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Condensed COP Report

Guyana

2005

Country Operational Plan (COP)

Country Name: Guyana

Fiscal Year 2005

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Table 1: Country Program Strategic Overview

1.1 **National Response**

There is a critical lack of reliable data to accurately describe the HIV/AIDS epidemic in Guyana. The true extent of the problem is unknown; AIDS case reporting is incomplete, with an estimated 60 percent of cases not reported, and seroprevalence data are outdated. The private sector contributes significantly to the underreporting. Because the Indo-Guyanese community is more likely to consult private practitioners, this contributes to an erroneous belief that HIV/AIDS is an Afro-Guyanese problem.

The epidemic is generalized, with a relatively low prevalence, and by the end of 2001, 3,068 cases had been reported. Females account for 39 percent of all HIV/AIDS cases, and in the 15–19 age group significantly *more females than males have HIV/AIDS. The largest number of HIV/AIDS cases is reported in the 20–39* age group, peaking in the 25-29 age group. Because of stigma and discrimination, few Guyanese are willing to be tested for HIV. Region 4, which includes the capital, Georgetown, has 74 percent of reported HIV/AIDS cases and an *incidence rate of 755 per 100,000 people*. One of the consequences is that the mean age of survival between diagnosis and death is 4.5 months.

The Ministry of Health reported limited data for 2002, indicating HIV prevalence rates of zero to 8.0 percent among pregnant women in Regions 4 and 6; 15.1 percent among men, and 12.0 percent among women seeking treatment for a sexually transmitted infection at the Genito-Urinary Medicine (GUM) Clinic in Georgetown. In 2001, seroprevalence among blood donors was reported to be 1.0 percent.

Little seroprevalence data are available for the most-at-risk populations in Guyana. A 1997 study of female commercial sex workers in Georgetown found a 45.0 percent HIV seroprevalence; a 2000 study found a rate of 31.0 percent. However, the two sets of data came from two different ad hoc studies with different sampling frames. A 1998 study of miners living in Guyana's interior and away from their families found a seroprevalence of 6.3 percent. Data do not exist for male and transvestite sex workers, or for men who have sex with men. HIV prevalence in patients with tuberculosis (TB) was 30 percent–41 percent in 2000–2001. Injecting drug use is not believed to be a significant problem in Guyana.

1.1.1 National HIV/AIDS Action Framework

Between 1998 and 2000, the Government of Guyana was the main source of financial support for HIV/AIDS programs. Since then, external funding has surpassed domestic sources funding by approximately 50 percent. USG Agencies have a close working relationship with the MOH and continues to be the largest source of financial and technical assistance to the national program. The current national response includes:

- Strengthening of the surveillance system to produce information that will inform the design of interventions for HIV/AIDS reduction and planning care for those affected.
- A plan to increase access to voluntary counseling and testing (VCT);
- A pilot program at ante-natal care sites to integrate services to prevent mother-to-child transmission of HIV;
- AIDS awareness and education training at worksites;
- To reduce the risk and vulnerability to infection with HIV through targeted public education efforts focused on health care providers, youth, employers, employees, entertainers, commercial sex workers and men who have sex with men ; and
- Provision of free antiretroviral therapy for HIV-positive patients with two OIs, through the GUM clinic.

Though the MOH has tried to stay abreast of current interventions in HIV/AIDS prevention and treatment, its programs are hampered by shortages of human and financial resources, poor infrastructure, and prevailing attitudes about HIV/AIDS. Recently, the GOG has made efforts to increase the involvement of other sectors in the fight against HIV/AIDS, but to date this involvement has been quite limited. However, the Ministry of Education, and the Ministry of Culture, Youth and Sport now have sectoral workplans in support of the National Strategic Plan.

1.1.2 National HIV/AIDS Coordinating Authority

The Presidential AIDS Commission was initiated at the behest of President Bharrat Jagdeo in June 2004. It is chaired by the president and includes nine Sector Ministers, representatives from funding agencies and project staff from the Health Sector Development Unit. The Commission's role is to support and supervise the implementation of the National Strategic Plan for HIV/AIDS 2002 – 2006. The Commission will provide strong visibility and accountability for the country's response and will operate through a Technical Support Unit, and provide funding for NGOs registered to work in HIV/AIDS and support and coordinate inter-ministerial involvement.

1.1.3 National HIV/AIDS M&E System

During various GOG and donor meetings, the issues of monitoring, performance indicators, information systems and evaluation have been raised extensively. The Government is concerned that all parties involved with the country's development consider this matter seriously and stress the importance of communication and solid collaboration in light of the increasing number of partners.

There is a need to create a central agency or inter-sectoral group that has a handle on HIV/AIDS information in-country, with the appropriate links to the Presidential AIDS Commission (PAC), Ministry of Health, the World Bank, the GFATM Country Coordination Mechanism, USG as well as the donor coordination forum currently used, the Expanded Theme Group on HIV/AIDS. A M&E Director, supported by PEPFAR funds, will work in partnership with the MOH and USG; together they will be responsible for coordinating the assistance/input given to all sectors and ministries of the GOG for managing data flow and use.

A structured approach to strategic information (including surveillance, HMIS and monitoring and evaluation) is therefore an urgent need at both strategic and operational levels. A HIV/AIDS Monitoring and Evaluation Advisory Group will be formed through a consultative group process, facilitated by the Expanded Theme Group on HIV/AIDS. Its purpose is to advise on the development and implementation of appropriate institutions, processes and capacities which will ensure the adequate monitoring and assessment of Guyana's national response to HIV/AIDS. Its first task will be the coordination of the development of a National HIV/AIDS Monitoring and Evaluation Strategy for the Government of Guyana.

1.2 Network Model

The Network Model proposed by the Office of the Global AIDS Coordinator (OGAC) will be the conceptual framework used to develop the Guyana system of HIV/AIDS treatment and care. This will involve active public-private partnerships and will build upon the current central health facility based model to establish a sustainable network model. In this approach, HIV/AIDS treatment and care will be integrated within the existing healthcare delivery system in Guyana. However, the capacity of this system will be increased to assure that services are available from the central facility at GPHC to rural facilities. Community health workers, community volunteers, NGOs, CBOs, FBOs and associations of PLWHA will be used to provide support, adherence and counselling systems to patients. Technical support will be provided from the central health facility (GUM) to treatment facilities at all levels of the network. In turn, these facilities will support patients and refer those needing higher levels of care. There will also be an emphasis on a family oriented, integrated, comprehensive, patient-centered approach to care and treatment.

Characteristics of the proposed network model for HIV care and treatment in Guyana will include:

• Strengthening the linkages between central health facilities (GUM clinic) and district hospitals, local health clinics and private and faith-based NGO's.

• Clinical and community based social support staff work together to care for the HIV infected patient.

• State-of the art clinical care settings where treatment is provided at designated "specialty" sites.

• Use of community health care workers to assist with follow-up and to support care and adherence.

• Inclusion of NGO's as partners to clinicians to provide support services to PLWHA's.

• Inclusion of international and private support to build network capacity and lend support and resources to HIV/AIDS initiatives.

1.3 Human Capacity Development

The Guyanese Diaspora has resulted in a "brain drain" of educated professionals. These emigrants span a broad spectrum, from entrepreneurs and financial experts to health care workers and teachers. Of note, the US Consulate reports that Guyana has the 10th highest rate of emigration rate in the world, and the MOH reports that 90% of medical school graduates leave the country following graduation. This loss of human capital undermines the GOG's capacity to provide quality health, education, and social services; impedes government administration and management; and fosters dependence on donors. The private sector also suffers from these human resource constraints, because the limited availability of qualified personnel requires difficult choices between increasing personnel costs (e.g., expatriate staff), decreasing profits, or lowering standards. Today, there are an estimated 700,000 Guyanese living abroad, roughly 30 percent living in New York alone. Declining fertility rates also contribute to a dwindling population. The use of non-health personnel and retired health personnel in positions such as VCT and PMTCT counseling and community outreach is one potential solution to the human capacity shortage; another is use of lower-level health care staff to provide services (e.g., medexes rather than physicians). Both these solutions require extensive investments in training, supervision, monitoring, and evaluation to assure that quality is maintained.

1.4 USG Partners

The American Embassy in Guyana is working hard to assist Guyana to cope with and reduce the effects of HIV/AIDS infection in the country. This effort is being led by Ambassador Bullen through an Embassy-wide HIV/AIDS Coordination Committee that meets biweekly consisting of US Peace Corps, Department of Defense, the Centers for Disease Control and Prevention (CDC) and U.S. Agency for International Development (USAID).

All agencies are working together to implement an integrated comprehensive HIV/AIDS response. The initial area of collaboration was the implementation of President Bush's Prevention of Mother to Child Transmission (PMTCT) Initiative. CDC and USAID have worked closely with the Ministry of Health to conduct a rapid PMTCT assessment, develop a PMTCT expansion plan, roll out services to 14 new sites, conduct ANC facility surveys, and are now working together to increase human and facility resource capacity. Other areas of joint implementation will include voluntary counseling and testing (VCT), surveillance, and risk reduction.

1.4.1 Public-Private Partnerships

The Ministry of Labor, Human Services and Social Security in collaboration with the International Labor Organization launched the USDOL-funded HIV/AIDS workplace education program in February 2004. The goals of the program are to develop policies and programs for prevention of HIV/AIDS in the workplace, implement HIV/AIDS education programs and develop a sustainable national plan for the prevention of HIV/AIDS in the world of work. To date approximately 23 entities have pledged their support for the project and have begun formulating programs, among them is the Guyana Post Office Corporation, the Guyana Telephone and Telegraph Company, Guyana Power and Light, Guyana Sugar Corporation, Guyana Trades Union Congress, Demerara Distillers Limited and the National Bank of Industry and Commerce Ltd.

1.4.2 Local Partner Capacity for Health Care Delivery

Like many developing countries, Guyana suffers from a shortage of health care professionals. In order to fill the gap of health care professionals GHARP, GOG, and USG partnered to carefully plan a recruitment process to attract providers for PMTCT who were not currently employed with the Ministry of Health. A total of 495 applications were received, of that amount approximately half were health care providers who had retired at age 55 but were still active and were previously trained in PMTCT service delivery. Some of the applicants were recent social work graduates with little work experience, but with the ability to effectively execute the necessary job functions; others were NGO volunteers with PMTCT experience. 89 applicants will be hired of that amount 61 have already started working. Due to the success of this application process, GHARP, GOG and USG would like to use this best practice in other health care areas.

1.5 Gender

Women presently constitute only 38 percent of AIDS cases, however, women comprise the fastest growing rate of new infections among women 15-25 (1.9 females: 1.0 males). Unfortunately, little is known about the gender dynamic of HIV/AIDS transmission here. It is important that both sexes are targeted to stop the spread of HIV/AIDS. Although, access to education and health care is equal, the health care system is structured more toward women with respect to antenatal and pediatric care.

In Guyana, gender issues are subsumed within the broader context of social, economic, and political dysfunctions and problems. The relations between men and women in terms of roles, access to resources and power are circumscribed by the conditions of crime and violence, political instability, governance issues and divisiveness. Of note is that although both men and women are affected by these conditions, in general, women carry a disproportionate burden relative to men, in economic and social terms.

Gender roles and relations powerfully influence the course and impact of the HIV/AIDS epidemic. Gender-related factors shape the extent to which men, women, boys and girls are vulnerable to HIV infection and the ways in which AIDS affects them. Reversing the spread of HIV therefore demands that women's rights are realized and that women are empowered in all spheres of life.

The negative impact of the disease on the lives of women and young girls cannot be disputed. Their socially defined roles as care-givers, wives, mothers and grandmothers mean they bear the greatest part of the AIDS-care burden. They also bear the brunt of the epidemic in other ways too, since they are most likely to lose jobs, income and schooling.

Given the growing 'feminization' of AIDS in Guyana, there is a special need to address the specific factors that contribute to women's vulnerability and risk. These include ensuring that adolescent girls have access to information, services and treatment, that violence against women are not tolerated, and that prevention options are expanded.

Men and young boys are also vulnerable. In a Gender Assessment report for USAID/Guyana, August 2003, a NGO working to prevent transmission reported that based on their experience, the principal gender issue in dealing with HIV/AIDS is the case of young men, devoid of employment opportunities or achievement and with low self-esteem, who consider themselves to be invincible but also are reluctant to seek information and advice.. The recent BSS reported that of the 702 male out-of-school youths surveyed, 47.8% felt that their chances of being infected were low or non-existent. At the same time, the risk for young women contracting the disease is increased by their limited capacity to negotiate sexual activity because of differences in power between men and women.

Institutionally, attention to women's rights and to gender issues has been bolstered by a nascent women's movement linked to regional Caribbean organizations and international conventions and UN conferences. Donor support, particularly from the Canadian International Development Agency (CIDA) Gender Equity Program, has been an important stimulus for improving the legal foundation for gender equality and building programs to deal with gender issues.

1.6 Stigma and Discrimination

Very few Guyanese are being tested for HIV/AIDS due to stigma. To reduce stigma, an anti-stigma and discrimination campaign was officially launched on September 12, 2003 by Ambassador Bullen and Minister of Health Dr. Leslie Ramsammy. The Words Have Power campaign is a three-month mass media campaign intended to promote changes in the attitudes, knowledge, language and incidences of stigma and discrimination toward people living with HIV and AIDS in the mini-bus environment. In addition to this campaign; USAID's NGO based strategy; the Guyana HIV/AIDS Youth Project working with nine NGO's, focuses on improved awareness, knowledge, and applied prevention activities targeting youth ages 8 to 25 using age-appropriate information and education materials. One of the goals of this project is to help reduce the stigma faced by those affected by the virus and their families. This youth project works with youth groups, and with youth not reached in a formal setting. The project has built strong ties to religious, ethnic, and cultural organizations as well.

Both the Global Fund and the Canadian International Development Agency have programs related to stigma as well.

Table 2: HIV/AIDS PREVENTION, CARE AND TREATMENT TARGETS

	National 2-7-10	USG Direct Support Target End FY05	USG Indirect Support Target End FY05	Total USG Support Target End FY05
Prevention	Target 2010: 44,252			
Number of pregnant women receiving a complete course of antiretroviral prophylaxis in a PMTCT setting		300	0	300
Number of pregnant women who received PMTCT services in FY05		10,200	0	10,200
Care	Target 2008: 9,000			
Number of HIV-infected individuals (diagnosed or presumed) receiving palliative care/basic health care and support at the end of FY05		2,500	0	2,500
Number of HIV-infected individuals (diagnosed or presumed) who received TB care and treatment in an HIV palliative care setting in FY05		100	25	125
Number of individuals who received counseling and testing in FY05		16,200	0	16,200
Number of OVCs being served by an OVC program at the end of FY05		600	0	600
Treatment	Target 2008: 1,600			
Number of individuals with advanced HIV infection receiving antiretroviral therapy at the designated PMTCT+ site at the end of FY05		75	0	75
Number of individuals with HIV infection receiving antiretroviral therapy at the end of FY05		730	0	730

Table 3.1: COUNTRY PLAN - FUNDING MECHANISMS AND SOURCE

Prime Partner: None Selected

Mech ID:	1,558
Mech Type:	Unallocated
Mech Name:	Unallocated
Planned Funding Amount:	
Agency:	
Funding Source:	
Local:	

Mech ID:	1,597
Mech Type:	Unallocated
Mech Name:	Unallocated
Planned Funding Amount:	
Agency:	
Funding Source:	
Local:	

Prime Partner: **American Red Cross**

Mech ID:	8
Mech Type:	Headquarters procured, centrally funded (Central)
Mech Name:	American Red Cross
Planned Funding Amount:	
Agency:	USAID
Funding Source:	GAC (GHAI account)
Prime Partner ID:	170
Prime Partner Type:	NGO
Local:	No
New Partner:	No

Sub-Partner Name:	The Guyana Red Cross Society
Sub Partner Type:	NGO
Planned Funding Amount:	☑ Funding To Be Determined
Local:	Yes
New Partner:	No

Prime Partner: **Catholic Relief Services**

Mech ID:	9
Mech Type:	Headquarters procured, centrally funded (Central)
Mech Name:	CRS
Planned Funding Amount:	
Agency:	HHS
Funding Source:	N/A
Prime Partner ID:	7
Prime Partner Type:	FBO
Local:	No
New Partner:	No

Sub-Partner Name:	Catholic Medical Mission Board
Sub Partner Type:	FBO
Planned Funding Amount:	☑ Funding To Be Determined
Local:	No
New Partner:	Yes

Prime Partner: *Catholic Relief Services*

Sub-Partner Name:	Institute of Human Virology at the University of Maryland
Sub Partner Type:	University
Planned Funding Amount:	
	☑ Funding To Be Determined
Local:	No
New Partner:	Yes

Sub-Partner Name:	Interchurch Medical Assistance
Sub Partner Type:	FBO
Planned Funding Amount:	
	☑ Funding To Be Determined
Local:	No
New Partner:	Yes

Sub-Partner Name:	Ministry of Health, Guyana
Sub Partner Type:	Host Country Government Agency
Planned Funding Amount:	
	☑ Funding To Be Determined
Local:	Yes
New Partner:	No

Sub-Partner Name:	St. Joseph's Mercy Hospital
Sub Partner Type:	FBO
Planned Funding Amount:	
	☑ Funding To Be Determined
Local:	Yes
New Partner:	No

Sub-Partner Name:	The Futures Group International
Sub Partner Type:	TBD
Planned Funding Amount:	
	☑ Funding To Be Determined
Local:	No
New Partner:	Yes

Prime Partner: **Center for Disaster and Humanitarian Assistance Medicine**

Mech ID:	13
Mech Type:	Headquarters procured, country funded (HQ)
Mech Name:	DoD1
Planned Funding Amount:	
Agency:	Department of Defense
Funding Source:	GAC (GHAI account)
Prime Partner ID:	630
Prime Partner Type:	University
Local:	No
New Partner:	Yes

Mech ID:	702
Mech Type:	Locally procured, country funded (Local)
Mech Name:	DoD2
Planned Funding Amount:	
Agency:	Department of Defense
Funding Source:	GAC (GHAI account)
Prime Partner ID:	630
Prime Partner Type:	University
Local:	No
New Partner:	Yes

Mech ID:	1,586
Mech Type:	Headquarters procured, country funded (HQ)

Prime Partner: Center for Disaster and Humanitarian Assistance Medicine
- **Mech Name:** D
- **Planned Funding Amount:** [ ]
- **Agency:** Department of Defense
- **Funding Source:** Deferred (GHAI)
- **Prime Partner ID:** 630
- **Prime Partner Type:** University
- **Local:** No
- **New Partner:** No

Prime Partner: Comforce
- **Mech ID:** 1,433
- **Mech Type:** Headquarters procured, country funded (HQ)
- **Mech Name:** Comforce
- **Planned Funding Amount:** [ ]
- **Agency:** HHS
- **Funding Source:** GAC (GHAI account)
- **Prime Partner ID:** 2,050
- **Prime Partner Type:** Private Contractor
- **Local:** No
- **New Partner:** Yes

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Prime Partner: Crown Agents
- **Mech ID:** 157
- **Mech Type:** Headquarters procured, country funded (HQ)
- **Mech Name:** Crowne Agents
- **Planned Funding Amount:** [ ]
- **Agency:** HHS
- **Funding Source:** GAC (GHAI account)
- **Prime Partner ID:** 422
- **Prime Partner Type:** Private Contractor
- **Local:** No
- **New Partner:** No

Prime Partner: Family Health International
- **Mech ID:** 4
- **Mech Type:** Locally procured, country funded (Local)
- **Mech Name:** GHARP
- **Planned Funding Amount:** [ ]
- **Agency:** USAID
- **Funding Source:** GAC (GHAI account)
- **Prime Partner ID:** 180
- **Prime Partner Type:** NGO
- **Local:** No
- **New Partner:** No

Sub-Partner Name: Artistes in Direct Support
Sub Partner Type: NGO
Planned Funding Amount:
☑ Funding To Be Determined
Local: Yes
New Partner: No

Sub-Partner Name: Caribbean Conference of Churches
Sub Partner Type: FBO
Planned Funding Amount:
☑ Funding To Be Determined
Local: Yes
New Partner: Yes

Prime Partner: **Family Health International**

Sub-Partner Name: Central Islamic Organization of Guyana
Sub Partner Type: FBO
Planned Funding Amount:
☑ Funding To Be Determined
Local: Yes
New Partner: Yes

Sub Partner Name: Cicatelli Associates Inc.
Sub Partner Type: NGO
Planned Funding Amount:
☑ Funding To Be Determined
Local: No
New Partner: Yes

Sub-Partner Name: Comforting Hearts
Sub Partner Type: NGO
Planned Funding Amount:
☑ Funding To Be Determined
Local: Yes
New Partner: No

Sub-Partner Name: Help & Shelter
Sub Partner Type: NGO
Planned Funding Amount:
☑ Funding To Be Determined
Local: Yes
New Partner: Yes

Sub-Partner Name: Hope For All
Sub Partner Type: NGO
Planned Funding Amount:
☑ Funding To Be Determined
Local: Yes
New Partner: Yes

Sub-Partner Name: Hope Foundation
Sub Partner Type: FBO
Planned Funding Amount:
☑ Funding To Be Determined
Local: Yes
New Partner: No

Sub-Partner Name: Howard Delafield International
Sub Partner Type: NGO
Planned Funding Amount:
☑ Funding To Be Determined
Local: No
New Partner: Yes

Sub-Partner Name: Lifeline Counseling Services
Sub Partner Type: NGO
Planned Funding Amount:
☑ Funding To Be Determined
Local: Yes
New Partner: No