DHS	2009	(76.7%)	34	44	Figures in parenthesis are based on 25-49 unweighted cases.
	Males 30-39	DHS	2009	56.6%	57	100	
	Males 40-49	DHS	2009	43.4%	24	55	
	1.5 Percentage of women and men aged 15-49 who received an HIV test in the past 12 months and know their results	DHS	2009	24.8%	2110	8518	
	All Females	DHS	2009	27.0%	1349	4996	
	All Males	DHS	2009	21.6%	761	3522	
	Females15-19	DHS	2009	21.9%	223	1016	
	Females 20-24	DHS	2009	39.3%	301	767	
	Females 25-29	DHS	2009	36.4%	240	658	
	Females 30-39	DHS	2009	27.7%	372	1342	
	Females 40-49	DHS	2009	17.6%	213	1213	
	Males15-19	DHS	2009	13.5%	93	689	
	Males 20-24	DHS	2009	23.6%	121	511	
	Males 25-29	DHS	2009	29.2%	135	462	
	Males 30-39	DHS	2009	22.6%	224	990	
	Males 40-49	DHS	2009	21.6%	188	870	
	1.6 Percentage of young people aged 15-24 who are living with HIV	ANC Programme data	2010 2011	0.88% 1.08%	101 147	11,441 13,490	There is no disaggregation by age for this indicator. Data represents all women testing

Targets	Indicator	Data origin	Period	Value	Numerator	Denominator	Remarks
							positive within the total ANC population
Sex Workers	**1.7** Percentage of sex workers reached with HIV prevention programmes	BBSS	2009	21.4%	42	196	This indicator is measured by two questions
	<25 yrs			17.6%	15	85	The Peer Educator Programme entails distribution of condoms, IEC materials and referral to HIV testing sites.
	25+ yrs			24.3%	27	111	
	Percentage who know of place in community to access HIV test	BBSS	2009	54.0%	108	200	
	<25 yrs			53.5%	46	62	
	25+ yrs			54.4%	86	114	
	Percentage who have been reached by a "Keep the Light on Programme" Peer Educator within the last 12 months	BBSS	2009	38.8%	76	196	This question was used to measure outreach to FSWs. The Peer Educator Programme entails distribution of condoms, IEC materials and referral to HIV testing sites.
	<25 yrs			38.8%	33	85	
	25+ yrs			38.7%	43	111	
	1.8 Percentage of sex workers reporting the use of a condom with their most recent client	BBSS	2009	94.2%	179	190	
	<25 yrs	BBSS	2009	92.4%	73	79	
	25+ yrs	BBSS	2009	95.5%	106	111	
	1.9 Percentage of sex workers who have received an HIV test in the past 12 months and know their results	BBSS	2009	83.9%	131	156	
	<25 yrs	BBSS	2009	87.9%	51	58	
	25+ yrs	BBSS	2009	81.6%	80	98	
	1.10 Percentage of sex workers who are living with HIV	BBSS	2009	16.6%	30	181	

Targets	Indicator	Data origin	Period	Value	Numerator	Denominator	Remarks
	<25 yrs	BBSS	2009	6.6%	5	76	
	25+ yrs	BBSS	2009	23.8%	25	105	
Men who have sex with men	**1.11** Percentage of men who have sex with men reached with HIV prevention programmes	BBSS	2009	-	-	-	This indicator is measured by two questions. Unable to calculate composite since one of the questions was not asked in the BBSS 2009.
	Percentage who know of place in community to access HIV test	BBSS	2005	17.2%			This question was asked in the 2005 BBSS but not in the 2009 BBSS
	Percentage who have been reached by a Peer Educator within the last 12 months	BBSS	2009	68.7%	90	131	The Peer Educator Programme entails distribution of condoms, IEC materials and referral to HIV testing sites.
	<25 yrs	BBSS	2009	61.2%	30	49	
	25+ yrs	BBSS	2009	73.2%	60	82	
	1.12 Percentage of men reporting the use of a condom the last time they had anal sex with a male partner						The BBSS indicator is the same, except that it distinguishes between 3 classes of partners as specified below.
	Regular partner	BBSS	2009	79.7%	51	64	
	<25 yrs	BBSS	2009	80.0%	16	20	
	25+ yrs	BBSS	2009	79.5%	35	44	
	Non-regular partner	BBSS	2009	75.0%	30	40	
	<25 yrs	BBSS	2009	82.4%	14	17	
	25+ yrs	BBSS	2009	69.9%	16	23	
	Commercial partner	BBSS	2009	84.2%	16	19	
	<25 yrs	BBSS	2009	100%	8	8	
	25+ yrs	BBSS	2009	72.7%	8	11	
	1.13 Percentage of men who have sex with men that have received an HIV test in the past 12 months and know their results	BBSS	2009	72.3%	73	101	

Targets	Indicator	Data origin	Period	Value	Numerator	Denominator	Remarks
	<25 yrs	BBSS	2009	85.7%	30	35	
	25+ yrs	BBSS	2009	65.2%	43	66	
	1.14 Percentage of men who have sex with men who are living with HIV *Note: Data not disaggregated by age group*	BBSS	2009	19.4%	21	108	
Target 2: Reduced transmission of HIV among people who inject drugs by 50 percent by 2015	**2.1** Number of syringes distributed per person who injects drugs per year by needle and syringes programmes	-	-				2009 BSS findings suggest that this is not a major population
	2.2 Percentage of people who inject drugs who reported the use of a condom at last sexual intercourse	-	-				
	2.3 Percentage of people who inject drugs who reported using sterile injecting equipment the last time they injected	-	-				
	2.4 Percentage of people who inject drugs that received an HIV test in the past 12 months and know their results	-	-				
	2.5 Percentage of people who inject drugs who are living with HIV	-	-				
Target 3: Eliminate mother-to-child transmission of HIV by 2015 and substantially reduce AIDS-related maternal deaths	**3.1** Percentage of HIV-positive pregnant women who received antiretrovirals to reduce the risk of mother-to-child transmission ***Note**: **Numerator** is number of pregnant women who received ARV drugs during the past 12 months to reduce mother-to-child transmission and **Denominator** is*	Most recent Modeling in Spectrum 4.47 ANC Programme Report	2010 2011	110.5% 132.6%	158 171	143 129	*Denominator from Estimates:* Number of HIV+ pregnant women is 143 (2010) and 129 (2011) *Numerator from programme data:* 158 (2010) and 171(2011)

Targets	Indicator	Data origin	Period	Value	Numerator	Denominator	Remarks
	the estimated number of HIV-positive pregnant women within the past 12 months						*Using programme data for Denominator HIV+ pregnant women:* 82.7% (158/191) in 2010 and 64.8% (171/264) in 2011
	3.2 Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth	NPHRL data	2011	34.1%	90	264	*Numerator:* 90 infants were tested within 2 months; 50 tested between 2 to 12 months. 73 tested 12 to 18 months. *Denominator:* 264 positive pregnant women giving birth in 2011
	3.3 Mother-to-child transmission of HIV modeled	Most recent Modeling in Spectrum 4.47	2011	4.5%	5	110	*From the Estimates:* *Numerator:* new infections 0-14 (5) denominator: women needing PMTCT (110) *According to programme data*, there were 5 babies testing positive out of 264 positive women giving birth (1.9% transmission)
Target 4: Have 15 million people living with HIV on antiretroviral treatment by 2015	**4.1** Percentage of eligible adults and children currently receiving antiretroviral therapy ***Note: Numerator*** *is number of adults and children currently receiving ARV combination therapy in accordance with the nationally recognized approved*	Most recent Modeling in Spectrum 4.47 NAPS	2010 2011	71.0% 77.2%	3,059 3,432	4,307 4,444	*Denominator from the Estimates:* Children and adults in need of ART 4,307 (2010) and 4,444 (2011) *Numerator from programme data:* Number of adults & children receiving ART: 3059

Targets	Indicator	Data origin	Period	Value	Numerator	Denominator	Remarks
	treatment protocol at the end of the reporting period and ***Denominator*** *is estimated number of eligible adults and children*	Programme Reports					(2010) and 3,432 (2011)
	Males		2011	60.7%	1535	2529	
	Females		2011	99.1%	1897	1915	
	<15 yrs		2011	97.6%	201	206	
	15+yrs		2011	76.2%	3231	4238	
	4.2 Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy ***Note****: This is the average survival values of 16 cohorts after 12 months on treatment. The cohorts cover the period January to December 2010.*	Patient Monitoring System (NAPS)	2010 2011	80.7% 80.4%	468 426	580 530	
	Males	PMS (NAPS)	2011	77%	208	270	
	Females	PMS (NAPS)	2011	83.9%	218	260	
	<15 yrs	PMS (NAPS)	2011	81.8%	18	22	
	15+ yrs	PMS (NAPS)	2011	80.3%	408	508	
Target 5. Reduce tuberculosis deaths in people living with HIV by 50 percent by 2015	**5.1** Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV ***Note:*** *Denominator: WHO estimated number of incidence TB cases in people living with HIV WHO estimate unavailable for 2011, therefore the 2010 estimate was reused as the denominator in 2011*	Chest Clinic Programme Reports WHO Estimates 2010	2010 2011	41% 65%	82 130	200 200	*Denominator from the 2010 WHO Estimates*: HIV/TB co-infected cases is 200 *Numerator from programme data:* 82 (2010) and 130 (2011) *Using Programme data for Denominator* TB/HIV co-infected cases: 50.9% (82/161) in 2010 and 88.4 % (130/147) in 2011

Targets	Indicator	Data origin	Period	Value	Numerator	Denominator	Remarks
Target 6: Reach a significant level of annual global expenditure (US22-24 billion) in low and middle-income countries	**6.1** Domestic and international AIDS spending by categories and financing sources	-	-				Information not available
Target 7: Critical Enablers and Synergies with Development Sectors	**7.1** National Commitments and Policy Instruments (prevention, treatment, care and support, human rights, civil society involvement, gender, workplace programmes, stigma and discrimination and monitoring and evaluation)	Key informant interviews	2011				Attached to the Narrative report
	7.2 Proportion of ever-married or partnered women aged 15-49 who experienced physical violence from a male intimate partner in the past 12 months						Data not available. The DHS 2009 asked about women's attitude towards wife beating: 16.3% of women 15-49 agree with at least one specified reason: DHS questions asked whether beating is justified by a husband if the wife burns the food, argues with him, goes out without telling him, neglects the children, refuses to have sexual intercourse with him.
	7.3 Current school attendance among orphans and non-orphans aged 10-14	-	-				Indicator relevant but data not available
	7.4 Proportion of the poorest households who received external economic support in the last 3 months	-	-				Indicator relevant but data not available

Annex 2: Consultation/preparation process for the national report on monitoring the follow-up to the Declaration of Commitment on HIV and AIDS

1) Which institutions/entities were responsible for filling out the indicator forms?

a) NAC or equivalent	Yes
b) NAP	Yes
c) Others (key stakeholders)	Yes

2) With inputs from

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

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

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

4) Are the survey results stored centrally? Yes

5) Are data available for public consultation? Yes

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

Name/title: Dr. Shanti Singh-Anthony, M.D., M.P.H.- Programme Manager, National AIDS Programme, Ministry of Health Guyana

ANNEX 3: National Commitment and Policy Instrument (through CRIS)

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ANNEX 4: Contributors to the Reporting Process

Country Team

1. Dr. Shanti Singh- Programme Manager, NAPS
2. Ms. Desiree Edghill, Civil Society Representative
3. Dr. Bendita Lachmansingh- Epidemiologist, NAPS
4. Ms. Fiona Persaud- M&E Lead, NAPS
5. Ms. Sophia Collier- M&E Officer, NAPS
6. Ms. Suzette Harald- M&E Officer, NAPS
7. Ms. Otilia St. Charles- M&E Advisor, UNAIDS, Guyana
8. Dr. Rosalinda Hernandez- FCH/HIV/STI Advisor/PAHO/WHO, Guyana
9. Mr. Dereck Springer- Consultant, Country Progress Report
10. Ms. Zenita Nicholson- NCPI Consultant

NCPI Interviewees

1. Dr. Shanti Singh- Programme Manager of NAPS
2. Dr. Bendita Latchmansingh- Epidemiologist, NAPS
3. Ms. Fiona Persaud- M&E Lead, NAPS
4. Dr. Mohanlall – Programme Manager, National TB Unit
5. Ms. Jennifer Ganesh- BCC Coordinator, NAPS
6. Mr. Nazim Hussain- Community Mobilization Coordinator, NAPS
7. Dr. Shamdeo Persaud- CMO, Ministry of Health
8. Dr. Ruth Ramos- National Care and Treatment Centre
9. Ms. Shevonne Benn- Home Based Care Coordinator, NAPS
10. Ms. Deborah Success- VCT National Coordinator, NAPS
11. Ms. Nafeeza Ally- Social Services Coordinator, NAPS
12. Mr. Somdatt Ramessar- Food Bank Manager, NAPS
13. Mr. Nicholas Persaud- Care & Treatment Coordinator, NAPS
14. Mr. Patrick Mentore- Line Ministries Coordinator, HSDU
15. Ms. Alisha Pompey- President's Youth Award PYARG, Ministry of Culture, Youth & Sport
16. Dr. R. Del Prado- Country Director, UNAIDS
17. Ms. Jewel Crosse- UNICEF
18. Dr. Rosalinda Hernandez, PAHO/WHO Rep/chair UN Theme group on HIV/AIDS
19. Mr. Oswald Alleyne- Strategic Information Officer, PEPFAR USAID
20. Mr. Sean Wilson- ILO
21. Mr. Crystol Albert- G+
22. Mr. Joel Simpson- SASOD
23. Ms. Colleen Mc Ewan- Guyana Rainbow Association
24. Ms. Sheila Fraser- Guyana Responsible Parenthood Association
25. Ms. Falicia Adams- Lifeline Counseling Services
26. Mr. Hazel Maxwell-Benn Managing Director, Linden Care Foundation

27. Ms. Shondell Butters- Hope for All
28. Ms. Marlyn Subryan- Hope Foundation
29. Ms. Desiree Edghill- Artistes In Direct Support
30. Ms. Ashanta Osbourne- Guyana Red Cross
31. Mr. Dwayne Mitchell- Executive Director, Youth Challenge Guyana
32. Ms. Jennifer Flats- Operation Restoration
33. Ms. Susan French- Guyana Business Coalition on HIV/AIDS
34. Ms. Miriam Edwards- Guyana Sex Worker Coalition
35. Ms. Shabakie Fernandes / Ms. Lorna Mc Pherson- Guyana Faith Coalition on HIV/AIDS

Participants at the Consensus Meeting

1. Dr. Bheri Ramsaran-Minister of Health
2. Mr. Leslie Cadogan -Permanent Secretary, MOH
3. Dr. Shanti Singh- Programme Manager, NAPS
4. Dr. Ruben Del Prado- Country Director, UNAIDS Guyana
5. Dr. Ruth Ramos- National Director, National Care & Treatment Centre
6. Dr. Janice Woolford- Director, Maternal Child Health Department MOH
7. Dr. Rosalinda Hernandez- FCH/HIV/STI Advisor/PAHO/WHO, Guyana
8. Ms. Otilia St. Charles- M&E Advisor, UNAIDS
9. Ms. Nicolette Henry- Programme Officer, CDC
10. Ms. Glendell Glen- Youth Friendly Services Coordinator, MOH
11. Ms. Shabakie Fernandes- Coordinator, Guyana Faith Coalition
12. Mr. Jason Shepherd- HIV/AIDS officer, UNFPA Guyana
13. Ms. Megan Kearns-Technical director, GHARP
14. Ms. Preeta Saywack- Surveillance Officer, MOH
15. Mr. Lyndon Welch- HIV/AIDS Support Group President, Davis Memorial Hospital
16. Dr. San San Min- Chief of Party, Supply Change Management Inc
17. Ms. Colleen Mc Ewan- Executive Director, Guyana Rainbow Foundation
18. Mrs. Beverley Braithwaite- Chan, Executive Director Guyana Responsible Parenthood Association
19. Ms. Falicia Adams- Lifeline Counseling Services
20. Ms. Rochelle Perry- Social Services Officer, Guyana Red Cross Society
21. Ms Merle Mendonca Co President Guyana Human Rights Association
22. Ms. Desiree Edghill Executive Director Artistes in Direct Support
23. Ms. Jewell Crosse- Youth and Adolescent Development Officer UNICEF, Guyana
24. Mr. Dmitri Nicholson Executive Director Youth Challenge Guyana
25. Ms. Miriam Edwards- Director Guyana Sex Work Coalition
26. Mr. Earl Morris- HIV Focal Point ,Guyana Sugar Cooperation
27. Ms. Shevonne Benn- HBC Coordinator, NAPS
28. Fiona Persaud – M&E Lead, NAPS
29. Ms. Sophia Collier- M&E Officer, NAPS
30. Ms. Jennifer Ganesh- Prevention Coordinator, NAPS
31. Ms. Elizabeth Mc Almont- MARPS Coordinator, NAPS

32. Dr. Ravi Homenauth- Healthqual Officer, NAPS
33. Ms. Deborah Success- Hall- VCT Coordinator, NAPs
34. Ms. Zenita Nicholson- NCPI Researcher
35. Mr. Nazim Hussain- Community Mobilization Coordinator, NAPS
36. Dr. Ravindra Swammy- Consultant/STI Coordinator, NAPS
37. Mr. Antonio Paul- HIV/AIDS Support Group Leader, West Demerara Regional Hospital
38. Mr. Earl Morris- HIV/AIDS Focal Point, Guyana Sugar Corporation
39. Ms. Sophia Brewer- PEPFAR Coordinator, USAID
40. Mr. Somdatt Ramessar- Food Bank Manager, NAPS
41. Ms. Edris George- USAID Guyana
42. Mr. Oswald Alleyne- Strategic Information Officer, USAID Guyana
43. Mr. Nicholas Persaud- Care and Treatment Coordinator, NAPS
44. Ms. Naomi Singh- Programme Officer, International labor Organization
45. Ms. Suzette Harald- M&E Officer, NAPS
46. Ms. Licelot Eralte Mercer- Epidemiologist, CDC
47. Ms. Schemel Patrick- Guyana Business Coalition on HIV/AIDS
48. Ms. Jessica Small- VCT Technical Officer, MOH
49. Ms. Jacqueline Delph- Vice Chair, National AIDS Committee
50. Ms. Roxanne George- Representative, Guyana Association of Women Lawyers
51. Mr. Pravesh Bhola- Assistant Store Keeper, National Milling Company, Guyana
52. Ms. Nafeza Ally- Social services Coordinator, NAPS
53. Ms. Merica George- Prevention Coordinator, Artiste in Direct Support
54. Ms. Lynette Baird- Researcher/Writer, NAPS
55. Ms. Mabiola Amsterdam- Prevention Coordinator, Hope for All
56. Ms. Angelina Karim- Administrative Assistant, Maternal & Child Health Programme, MOH
57. Ms. Alisha Pompey- President, President Youth Award
58. Ms. Latoya Giles- Reporter, Kaieteur News
59. Ms. Samantha Hall- Programme Associate, UNAIDS Guyana
60. Ms. Ariana Gordon- Senior Reporter, Guyana Times