



Country Report

UNGASS COUNTRY PROGRESS REPORT

Republic of Guyana

Reporting period: January 2006 - December 2007

Presidential Commission on HIV and AIDS



TABLE OF CONTENTS

FOREWORD	3
ACRONYMS	5
1. STATUS AT A GLANCE	7
2. OVERVIEW OF THE AIDS EPIDEMIC	15
3. NATIONAL RESPONSE TO THE AIDS EPIDEMIC	20
4. BEST PRACTICES	32
5. MAJOR CHALLENGES AND REMEDIAL ACTIONS	35
6. SUPPORT REQUIRED FROM DEVELOPMENT PARTNERS	36
7. MONITORING AND EVALUATION ENVIRONMENT	37
ANNEXES	
ANNEX 1: Consultation/preparation process for the national report on monitoring the follow-up to the <i>Declaration of Commitment on HIV and AIDS</i>	40
ANNEX 2: National Composite Policy Index Questionnaire (through CRIS)	
ANNEX 3: National return forms for programme, knowledge, behaviour and impact indicators (through CRIS)	

FOREWORD

The UNGASS Report 2006/2007 chronicles an increasingly successful response to the HIV epidemic on multiple fronts. Guyana's early response was based on our best judgement, rather than on insights provided by strategic information. In spite of this limitation, leadership and commitment have always been strong. This has led us to work with many technical partners and donors to effectively mobilize the resources required for the comprehensive response required to control HIV.

Since 2005, a significant amount of work has been undertaken by all contributors to the national response. This has resulted in very rapid scale-up of all programme areas. Key HIV services, such as VCT and ART, are now accessible in all regions of Guyana, and we are well on our way to achieving universal access to essential HIV services. Needless to say, none of these successes could have been achieved without the strong financial support of our many donors and the outstanding capacity brought to bear by our technical partners. We strongly believe that Guyana is an excellent example of a country that has made effective use of financial and technical support.

During the reporting period, we have taken many steps to enhance the national response. In addition to a giant scale-up in the coverage of key services, we have also seen a significant amount of capacity building. Increasing attention is being given to monitoring the quality of our services and to scaling up capacity to provide accurate and timely strategic information to policy makers, planners and all other stakeholders.

The investment in strategic information is a demonstration of Guyana's willingness to, not only be transparent, but also to be accountable to all stakeholders. We have reviewed the lessons learnt from implementing the previous strategic plan and prepared a new National Strategic Plan for 2007 to 2011. Guyana is the one of the first country in this hemisphere that has implemented a patient tracking system for the treatment and care programme. A National Monitoring and Evaluation Plan has been formulated to monitor achievements during this period, and targets for the core national indicators have been established. These targets will now challenge us to maximize our achievements over the next four years.

The results of our collective efforts over the past two years are extremely encouraging. We see clear evidence that the epidemic has been stabilized and even evidence that the epidemic may be reversing. There is convincing evidence that prevalence among pregnant women is decreasing. Prevalence among persons utilizing VCT services nationally also appears to be declining. HIV patients are surviving in greater proportions and have higher CD4 count on average. And most importantly, the number and proportion of AIDS related deaths are declining.

The multi-sectoral response has also been a huge success. The Ministry of Health has been joined by other sectors in implementing initiatives to control the epidemic. Many CSOs and Line Ministries have utilized financial resources, provided with the assistance of our donors, to implement HIV control programmes. And increasingly, the private sector is undertaking workplace programmes, as well as supporting the implementation of key programme areas. In all of these we see evidence of best practices that we would like to share with the rest of the world.

Guyana's response to HIV is characterised by a strong commitment to provide an enabling environment to control the epidemic. During the reporting period, we have sought to update our

National HIV Policy, as well as to provide policy frameworks in other key areas, such as Blood Safety and OVC. We are also working to provide a strong legal framework for HIV control by promulgating HIV and Blood Transfusion legislation. A Child Protection Bill is also being prepared.

Our successes have not blinded us to the many challenges still ahead. We need to strengthen our framework for comprehensive HIV strategic planning, which is fully informed by strategic information. Key populations with high prevalence have to be targeted more and more effectively, to ensure control of the epidemic.

We cherish our achievements, but we also recognize the work is far from over. We will continue to work to create an optimal policy environment, while challenging and applauding the efforts of all contributors to the national response. Guyana is confident we would achieve our 2010 targets. We must be challenged to work toward the goal of bringing and maintaining the national HIV prevalence to less than one percent. Finally, the work will never be over as long as there is one child being born with HIV.

*Honourable Minister of Health
Dr Leslie Ramsammy*

ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
AIS	AIDS Indicator Survey
ANC	Antenatal Clinic
ART	Anti-retroviral Therapy
ARV	Anti-retroviral
BCC	Behaviour Change Communication
BSS	Behavioural Surveillance Survey
BBSS	Biological and Behavioural Surveillance Survey
CBOs	Community-based Organisations
CCM	Country Coordinating Mechanism
CDC	US Centres for Disease Control & Prevention
CRIS	Country Response Information System
CSO	Civil Society Organisation
DNA	Deoxyribonucleic Acid
FBO	Faith-based Organisation
FXB	Francois Xavier Bagnaud
GDP	Gross Domestic Product
GBoS P&HC	Guyana Bureau of Statistics, Population & Housing Census
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GHARP	Guyana HIV/AIDS Reduction & Prevention Project
GoG	Government of Guyana
GUM	Genito-Urinary Medicine Clinic
HFLE	Health and Family Life Education
HBC	Home-based Care
HPC	Home and Palliative Care
HIV	Human Immuno-deficiency Virus
HSDU	Health Sector Development Unit
HTLV	Human T-Lymphotropic Virus
IEC	Information, Education, Communication
IPED	Institute for Private Enterprise Development
MARP	Most At-Risk Population
M&E	Monitoring and Evaluation
MICS	Multi-Indicator Cluster Survey
MoLHSS&S	Ministry of Labour, 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
NGOs	Non Governmental Organisations
NLID	National Laboratory for Infectious Disease
NSP	National Strategic Plan
NBTS	National Blood Transfusion Service
OIs	Opportunistic Infections
OVC	Orphans and Vulnerable Children

PCHA	Presidential Commission on HIV and AIDS
PEP	Post Exposure Prophylaxis
PCR	Polymerase Chain Reaction
PEPFAR	President Emergency Plan for AIDS Relief
PLHIV	People Living with HIV
PMTCT	Prevention of Mother-to-Child Transmission
PRSP	Poverty Reduction Strategy Paper
RACs	Regional AIDS Committees
SWs	Sex Workers
STIs	Sexually Transmitted Infections
SPA	Service Provision Assessment
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNV	United Nations Volunteers
VCT	Voluntary Counselling & Testing

1. STATUS AT A GLANCE

1.1 Inclusiveness of stakeholders in report preparation

The National Composite Policy Index (NCPI) interviews provided a unique opportunity for all 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. All key stakeholders were also invited to a participatory workshop to ensure consensus on the content of the report.

1.2 Status of the Epidemic

A detailed overview of the epidemic is presented in Section 2. The key elements of the epidemic are as follows:

1. The evidence from ANC Surveys, routine PMTCT programme data and blood bank programme reports all suggest that prevalence of HIV in the general population has stabilized and may be decreasing. For example, ANC Surveys have revealed a reduction in prevalence from 2.3 percent in 2004 to 1.55 percent in 2006. Routine PMTCT programme data revealed prevalence rates of 3.1 percent in 2003, 2.5 percent in 2004, 2.2 percent in 2005, and 1.6 percent in 2006. These routine programme data correspond fairly closely with the results of the 2004 and 2006 ANC sero-prevalence surveys. There has also been a decreasing trend in the HIV prevalence among blood donors: 0.9 percent in 2005, 0.42 percent in 2006, and 0.29 percent in 2007 (Programme data). Data from a massive National Day of Testing conducted in November 2007, revealed a prevalence of 1.01 percent among the 4,504 persons tested.
2. While the epidemic is still considered to be generalized, it is known that several sub-populations have much higher prevalence rates. The BBSS of 2005 has revealed a prevalence of 26.6 percent and 21.2 percent among CSWs and MSM in the capital city respectively. In 2007, a national BBSS among prisoners revealed a prevalence of 5.24 percent.
3. While HIV appears to have initially been most prevalent among males, the disease has been transmitted to increasing numbers of women. By 2003, the annual number of reported cases of HIV was higher among females and has remained so to date.
4. Based on the data available for 2006, there was a combined total of 25 HIV and AIDS cases reported among children aged 0-4 (Dept. of Disease Control, MOH). This represented 1.7 percent of the total HIV and AIDS cases for 2006. The highest number of reported HIV cases occurred in the 30-34 age-group during 2006, while the highest number of reported cases of AIDS occurred in the 34-39 age-group (Draft PCHA Report, 2006). Although a low number of HIV cases were reported among the elderly (age 50 and above), some one percent of AIDS cases occurred within this group during 2006 (Draft PCHA Report, 2006).
5. Cumulative data on AIDS cases from 1989 to 2006 indicate that Region Four accounts for 68.96 percent (3744/5429) of the cases, even though the region only accounts for 41.3 percent of the total population.

6. The proportion of all deaths attributable to AIDS has been declining since 2002, when it was 9.5 percent, to 6.86 percent in 2005. The actual number of AIDS related deaths has also generally declined from 475 in 2002, to 360 in 2005 (MOH, Statistics Unit).

1.3 Policy Response

The National Policy on HIV/AIDS was first approved by Parliament in 1998. This policy was revised in 2003 to reflect changes within NAPS and to reflect a policy of universal access to treatment and care for all PLHIV. Additional policy decisions, such as no stigma or discrimination when applying for social benefits and universal access to VCT and PMTCT, have also been integrated into the most recent revision of the National Policy during 2006.

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 has therefore been developed and presented to Cabinet for approval during the reporting period. A draft OVC Policy has also been prepared and has been presented to the Ministry of Labour, Human Services and Social Security for approval.

In 2006, draft HIV legislation was also developed and will be presented to Parliament during 2008. The draft HIV legislation addresses a range of issues including the protection of PLHIV from discrimination. A final draft of Blood Transfusion Legislation has been developed.

1.4 Programmatic Response

The period under review saw significant improvements in all major programme areas. The major programmatic developments during the reporting period are outlined below.

The Guyana HIV treatment programme was significantly scaled-up to provide comprehensive care, treatment and support for all PLHIV. Since the establishment of free first line treatment in 2002, the service had expanded to eight sites by the end of 2005. By the end of 2007 there were 14 (including one mobile) treatment sites (Programme Report). Second line treatment has been available to PLHIV since 2006.

The home-based and palliative care (HPC) programme was launched in 2005. One thousand and twenty-six (1,026) persons received home-based care in 2006 and this increased to 1,223 in 2007 (NAPS Programme Report). Guyana's first temporary live-in care facility, with a capacity to accommodate 20 PLHIV, was established in 2007 to provide palliative/end of life care, as well as rehabilitative care for PLHIV.

PLHIV are benefiting from training to improve their skills to facilitate their participation in income generating ventures. This is complemented by arrangements to facilitate access to small loans through the Institute for Private Enterprise Development (IPED). PLHIV support groups were established at each treatment site.

The VCT programme has expanded to facilitate better access and ensure greater geographic coverage. The period under review saw an increased from 27 VCT sites, including one mobile site,

in 2005, to 44 sites, including two mobiles in 2007. Eight of the 10 administrative regions now have fixed sites and the mobile teams deliver services to remote locations thereby ensuring national coverage (NAPS Programme Report).

The national PMTCT programme was expanded and strengthened, which resulted in PMTCT services being available at 110 facilities, an increase of 53 sites from 2005. Routine programme data revealed a 97.8 percent acceptance rate among the 13,771 mothers offered testing.

The 2005 BBSS targeted key Most at Risk Populations (MARPS): sex workers, men who have sex with men (MSM), among others. The MoH is directing efforts at risk elimination and risk reduction for MARPS. Female sex workers and MSM are also being reached with combined targeted outreach and referrals to “friendly” clinical care and treatment services. This programme is being implemented in Regions Four and Six with plans for expansion into other regions.

The Private Sector Partnership Programme developed in 2005 has evolved into a robust coalition of private sector organizations that are actively engaged in helping the GoG reach its goals of preventing and reducing HIV in Guyana. Forty-three (43) local private sector companies are currently collaborating with the Public/Private Sector Partnership Programme in an effort to protect the workforce against HIV and ensure the viability of private enterprise in Guyana.

The 2007 BBSS conducted among the prison population in Guyana revealed an HIV prevalence of 5.24 percent. Intervention programmes in prisons include VCT, provision of treatment, care and support services for prisoners. These programmes will be strengthened to ensure that all prisoners have access to these services.

The GoG’s sustained campaign to create awareness of the importance of blood donation has resulted in a considerable increase in voluntary blood donations, from seven percent in 2005 to 31 percent in 2006, and rising to 47 percent in 2007 (NBTS, Programme data).

Table 1 Overview of UNGASS Indicator Data

UNGASS or UNGASS-related Indicator	Data Origin	Period	Value
NATIONAL COMMITMENT AND ACTION			
1. Domestic and international AIDS spending by categories and financing sources			
1a. Government funds allocated to the National AIDS Programme Secretariat (Ministry of Health) (excludes several HIV related programmes such as the Blood Bank, TB, PMTCT, etc.)	Ministry of Health	2007	USD\$ 503,805
2. National Composite Policy Index	Key informant interviews	2007	See Annex 2

NATIONAL PROGRAMME				
3. Percentage of donated blood units screened for HIV in a quality assured manner				
3a. Percentage of donated blood units screened in public sector for HIV in a quality assured manner	National Blood Transfusion Service routine data	2006	100%	
		2007	100%	
4. Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy <i>Note: denominator based on estimated number of persons requiring ART in specific years (modelled in 2006 ANC Survey). The numerator is all persons on ART at the end of the reported period.</i>	NAPS Programme Reports & ANC Survey (2006)	2006	50.29%	
		2007	60.25%	
	All Females		55%	
	All Males		45%	
5. Percentage of HIV-positive women who received antiretroviral to reduce the risk of mother-to-child transmission <i>Note: Numerator is actual number of pregnant women uptaking ART. Denominator is the number of women giving birth multiplied by the estimated HIV prevalence rate among pregnant women (i.e., 1.55%)</i>	ANC Programme Report	2006	63.50%	
		2007	NA	
6. Percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV	Chest Clinic Programme Reports	2006	14.09%	
		2007	77.18%	
All Females	Chest Clinic Programme Reports	2006	14.29%	
		2007	41.74%	
All Males	Chest Clinic Programme Reports	2006	85.71%	
		2007	58.26%	
7. Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and who know their results	AIS	2005	10.83%	
	All Females	-	-	11.29%
	All Males	-	-	10.23%
	Females 15-19	-	-	9.0%
	Females 20-24	-	-	17.8%
	Females 25-49	-	-	10.35%
	Males 15-19	-	-	4.2%

Males 20-24	-	-	16.0%
Males 25-49	-	-	10.4%
8. Percentage of most-at-risk populations who received an HIV test in the last 12 months and who know their results <i>Note: This indicator is not defined in the same way in the 2005 BBSS. The indicators actually used in the BBSS are presented here as a proxy. This is baseline data, since significant progress has since been made.</i>			Data not available (see note)
Percent tested within last 12 months (FSW)	BBSS	2005	64.3%
Percent returned to receive results – from any test ever taken (not necessarily within past 12 months) (FSW)	BBSS	2005	85.2%
Percent ever had an HIV test (MSM)	BBSS	2005	43.8%
Percent returned to receive results – from any test ever taken (not necessarily within past 12 months) (MSM)	BBSS	2005	87.6%
9. Percentage of most-at-risk populations reached with HIV prevention programmes <i>Note: This indicator is not defined in the same way in the 2005 BBSS. The indicators actually used in the BBSS are presented here as a proxy. This is baseline data, since significant progress has since been made.</i>	-	-	Data unavailable
Percent who know of place in community to access HIV test (FSW)	BBSS	2005	28.4%
Percent who know of place in community to access HIV test (MSM)	BBSS	2005	17.2%
10. Percentage of orphaned and vulnerable children aged 0-17 whose households received free basic external support in caring for the child	-	-	Not required to report since national prevalence is below 5%
11. Percentage of schools that provided life skills-based HIV education in the last academic year	-	-	Data unavailable
KNOWLEDGE AND BEHAVIOUR			
12. Current school attendance among orphans and among non-orphans aged 10-14	-	-	Data unavailable MICS sample too small
13. Percentage of young women and men aged 15-24 who both correctly identified ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	BBSS	2005	39.48%

All Females			44.46%
All Males			34.49%
All Rural			37.08%
Rural Females			41.70%
Rural Males			31.94%
All Urban			46.23%
Urban Females			51.41%
Urban Males			40.94%
14. Percentage of most-at-risk-populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject misconceptions about HIV transmission			
FSWs 14.1 Percent who has knowledge of HIV prevention methods (defined as: correctly identified abstinence, faithfulness, and consistent condom use as ways that HIV can be transmitted) <i>Note: the specific indicators for a faithful partner and use of condoms are reported separately immediately below</i>	BBSS	2005	63.1%
14.1.1 Percent who identify that having one faithful uninfected partner can reduce the risk of HIV transmission (FSW)	BBSS	2005	74.2%
14.1.2 Percent who identify that consistently using a condom correctly can reduce the risk of HIV transmission (FSW)	BBSS	2005	84.6%
FSWs 14.2 Percent with no incorrect beliefs about HIV (correctly rejected three most common local misconceptions: mosquito bites, sharing a meal with infected persons and healthy looking persons) <i>Note: the specific indicators for the above misconceptions are reported separately immediately below</i>	BBSS	2005	59.1%
14.2.1 Percent with knowledge that mosquitoes cannot transmit HIV (FSW)	BBSS	2005	69.5%
14.2.2 Percent with knowledge that sharing a meal cannot transmit HIV (FSW)	BBSS	2005	78%
14.2.3 Percent with knowledge that a healthy looking person can transmit HIV (FSW)	BBSS	2005	97.3%
MSM 14.1 Percent who has knowledge of HIV prevention methods (defined as: correctly identified abstinence, faithfulness, and consistent condom use as ways that HIV can be transmitted) <i>Note: the specific indicators for a faithful partner and use of</i>	BBSS	2005	67.1%

<i>condoms are reported separately immediately below</i>			
14.1.1 Percent who identify that having one faithful uninfected partner can reduce the risk of HIV transmission (MSM)	BBSS	2005	84.3%
14.1.2 Percent who identify that consistently using a condom correctly can reduce the risk of HIV transmission (MSM)	BBSS	2005	83.4%
MSM 14.2 Percent with no incorrect beliefs about HIV (correctly rejected three most common local misconceptions: mosquito bites, sharing a meal with infected persons and healthy looking persons)	BBSS	2005	72%
14.2.1 Percent with knowledge that mosquitoes cannot transmit HIV (MSM)	BBSS	2005	63.1%
14.2.2 Percent with knowledge that sharing a meal cannot transmit HIV (MSM)	BBSS	2005	73.4%
14.2.3 Percent with knowledge that a healthy looking person can transmit HIV (MSM)	BBSS	2005	97.6%
15. Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15	BSS	2005	21.12%
All Females	-	-	11.76%
All Males	-	-	30.48%
All Rural	-	-	20.21%
Rural Females	-	-	11.37%
Rural Males	-	-	27.86%
All Urban	-	-	25.18%
Urban Females	-	-	12.75%
Urban Males	-	-	37.07%
16. Percentage of women and men aged 15-49 who have had sexual intercourse with more than one partner in the last 12 months	AIS	2005	4.92%
All Females	-	-	1.4%
All Males	-	-	9.4%
Females 15 – 19	-	-	7.2%
Females 20 – 24	-	-	2.4%
Females 25 - 49	-	-	0.53%
Males 15 - 19	-	-	17.5%
Males 20 - 24	-	-	20.4%
Males 25 - 49	-	-	6.50%
17. Percentage of women and men aged 15-49 who had more than one sexual partner in the past 12 months reporting the use of a condom during their last sexual intercourse	AIS	2005	58.99%
<i>Note: This precise indicator is not measured by the AIS.</i>			

<i>Higher risk intercourse is defined in the AIS as having sex with a partner who is neither a spouse nor who lived with the respondent. The data below reflects higher risk sex as defined by the AIS and is therefore only a proxy for the UNGASS indicator.</i>			
All Females	-	-	49.96%
All Males	-	-	65.94%
Females 15 -19	-	-	67.9%
Females 20 - 24	-	-	55.5%
Females 25 - 49	-	-	39.45%
Males 15-19			74.6%
Males 20-24			62.0%
Males 25-49			64.13%
18. Percentage of female and male sex workers reporting the use of a condom with their most recent client <i>Note: male sex workers not included in last BBSS.</i>	-	-	-
18.1 Percent of FSWs who used a condom with last paying partner (client)	BBSS	2005	89.33%
19. Percentage of men reporting the use of a condom the last time they had anal sex with a male <i>Note: the BBSS indicator is the same, except that it distinguishes between 3 classes of partners as specified below</i>	BBSS	2005	Data available and disaggregated by partner type only
Regular partner	-	-	68.1%
Non-regular partner	-	-	80.7%
Commercial partner	-	-	83.8%
20. Percentage of injecting drug users reporting the use of a condom the last time they had sexual intercourse	-	-	2005 BSS and AIS surveys findings suggest that this is not a major population
21. Percentage of injecting drug users reporting the use of sterile injecting equipment the last time they injected	-	-	2005 BSS and AIS surveys findings suggest that this is not a major population
IMPACT			
22. Percentage of young women and men aged 15 – 24 who are HIV infected	ANC survey	2006	1.0%
15 – 19	-	-	0.61%
20 - 24	-	-	1.34%

23. Percentage of most-at-risk populations who are HIV infected	BBSS	2005	25.4% Data not disaggregated by age group
FSW	-	-	26.6%
MSM	-	-	21.25%
24. Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy <i>Note: This is the average survival values of ten cohorts after 12 months on treatment. The cohorts cover the period January 2006 to October 2006.</i>	Patient Monitoring System (NAPS)		
Males: 0-14			86.67
Males: 15+			66.83
All Males			70.01
Females: 0-14			70.00
Females: 15+			76.92
All Females			78.18
All 0-14			96.67
All 15+			72.55
All Males & Females			74.51
25. Percentage of infants born to HIV-infected mothers who are infected	-	-	Will be modelled at UNAIDS from data reported at indicator 5

2. OVERVIEW OF THE HIV EPIDEMIC

Guyana has a population of 751,223 with a landmass of 215,000 km² extending along the north-eastern coast of South America. It is the only English-speaking country in South America and is 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 ten administrative regions, with three coastal regions (Three, Four, and Six) collectively accounting for 72 percent of the total household population. Per capita GDP is US\$974.90 (GBoS, 2006) and the country is ranked 97th in the Human Development Index (HDI) 2007 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 HIV epidemic in Guyana is considered generalized, as a HIV prevalence of greater than one percent has been consistently found among pregnant women attending antenatal care clinics. A cumulative total of 5,429 AIDS cases had been officially reported to the Ministry of Health by the end of 2006. The cumulative cases of AIDS reported by region and gender to the Ministry of Health between 1989 and 2006 are presented in **Table 2** below.

Table 2 Cumulative Cases of AIDS Reported by Region and Gender (1989 to 2006)

Region	Number of Cases Reported			
	Male	Female	Unknown	Total
1	11	10	0	21
2	45	54	0	99
3	209	169	10	388
4	2,169	1,483	92	3,744
5	67	64	1	132
6	240	173	9	422
7	40	30	2	72
8	3	2	1	6
9	8	6	0	14
10	181	170	7	358
Unknown	107	56	10	173
Total	3,080	2,217	132	5,429

HIV Prevalence

Guyana's aggressive response to HIV has seen the epidemic stabilizing over the last three years. The results of the 2006 ANC survey among pregnant women, when adjusted for urban/rural setting, showed an HIV prevalence of 1.55 percent. This represented a decrease when compared to the 2.3 percent found in a similar ANC survey in 2004. Routine PMTCT programme data has been consistent with the results of the ANC surveys and also show a similar decreasing prevalence among pregnant women since 2003 as illustrated in **Table 3**. While a similar pattern of decreasing prevalence is reflected among blood donors, as shown in the table below, it is recognized that improved screening of potential donors would also contribute to this decrease. A National Day of Testing in 2006 revealed a prevalence of 0.92 percent. A more massive National Day of Testing conducted in November 2007, revealed a prevalence of 1.01 percent among the 4,504 persons tested.

In 2005, UNAIDS estimated that the percentage of adults (15-49) living with HIV was 2.4 percent (UNAIDS EpiProfile). The Ministry of Health had also projected that the incidence of HIV cases would decrease by 2007 (ANC Survey 2006).

Although the HIV epidemic is generalized, the prevalence is higher among specific sub-populations such as female sex workers, MSM, STI patients and prisoners. According to the BBSS (2005), the prevalence among CSWs and MSM in the capital city was 26.6 percent and 21.2 percent respectively.

In 2007, a BBSS revealed a prevalence of 5.24 percent among prisoners nationally. Among STI patients, the prevalence of HIV infection in males was 13.2 percent in 1992 and 17.3 percent in 2005, while for females it was 6.5 percent in 1993 and 16.9 percent in 2005 (MoH).

Table 3 HIV Prevalence among Pregnant Women and Blood Donors in Guyana

POPULATION	GENDER	YEAR	PREVALENCE	REMARKS
Pregnant Women	Female	2004	2.3	ANC Survey
Pregnant Women		2006	1.55	ANC Survey
Pregnant Women		2003	3.1	PMTCT Prog. Report
Pregnant Women		2004	2.5	PMTCT Prog. Report
Pregnant Women		2005	2.2	PMTCT Prog. Report
Pregnant Women		2006	1.6	PMTCT Prog. Report
Blood Donors	All	2004	0.7	Blood Bank
		2005	0.9	
		2006	0.42	
		2007	0.29	

Gender Distribution of Reported Cases

While HIV appears to have initially been most prevalent among males, the disease has been transmitted to increasing numbers of women. By 2003, the annual number of reported cases of HIV was higher among females and has remained so to date as shown in **Table 4**. Trends in the male: female ratio is also shown in the table below. The current male to female ratio for HIV cases is practically 1:1, down from 1:2.8 in 1989. This is consistent with a true heterosexual epidemic where males and females are equally affected. Overall, the number of AIDS cases in males outnumbers the number of cases in females, except within the younger age groups (15-24), where there are more female than male cases.

Table 4 Trends in Reported Cases of HIV and AIDS by Gender

CLASSIFICATION		2000	2001	2002	2003	2004	2005	2006	Sept. 2007
HIV	Male	348	174	301	339	368	325	591	239
	Female	300	226	268	368	408	421	626	375
	Unknown	0	9	39	55	61	36	41	36
	Total	648	409	608	762	837	809	1,258	704
	Sex Ratio	1.16	0.77	1.12	0.92	0.90	0.77	0.94	
AIDS	Male	175	232	243	232	117	58	99	57
	Female	132	185	146	163	204	77	68	38
	Unknown	0	18	26	22	27	7	5	1
	Total	307	435	415	417	348	142	172	96
	Sex Ratio	1.33	1.25	1.66	1.42	0.57	0.75	1.46	

Age Distribution

Based on the data available for 2006, there was a combined total of 25 HIV and AIDS cases reported among children aged 0-4 (Dept. of Disease Control, MOH). This represented 1.7 percent of the total HIV and AIDS cases for 2006. This is a significant number and provides justification for the continued aggressive implementation of the national PMTCT programme. The vast majority of the remaining HIV and AIDS cases occurred in the active labour force and has potential implications for long-term productivity. The highest number of reported HIV cases occurred in the 30-34 age-group during 2006, while the highest number of reported cases of AIDS occurred in the 34-39 age-group (Draft PCHA Report, 2006). Although a low number of HIV cases were reported among the elderly (age 50 and above), some one percent of AIDS cases occurred within this group during 2006 (Draft PCHA Report, 2006).

Spatial Distribution of HIV and AIDS

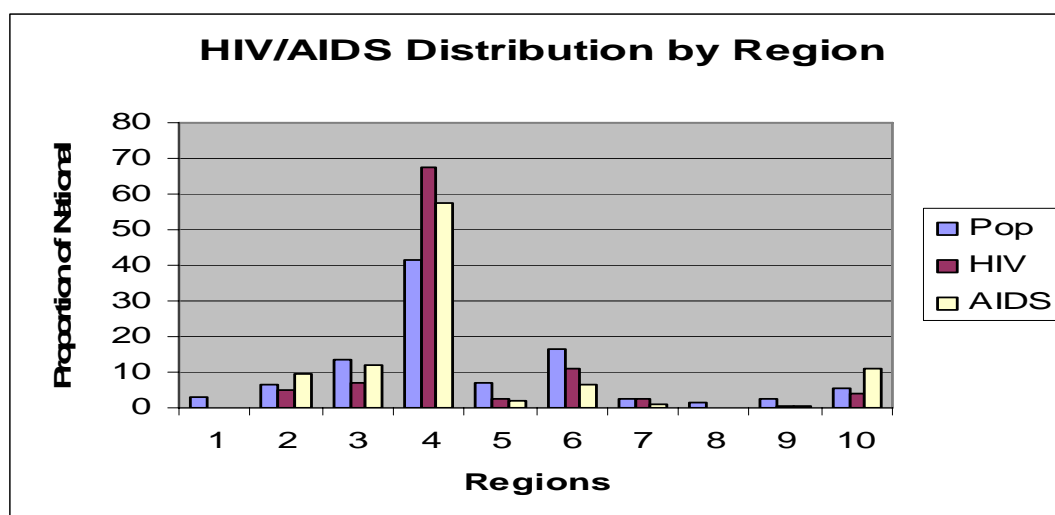
Cumulative data on AIDS cases from 1989 to 2006 indicate that Region Four accounts for 68.96 percent (3,744/5,429) of the cases, even though the region only accounts for 41.3 percent of the total population. The spatial pattern of HIV and AIDS relative to population distribution is analysed in **Table 5** and illustrated in **Figure 1** for 2006. Region Four accounts for a disproportionate amount of the reported HIV (67.7%) and AIDS (57.6%) cases. In contrast, most of the other regions had a lower proportion of reported HIV cases relative to their population distribution during this period. Region Ten stands out with a higher proportion of AIDS cases relative to population proportion during 2006. A similar pattern exists for Region Two. These spatial patterns constitute an important criterion for allocating resources to control the epidemic.

Table 5 HIV and AIDS Distribution by Region and Gender (2006)

Region	Regional Population		HIV					AIDS				
	Total	%	Male	Female	Unknown	Total	Reg'l %	Male	Female	Unknown	Total	Reg'l %
1	24,275	3.2	1	1	0	2	0.2	0	0	0	0	0
2	49,253	6.6	22	36	0	58	4.8	12	4	0	16	9.4
3	103,061	13.7	45	37	3	85	7.0	13	7	0	20	11.8
4	310,320	41.3	384	407	29	820	67.7	56	38	4	98	57.6
5	52,428	7.0	12	17	0	29	2.4	2	1	0	3	1.8
6	123,695	16.5	67	61	4	132	10.9	3	7	1	11	6.5
7	17,597	2.3	17	13	1	31	2.6	1	1	0	2	1.2
8	10,095	1.3	0	0	1	1	0.1	0	0	0	0	0.0
9	19,387	2.6	1	3	0	4	0.3	1	0	0	1	0.6
10	41,112	5.5	20	29	1	50	4.1	10	9	0	19	11.2
Unknown	-	-	23	21	2	46	-	1	1	0	2	-
Total	751,223	100	592	625	41	1,258	100	99	68	5	172	100

Source: Adapted from Ministry of Health, Dept. of Disease Control

Figure 1 HIV and AIDS Relative to Population Distribution by Region (percentage)



AIDS Related Mortality

The proportion of all deaths attributable to AIDS has been declining from 2002 when it was 9.5 percent. In 2003, eight percent of all deaths were attributed to AIDS, while in 2004 it was 7.1 percent. This proportion further declined to 6.86 percent in 2005. The actual number of AIDS related deaths has also generally declined as illustrated in the **Table 6** below (MOH, Statistics Unit).

Table 6 Annual Number and Proportion of AIDS Related Deaths

Year	% of AIDS Related Deaths	No. of AIDS Related Deaths
2002	9.5	475
2003	8	399
2004	7.1	356
2005	6.86	360

Assessment of Key Outcomes

HIV continues to affect all segments of the population and all regions of Guyana. Data from the 2005 Behavioural Surveillance Surveys (BSS) and Biological and Behavioural Surveillance Surveys (BBSS), conducted among youths, employees of the sugar industry, members of the uniformed services, female sex workers, and MSM, suggested that the overall knowledge of HIV transmission is very high but a number of misconceptions regarding HIV transmission still prevail. For instance, among out-of-school youths, approximately 30 percent of all respondents believed that HIV can be transmitted via mosquitoes and close to one-quarter thought it could be transmitted through the sharing of a meal with an infected person.

The report also suggested that there are attitudes and beliefs that may lead to significant levels of stigmatisation and discrimination of HIV-infected persons. For example, approximately one-quarter of the respondents reported they would not purchase food from an HIV-infected shopkeeper and approximately one-third believed that if they have a family member who is infected their status should remain a secret.

The BSS and BBSS data also found that in all of the populations, the level of condom use was higher with non-regular than with regular partners and that the probability of a condom being used during a sexual encounter decreases as familiarity increases.

3. NATIONAL RESPONSE TO THE AIDS EPIDEMIC

“The work will never be over as long as there is one child being born with HIV.”
- Honourable Dr. Leslie Ramsammy, Minister of Health

3.1 National Commitment

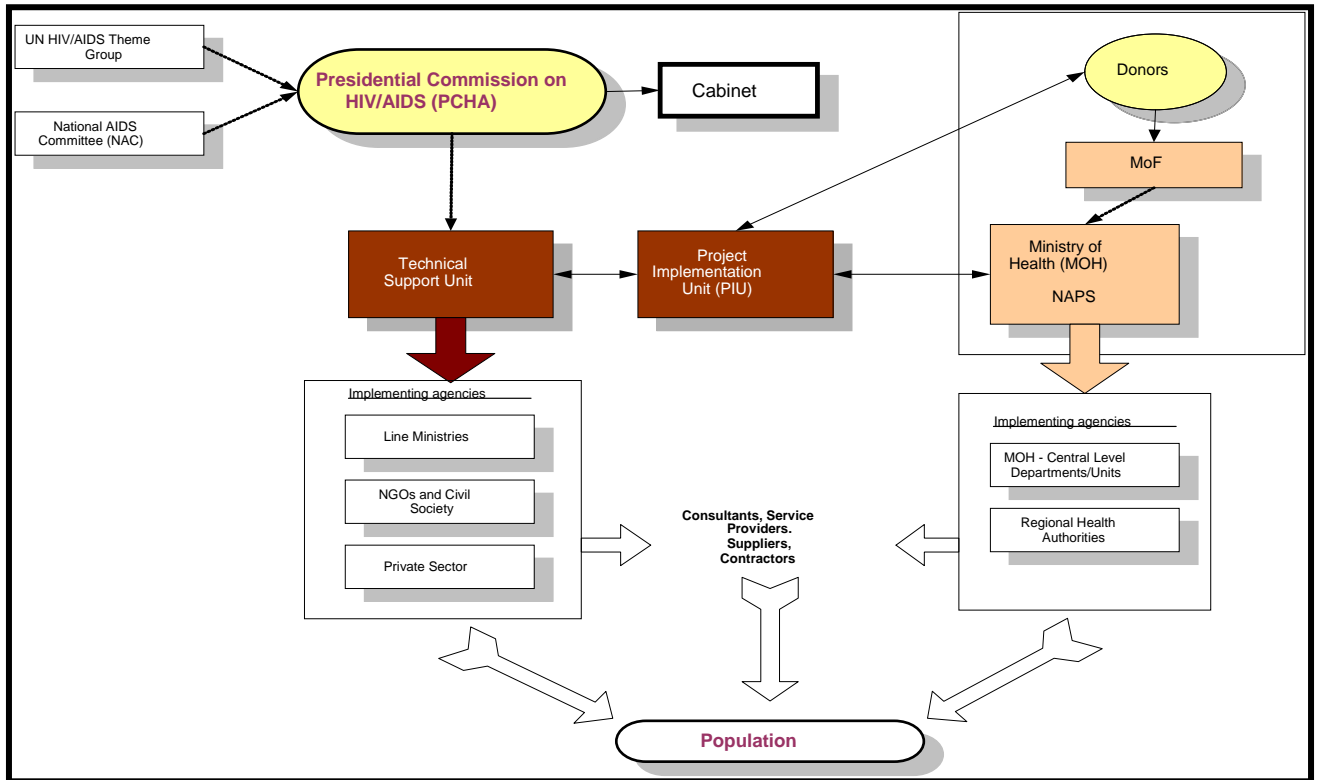
Following the first diagnosed case of AIDS in Guyana in 1987, the GoG, being cognizant of the devastating effects of the disease, responded quickly as did other countries, with a medical approach.

In 1989, the GoG 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 HIV epidemic. Regional AIDS Committees (RAC) were also established to coordinate and implement HIV and AIDS activities at the sub-national level. The government’s response was complemented by the activities of various civil society organizations, whose approach focused primarily on prevention (disseminating information, education and communication initiatives).

The management and coordination of the National AIDS Programme were strengthened over the last two years with the construction of a modern and spacious National AIDS Programme Secretariat building and recruitment of key technical and administrative staff.

Political commitment to fight HIV and AIDS is strong in Guyana. This 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 2** represents the Guyana multi-sectoral response mechanism for HIV and AIDS.

Figure 2 Guyana multi-sectoral response mechanism for HIV and AIDS



The 2007 NCPI survey revealed that all stakeholders are happy with the public leadership demonstrated by both the President and, in particular, the Minister of Health in rolling out the national response to HIV.

3.2 Prevention

3.2.1 Behaviour Change Communication (BCC)

Guyana like many countries recognized the need to move beyond information, education and communication (IEC) to Behaviour Change Communication (BCC) which requires a supportive environment and is influenced by development and health services provision. With this in mind Guyana developed a Behavioural Change Communication (BCC) Strategy and subsequently developed and launched a markedly strengthened BCC campaign in 2005 aimed at:

1. Promoting abstinence and being faithful;
2. Promoting safer sexual practices;
3. Reducing stigma and discrimination;
4. Encouraging early HIV testing; and
5. Increasing community involvement in HIV/AIDS treatment and care.

In 2006 and 2007, new campaigns were developed to build upon the 2005 campaign. These campaigns were targeted at:

1. Controlling opportunistic infections;
2. Encouraging treatment adherence;
3. Empowering women to successfully negotiate condom use; and
4. Reaching high risk groups (FSWs, MSM and youths in and out of school).

The BCC programme comprised a variety of activities during 2006-2007:

- Two hundred thousand (200,000) brochures on HIV highlighting condom use and early HIV testing were distributed and an 'AIDS in our community' magazine was produced to target youth and the general community.
- Posters, television and radio advertisements, with a series of half-hour television documentaries on HIV have been produced. Additionally a twice-weekly BCC radio serial drama, Merundoï, was launched in October 2006 with accompanying community-based reinforcement activities. To date 19,157 persons were reached in eight regions with abstinence, faithfulness, correct and consistent condom use, positive parent and child communication, alcohol reduction and prevention, access to quality HIV and STIs services, and reduction of stigma and discrimination information.
- At the regional level sales promoters in Regions Three, Four, Five, Six, Seven, and Ten, promote condom use through interpersonal communication. Eight hundred and ninety (890) condom service outlets are currently in existence. Some 2.3 million male condoms were distributed in 2006 and 2.9 million in 2007 through a focused effort on increasing access to condoms by high-risk groups with the strategic placement of condom vending machines at high traffic locations, for example, bars and clubs. It is anticipated that 6.9 million male condoms will be distributed during 2008 – 2009.
- The training of peer educators and engagement of community leaders, including FBO leaders, were intensified during this period. FBOs' interventions focused on the promotion of abstinence, faithfulness, the reduction of HIV-related stigma and discrimination, and delivery of care and support services. Four hundred and twenty-one community leaders and 665 peer educators were trained in regions Three, Four, Five and Six during 2006 and 2007.
- A national hotline programme was initiated during February 2005 to fulfil information requests and provide psychosocial support for the public.

All respondents of the 2007 NCPI survey agreed that Guyana has a comprehensive policy and strategy that promotes information, education and communication on HIV to the general population. However, it was noted that the elderly (age 50 and above) is not specifically targeted. Perception of national coverage for IEC services varied significantly among government and CSOs respondents. CSOs noted that most regions of Guyana regularly receive IEC information. Government respondents on the other hand felt that all regions are regularly receiving IEC messages.

3.2.2 Prevention of Mother-to-Child-Transmission (PMTCT)

The prevention of mother-to-child-transmission programme is an integral part of the overall strategy to prevent and control the spread of HIV. With a consistently generalised epidemic among pregnant women in Guyana it was clear that a strong national programme had to be developed to prevent HIV-infected women from infecting their newborn babies. Beginning in November 2001, a pilot phase of the programme was initiated at 11 sites in two regions. By the end of 2005, the programme had expanded to 57 sites in eight regions.

During 2006 and 2007, the focus continued to be on expanding and strengthening the national PMTCT programme. Some of the achievements in PMTCT include:

- The PMTCT Programme was integrated into the Maternal and Child Health Unit of the Ministry of Health.
- PMTCT services were available at 110 facilities and in all regions of the country by the end of 2007. These include four private hospitals that have initiated HIV testing of pregnant women.
- In 2006, an ANC survey was conducted at 137 ANCs and this revealed a HIV prevalence of 1.55 percent among pregnant mothers. This represented a decrease from the 2.3 percent estimated in the 2004 ANC survey.
- Babies born to HIV-positive mothers are provided with early HIV diagnosis through DNA PCR testing.
- In 2005, some 31.66 percent of HIV positive pregnant mothers received ART to prevent MTCT. This proportion was increased to 66.92 percent during 2006 (PMTCT programme data).

Key trends in the PMTCT programme are illustrated in **Table 6** below.

Table 6 Major Trends in the PMTCT Programme (2003 – 2006)

CATEGORY	2003	2004	2005	2006
No. of Sites with PMTCT	23	37	57	92
Total Births	17,209	16,676	15,123	14,990
ANC mothers tested for HIV	3,279	4,741	9,675	13,041
Uptake of VCT among pregnant women (%)	84.9	86.3	93.8	97.8
No. of HIV positive mothers	103	118	212	215
Prevalence of HIV (%)	3.1	2.5	2.2	1.6
Exposed live infants who received ARVs	71	99	148	174

Adapted from MCH 2006 Annual Report, Birth data from Statistical Unit (Min. of Health)

3.2.3 Voluntary Counselling and Testing

VCT was initiated as a key part of the national response to HIV in Guyana and has demonstrated outstanding results over the past two years. The national programme has been significantly scaled up and by 2005 had achieved national coverage (all ten administrative regions) through a combination of fixed and two mobile sites. In Guyana, VCT services are provided by a range of CSOs and private facilities, in addition to public health care facilities.

During the reporting period, two persons were trained as ‘trainer of trainers’ and a national VCT training curriculum was finalized. This includes a trainer’s manual as well as a participant’s manual. By the end of 2007, some 102 counsellors/testers were trained and 75 were employed across 44 sites nationally. A national VCT testing algorithm was developed, tested and approved. In addition, National VCT Guidelines were also prepared. All VCT sites are currently adhering to these Guidelines, which addresses issues such as the age of consent for access to testing. Also, as the programme scales-up, increasing attention is being given to quality control nationally.

Stimulated by a strong social marketing campaign, significant strides have been made toward encouraging individuals to know their status. A total of 16,065 persons were tested in 2005. In 2006, this number increased to 25,063. During 2007, there was an even greater increase to 48,578 accepting VCT (NAPS VCT programme reports). This rapid increase in the number of persons accepting VCT is clear evidence that the programme is generating the desired results.

A national day of testing was held in November 2006 where 1,198 persons were tested and counselled, with a prevalence rate of 0.92 percent. The national day of testing in 2007 saw a massive increase to 4,504 persons accepting VCT, and this revealed a prevalence rate of 1.01 percent. These national days of testing were each accompanied by massive promotional campaigns, and it is clear that the national days of testing are contributing to raising awareness of the importance of knowing one’s status.

To enhance the linkage between the VCT and treatment programmes, a pilot intervention was initiated to keep track of persons testing positive to ensure they follow through on their referral to the treatment programme. Over the long-term, it is expected that the persons implementing this initiative (‘Case Navigators’) will contribute to a smooth flow of clients between the two programmes, thereby enhancing earlier uptake of treatment and care.

3.2.4 Blood Safety

Generally, high standards are followed for laboratory control and blood screening at the National Blood Transfusion Service (NBTS), which includes proficiencies in the National External Quality Assessment Scheme for blood transfusion laboratory practice. The NBTS performs confirmatory tests for HIV and syphilis for all clinic facilities and also serves as a reference centre for private facilities.

The national blood supply is also routinely screened for hepatitis B & C, syphilis, HTLV, malaria, and filaria. Efforts are being directed at ensuring that private hospitals, which screen blood units for transfusion, follow documented standard operating procedures and participate in an external quality assurance scheme. There have been significant achievements in blood safety over the last two years and these include:

- The National Blood Transfusion Service was increased with the expansion of the central blood bank and construction of a blood transfusion centre in Region Six.
- This period has also seen intense training in quality assurance and greater focus on blood donor recruitment which has resulted in a substantial increase in voluntary blood donation from seven percent in 2005 to 47 percent in 2007.
- The draft Blood Transfusion Legislation was finalized and presented to the Minister of Health in September 2007. The document is expected to be tabled in Parliament in 2008. This legislation will provide a legal framework for managing the national blood programme.
- A National Blood Policy was prepared and the Caribbean Regional Standards for Blood Banks was adopted by Guyana in 2006.
- The National Blood Transfusion Service reported 100 percent screening of donated blood units (6,130) for HIV in a quality assured manner in 2006 and 6,598 units in 2007. This includes blood screened at all public sector sites and one private hospital.

3.2.5 Safe Injections

For some time now, Guyana has been promoting 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. In 2004, a concerted intervention was initiated with the goal of reducing the number of unnecessary and unsafe injections. The strategy emphasized preventing the transmission of blood borne diseases through contaminated sharps, since needle stick injuries are the primary cause of blood borne transmission among health care workers. Complementary interventions include improving the national system for the management and disposal of medical waste, sustainable procurement of required safety supplies, raising national awareness of the risks and preventative measures for medical transmissions of blood borne diseases and enhancing worker safety with pre-exposure vaccinations as well as Post Exposure Prophylaxis (PEP). The following were some of the main achievements during the reporting period:

1. By the end of September 2007, 42.7 percent of the national population was covered with safe injection practices at 105 medical facilities in four regions (Three, Five, Six and Ten) when compared to 22.0 percent coverage within 54 facilities in two regions at the end of 2005;
2. Worker safety was enhanced by providing personal protective gear and pre-exposure vaccination; and
3. A relatively simple low-tech needle remover and sharps barrel was introduced to minimize the amount of infectious waste.

3.2.6 Targeted Sub-populations

The 2005 BSS and BBSS targeted key Most at Risk Populations (MARPS): sex workers, men who have sex with men (MSM), youth, uniform services, PLHIV, miners, and migrant workers. The results of the 2007 NCPI suggest that most at risk populations groups can now access confidential and individualized care and treatment at public and private centres.

Female sex workers and MSM are currently being targeted in regions Four and Six. The objective of the programme is to facilitate MARPS access to HIV and STI-related services at ‘friendly sites’, where the staff are sensitized to provide treatment and support services for these sub-populations, as well as provide them with skills to negotiate condom use. Selected sex workers were trained in 2006 as peer educators to discuss prevention and safer sex strategies with their peers. Clients of these sex workers and brothel owners are also being targeted. Some work has been done with MSM including the training of a core group to deliver peer education. The MSM programme will be fully implemented in 2008.

Guyana’s uniformed services are becoming increasingly involved in the efforts to stop the spread of HIV both as “frontline soldiers’ in the prevention efforts and as beneficiaries of targeted interventions. VCT services are offered on residential facilities for both officers of the Guyana Police Force and Guyana Defence Force. Key informant interviews revealed that all stakeholders are aware and supportive of the national efforts to reach uniform services.

The AIDS Indicator Survey (2005) showed that 74 percent of females and 64 percent of males between the ages of 15 and 19 never had a sexual encounter, but among the 20-24 year olds there is a sharp decline to 48 percent (females) and 21 percent (males) reporting the same behaviour. The AIS also showed that 29 percent of youths aged 15-19 are sexually active. Based on these findings, the MoH with support from its donor partners is supporting faith-based and non governmental organizations to implement a new modelling and reinforcement behaviour change communication programme aimed at encouraging primary and secondary abstinence, as well as the delay of sexual debut among in and out-of-school youth.

Interventions also focus on other prevention methods for high risk populations by promoting the correct and consistent condom use. Efforts are being directed at educating young men and young boys to ensure that behaviours which fuel HIV transmission and other social and health challenges may be disrupted. “Be faithful” messages complement abstinence messaging in groups of sexually active young adults to encourage mutual fidelity.

Some work has commenced on reinforcing “prevention for positives” aimed at helping PLHIV prevent secondary infection and further transmission of HIV among sero-discordant couples.

The 2007 BBSS among prisoners revealed the need to expand the prevention, treatment, care and support services for this population. The work done so far will be consolidated while the expansion of the prison’s programme will continue in 2008 to ensure easier access to services by this population.

Intervention programmes targeting non-injection drug users, miners and migrant workers will be developed and implemented in 2008 and 2009.

The abovementioned prevention efforts provide evidence of Guyana's commitment to halting the spread of HIV through a multi-prong and targeted approach. These efforts could be enhanced by an even better understanding of the determinants of HIV-related behaviours. Such an understanding will help both to identify vulnerable groups within the population and to devise appropriately targeted interventions to improve HIV knowledge and reduce risk behaviours.

3.2.7 Health and Family Life Education (HFLE)

The primary avenue for delivery of teaching about school health, nutrition and HIV prevention in Guyana is the "Health and Family Life Education" (HFLE) curriculum. HFLE was developed in response to the desire of Caribbean governments to equip the region's youth to cope better with the situations that arise from changing societal and family values and traditions, the perception of disintegrating community life and the development of new health problems. The initiative is a CARICOM multi-agency activity that seeks to empower young people with skills for healthy living and focuses on the development of the whole person (emotional, social, mental, physical and spiritual).

Until recently, use of HFLE in Guyana has been slow to take off. During 2006 and 2007, however, there was rapid progress with the in-service training of approximately 2000 teachers who are now distributed across all regions of the country. Training in HFLE has concluded until an evaluation of the impact of the training is complete.

3.2.8 Adolescent and Young Adults Health Issues

An Adolescent and Young Adults Health and Wellness Unit was established in the Ministry of Health in February 2005. This unit encompasses several programmes which ultimately contribute to preventing HIV among youths. These programmes include developing youth friendly health centres, health promotion and drug demand reduction. This Unit also collaborated with the Ministry of Education to prepare HIV materials for the HFLE curriculum.

3.3 Treatment

In April 2002, the national treatment programme was launched at one treatment facility in Georgetown using locally manufactured anti-retrovirals (ARVs). At that time, the government declared a universal treatment programme for people living with HIV. In 2005, the GoG provided antiretroviral (ARV) treatment to 942 persons through eight treatment facilities in Regions Two, Three, Four, Six and Seven. These services were expanded to include the prison populations through a satellite clinic operated from the Genito-Urinary Medicine (GUM) Clinic (Draft PCHA Report, 2006).

The GoG's policy of universal access to treatment has seen a rapid scale-up in the delivery of treatment services both in number and geographic reach between 2006 and 2007. The following are the main achievements to enhance the national treatment programme during the reporting period:

- A drug procurement committee was established at MoH to coordinate and harmonize drug importation, registration, storage, and point-of-service management. The successful implementation of a supply chain management system for ARVs ensured that there was no

stock out. Additionally, an ARV dispensing tool was developed in 2006 and is being used by all pharmacies at each of the treatment sites to monitor stock and the uptake of ARVs.

- The national HIV/AIDS treatment guidelines were updated to start HIV positive patients on treatment earlier with CD4 counts of 350 and below, which is consistent with current internationally recognized standards for HIV/AIDS care and treatment (Draft PCHA Report, 2006).
- By the end of 2007, a total of 1,952 persons were on ART as a result of the expansion of the national treatment network which now comprises 14 treatment sites across the country. These sites include two private sector facilities and one mobile team. The Mobile Outreach treatment and care programme provides a complete package of comprehensive treatment, care and support to PLHIV in the hinterland regions of Guyana twice monthly.
- Second line therapy has been available to patients since 2006.
- Ten United Nations Volunteer (UNV) physicians trained in HIV and STI management were placed at treatment sites across the country in 2006 to support the expanded treatment programme.
- A patient tracking system to monitor all patients (new and existing) enrolled in HIV care and treatment, is currently being implemented.
- There were increased investments in targeted training of laboratory personnel and the capacity to diagnose opportunistic infections has expanded with a wider range of available testing including TB culture, India Ink Stain, and modified Zeil Nelson.
- There is also limited access to viral load testing with plans to increase capacity by the expansion of laboratory infrastructure through the establishment of a National Public Health Reference Laboratory in 2008.
- Babies under 18-month are currently being tested through an arrangement where samples are sent abroad for testing. The MoH is in the process of procuring equipment to do DNA PCR testing in country.
- An 'Adolescent Clinic' at the Genito-Urinary Medicine (GUM) Clinic has also been initiated to stimulate the uptake of services among youths. An adolescent day is identified every month and members of this target group are referred or encouraged to attend clinic on that day for services. There is also a broader move to promote 'youth friendly' adolescent clinics to stimulate the uptake of a range of HIV related services. These 'youth friendly' clinics also serve an important role in prevention, since it facilitates the dissemination of key prevention messages among youths. Several health facilities have also been earmarked as 'friendly' for members of specific MARPS, such as CSWs and MSM, to stimulate greater uptake of services.
- A programme of Continuous Quality Improvement (CQI) was initiated for the national treatment programme. Initial results suggest that the overall quality of the treatment programme

has shown some improvement. A recent assessment shows that there is a smaller proportion of adults with CD4 less than 50 when compared to the study's baseline. Similarly, there is a reduced proportion of patients with CD4 count less than 200 when compared to the baseline. In contrast, there was a higher proportion of adults with CD4 higher than 500 when compared to the baseline.

In spite of the achievements of the treatment programme, it has been observed that there are still delays in patients' decision to seek treatment. This is reflected by the relatively low CD4 count of some patients when initiating treatment. It has also been noted that some of these patients are elderly (over 50 years) and this may suggest that there is need to target the elderly specifically.

All respondents of the 2007 NCPI survey agreed that Guyana has a national strategy to promote comprehensive HIV treatment, care and support, which gives sufficient attention to barriers for women, children and most at risk populations. Respondents also pointed out that there are several regional initiatives that facilitate Guyana's access to various critical commodities. The Clinton Foundation, which facilitates Guyana's access to regional procurement mechanism for paediatric drugs, was cited as an example. Additionally, it was noted that the Government of Guyana is currently building capacity in the area of commodities supply chain management.

Most respondents of the 2007 NCPI agreed that Guyana has made significant strides in keeping with its commitment to universal access. They pointed out that anyone living with HIV or AIDS in need of antiretroviral therapy is able to access medication at a public or private non-profit ARV site. Additionally, respondents observed that there is at least one ARV fixed or mobile site in each region across Guyana. However, knowledge on the extent to which HIV treatment, care and support services were available throughout the 10 regions of Guyana varies significantly among CSOs and Government informants. For example, most respondents felt that paediatric AIDS treatment was only available at the Gum Clinic, Georgetown Public Hospital.

3.4 Care and Support

As part of the response to HIV/AIDS, the need for home based and palliative care programme was identified and launched in June 2005. Care services are provided directly by the MoH through its national Home-Based Care (HBC) programme in collaboration with local NGOs. The support provided to PLHIV includes counselling to address disclosure, relationships and diet. Referrals for social, nutritional, and economic support were also provided to PLHIV.

In 2005, 57 persons were trained to provide HIV-related palliative care (excluding TB/HIV). This number was increased to 300 persons in 2006. In 2005, a total of 280 persons were provided with HPC services. This number increased to 1,026 in 2006, and 1,223 in 2007 (HPC Programme Reports). By the end of 2007, PLHIV in 60 percent of the regions in Guyana had access to HPC services. During 2007, the first hospice was also established in Guyana to provide both palliative and rehabilitative care. Persons in need of such care are referred from public and private hospitals.

The Ministry of Home Affairs initiated a programme in 2007 to increase the capacity of the Prison Department to provide better quality medical care to the prison population. A high dependency care unit was established at the Lusignan Prison to facilitate the proper care and management of prisoners living with HIV. Three prisoners were trained in home-based care, thereby equipping them with enough knowledge to offer support to medical staff in the provision of care and support

to prisoners living with HIV. Additionally, one prison officer was trained in HIV Life Cycle management.

Based on NCPI interviews, CSOs identified several gaps related to the availability of services regionally. These were mainly in the areas of paediatric AIDS treatment, HIV treatment services in the workplace, and HIV care and support in the workplace. An overwhelming number of NGOs felt that treatment, care and support services were not available to all regions in Guyana. Conversely, most of the government key respondents suggested that treatment, care and support services were available in all regions. There was agreement however, that HIV-related services are more accessible in 2007 as compared to 2005. Some of the specific areas commonly identified as examples of progress include:

- More involvement of NGOs in care and support;
- More emphasis on family level care and support, including a more structured and coordinated effort to provide Home-Based Care;
- Reduced stigma and discrimination and consequently more individuals and organisations are embracing PLHIV;
- A more deliberate effort to engage PLHIV in the national response to ensure that national efforts are addressing the real needs; and
- Most at risk populations can now access confidential and individualized care and treatment at public facilities.

3.5 Impact Alleviation

3.5.1 Orphans and Vulnerable Children (OVC)

It is the GoG's policy to provide free health care, protection, socio-economic security, education, nutritional and psychosocial to OVCs, regardless of whether the children are affected by HIV. OVC programme activities are therefore not HIV-specific. A primary objective is to enhance the coping mechanisms of both caregivers and children in dealing with HIV within a household.

The 2007 NCPI survey revealed varying perceptions among CSOs, donors and government representatives on the response to the needs of OVCs. All CSOs interviewed were unaware that a national policy on OVCs existed. Donors recognized that a national operational definition of OVCs existed and pointed out that major HIV partners had varying definitions of OVCs. All government representatives stated that there was an OVC policy, a national definition of OVCs and that there was a national plan of action for OVCs.

OVC Operational Definition

Orphans are defined as children under 18 years old, of whom at least one or both of their biological parents have died through causes such as AIDS, other illnesses, violence, suicide or other causes. ***Vulnerable children*** include those living without one or both parents because of long-term or permanent (national or international) migration or chronic illness and those who are living without any caregivers at all. Furthermore, OVC include those living on or who spend most of their time on the streets, and children in orphanages or other institutions of care. Moreover, children with a disability, in conflict with the law, or who are survivors of various forms of violence and/or neglect are included in the definition of OVC.

A National Plan of Action providing a comprehensive list of priorities for OVCs was developed in 2006. OVCs have also been targeted in the Guyana National HIV Strategy 2007-2011 with the objective of ‘reducing the socio-economic impact of HIV and AIDS on children and increase protection of OVC’. Additionally, it must be noted that all partners agreed that government provides support to OVC through the Ministry of Labour, Human Services and Social Security (MLHS&SS).

The primary achievements in this programme area during 2006 – 2007 include:

- The operational framework on OVC was aligned to the 2007-11 NSP on HIV.
- A draft OVC Policy has been prepared and has been presented to the Ministry of Labour, Human Services and Social Security for approval.
- A Child Protection Unit was established within the MLHS&SS in 2006. During this time the pending draft Child Protection Bill was brought to the forefront and stakeholders were consulted to facilitate its finalization.
- The MoLHS&SS and the MoH initiated a programme which seeks to assess the quality of care in institutions that includes the establishment of Minimum Operation Standards for institutional care and the formalization of foster care systems. Currently the Government of Guyana provides financial support to all 23 orphanages/children’s homes across Guyana and is the process of refurbishing all of these institutions to ensure that they meet the minimum standards.
- The NAPS established an Amenities Programme for OVC in 2007 as a means of increasing their access to education. Items such as text books, school bags, rain coats, and stationery, are supplied to complement the school uniform voucher programme provided by the MoLHS&SS.
- A total of 849 HIV-related OVC were reached with external support in 2006 and 903 in 2007. External support includes counselling, mentoring, access to education and health care services, lifeskills education, and skills training for caregivers. Six hundred and twenty (620) OVC in institutions received support from the GoG in 2007.

3.5.2 Support for PLHIV

During the reporting period the level of psychosocial and economic support provided to PLHIVs was significantly improved. In 2007, a Food Bank was established to provide nutritional support to clients meeting established criteria. A new structured programme was also initiated to establish support groups for all PLHIVs attending treatment sites. Further details on the food bank and the support groups are outlined in the '*Best Practice*' section below. In addition, a human rights desk was established at NAPS to facilitate the documentation and investigation of complaints of stigma and discrimination among PLHIV.

3.6 The National Multi-sector Response

Civil Society

Using external funds, the Ministry of Health was able to provide financial resources to CSOs to significantly scale-up their contribution to the national response. As a result, the capacity of CSOs was increased and this is reflected in the increasing national coverage of services provided through these entities. While in 2005 there were 30 CSOs active in the response to HIV, this number had increased to 55 by the end of 2007. Key services were provided by CSOs in the areas of prevention (condom distribution, BCC and VCT) as well as care and support (HPC, OVC and reducing care and support).

Line Ministries

As with CSOs, the Ministry of Health was able to leverage external funds to stimulate a broader response among other Line Ministries. Focal Points were hired to stimulate the development of workplans and policies within the participating ministries. In 2005 there were seven Line Ministries with workplans and budgets to support the control of HIV. By the end of 2007, this number had increased to 11. In addition, there were two additional state entities with workplans and budgets to implement activities to control HIV. The strategy targeted both the staff and clients of the various ministries. The major activities implemented revolved around prevention (educational sessions for staff and their families, training peer educators) as well as care and support (training in HPC).

Private Sector

The private sector has long provided support to CSOs to enhance their response to HIV. Further details on this aspect of the response are outlined under the '*Best Practice*' section below.

4. BEST PRACTICES

Private Sector Participation

An important objective of the national response is to develop strong private sector support to prevent HIV in Guyana, and to assist PLHIV. The private sector is being engaged through the separate, but coordinated, efforts of two technical partners as discussed below.

The Private Sector Partnership Programme

This programme encourages private enterprises to create a partnership with the Ministry of Health as a means of protecting their human resources by investing in HIV awareness and prevention. The employees of each enterprise receive workplace training on HIV education, and guidance in developing their HIV policy and workplace programme. Each workplace programme is tailored to

the specific needs and capacity of the company. Home-based care, VCT, PMTCT, behavioural change communication, stigma and discrimination, community outreach, and support for PLHIV and OVCs are the main areas being addressed by the companies. The initiative goes beyond the workforce to influencing family members, clients and the community as a whole. Specific programme areas that impact beyond the workplace include OVC and support for PLHIV. Several companies have collaborated to provide loans to PLHIV to start small enterprises.

Through this private sector partnership programme, a total of 43 entities have been formally engaged with Memoranda of Commitment by the end of 2007. Of these 22 companies have established workplace programmes and 15 have HIV workplace policies in place. Over 12,000 workers have been reached so far. When combined with the supply chain of distributors, contractors and household members, it is estimated that more than 100,000 persons have been reached by the end of 2007. A Private Sector Advisory Committee was also established as a forum for private companies to share experiences and stimulate further development.

The fact that many companies are on a waiting list to participate in this programme, is an indication of Guyana's success in encouraging private sector entities to join in the response to HIV and to address the associated stigma. This initiative is now considered a Best Practice and staff from the implementing partner has been recruited to help develop and assist similar programs in the Caribbean and South America.

It should be noted that there is a small overlap in the number of participating companies reported under this initiative and the Workplace HIV Programme reported below. However, in every case where companies are being targeted by both initiatives, there is coordination to ensure that the interventions do not duplicate each other.

Workplace HIV Programme

The current workplace programme evolved from collaboration between an implementing partner, the Ministry of Labour and the Ministry of Health in 2000 to raise HIV awareness in the workplace, and to develop policies, programmes and legislation to control the epidemic. This programme was restructured in 2003 with external financial support and focussed on reducing both risk behaviours among workers, as well as employment related stigma and discrimination. The programme is guided by the International Labour Organization (ILO) Code of Practice on HIV and the World of Work, which provides guidance for developing policies and programmes to reduce the spread of HIV and mitigate its impact.

By the end of 2005, an Inter-agency Coordinating Committee for Workplace Programmes was created to coordinate the overall development of the programme and guidelines were developed for establishing workplace HIV programmes and policies. At the end of 2005, eighteen companies had signed on to the process and 16 had finalized workplace policies. One large company joined the process during the 2006, with the result that there were 19 companies participating, with 17 of these having completed workplace policies. No new companies joined the process during 2007.

Other Private Sector Participation

During 2007, several private enterprises have independently demonstrated leadership in the response to HIV by making significant financial contributions to the National AIDS Programme Secretariat, as well as CSOs, to support the care of OVCs. And as noted above, the private sector is also supporting the national Food Bank for PLHIV.

Food Bank and Nutritional Support for PLHIV

In 2007, a Food Bank was established by NAPS to improve the nutritional status of PLHIV, thereby reducing morbidity associated with nutritional deficiency. Potential beneficiaries are screened at treatment sites and those meeting economic and medical criteria are referred to NAPS for food hampers comprising items from the major food groups. The Food Bank is increasingly being supported by the private sector and is clear demonstration of the commitment of the private sector to the HIV response. It is noteworthy that even private entities that are not in the food business are also supporting the Food Bank with cash contributions, which is directly paid a designated vendor to purchase food items.

The primary beneficiaries of the Food Bank are unemployed females. Most of the unemployed females are also heading single parented households. Clients are referred from Regions one, three, four, seven, eight, nine and ten. Logistics arrangements are continually evolving to ensure that food hampers reach patients in outlying regions, when they are not able to travel to the city.

Support Groups for PLHIV

Over the years, a range of CSOs have been providing psychosocial support to PLHIVs. During 2006, a structured Support Group Programme for persons living with and affected by HIV was initiated. The primary targets are the patients at the various treatment sites. In 2006, there were four support groups with a membership totalling 214. By the end of 2007, there was a rapid increase to nine support groups with a total membership of 444 persons. The members in these support groups benefited from various skills training programmes to support income generating activities. A voucher programme was also initiated during 2007 to provide financial assistance to PLHIV travelling for treatment to ART sites. Some 364 persons from nine sites in regions Two, Three, Four, Six and Ten benefited from the programme during 2007. A national conference for PLHIV was also organized during 2007 and members were trained in HPC.

These support groups not only serve as a forum for highlighting key issues, but are also a source of new ideas for enhancing the quality of lives of PLHIV. For example, on the recommendation of the membership of the support groups, the Ministry of Housing and Water, in collaboration with the Ministry of Health, introduced a special lottery which enabled five PLHIV to receive free house-lots on which to build their homes. A local NGO will build a house on the lot won by each, free of charge.

Members of these support groups also play a key role in a range of policy and oversight committees. These include the Country Coordinating Mechanism and a range of Steering Committees for various programme areas, such as HPC and BCC.

5. MAJOR CHALLENGES AND REMEDIAL ACTIONS

The 2005 Guyana UNGASS Progress Report identified the following challenges to achieving the UNGASS goals/targets:

1. Limited personnel at all levels;
2. Deficient procurement & commodity management system;
3. Inadequate coordination of implementing partners;
4. Insufficient coordination of implementing partners;
5. Ineffective mobilization of resources; and
6. Limited service provision in remote areas.

Over the last two years, the GoG took a number of actions to address these challenges:

1. Qualified personnel recruited with donor support;
2. Establishment of a Supply Chain Management System has significantly improved the timely procurement, storage capacity, and distribution of drugs and commodities;
3. Programme coordinators were hired to coordinate national programme areas;
4. Key programme areas are managed by coordinating committees; and
5. Services significantly scaled up to provide national coverage.

Despite major progress, some important challenges remain, and these include:

1. Attracting and retaining suitable staff remains a challenge due to both rural to urban migration and emigration;
2. Implementing standard operational procedures for TB health care workers to protect themselves and clients;
3. External quality control for all laboratories; currently, not all private sector laboratories participate in external quality programmes;
4. General discrimination against PLHIV;
5. Insufficient coordination of donors to streamline the allocation of resources; and
6. Need for increasing access to services in remote areas to meet the demand generated by the BCC programme.

The GoG would need to take the following actions to address the some of the challenges mentioned above:

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.
2. A multi-year workplan and budget to support the implementation of the current National Strategic Plan will be developed and implemented. It is expected that this will contribute to resolving many of the challenges currently facing the national programme.
3. While the Presidential Commission on HIV and AIDS, the UN Theme Group on HIV & AIDS & the CCM exist, there is need for further national coordination to avoid both duplication and gaps in resource allocation.

4. Efforts will continue to educate health care workers in standard operational procedures to minimize incidents of discrimination and to provide quality care to patients, while protecting themselves.
5. The recently passed Health Facilities Licensing Act 2007 which seeks to strengthen regulations of public and private hospitals, laboratories, and other services will assist in addressing the challenge of ensuring that private laboratories participate in external quality control programmes.
6. There is an ongoing media campaign against stigma and discrimination. Modules addressing this issue are also being incorporated into all training programmes. An Advocacy Desk has also been established in the NAPS office to address this issue. Finally, the draft HIV legislation once passed in Parliament will assist in addressing this issue.
7. Strategic partnership with CSOs is contributing to increasing coverage of HIV services. However, the relatively low population density of the hinterland, together with difficulties of access, mean that providing all services, including HIV to the hinterland population will always be a challenge in the foreseeable future.

6. SUPPORT REQUIRED FROM DEVELOPMENT PARTNERS

The progress reported herein is directly related to a significant increase in financial resources provided by donors and technical partners to Guyana. The Government of Guyana is appreciative of the support provided by development partners and looks forward to:

1. Collaborating with partners to develop a plan for sustaining human resources;
2. Support for Guyana to continue benefiting from competitive pricing and access to goods and services;
3. Continued 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 NSP;
5. Harmonization of donor reporting commitments to facilitate a single national report to fulfil 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. MONITORING AND EVALUATION ENVIRONMENT

Guyana has made significant collaborative progress on monitoring and evaluation. Key M&E achievements during 2006-2007 include:

1. A participatory national monitoring and evaluation plan was developed to measure the effectiveness of the national response as envisaged in the National Strategic Plan for HIV (the M&E Plan includes core indicators and was developed with the consensus of all stakeholders);
2. National targets were established for core indicators in the M&E Plan;
3. Increased awareness at all levels on the importance of M&E and greater ownership of core indicators by programme coordinators;
4. Dedicated M&E staff for HIV;
5. Two critical reviews of the HIV M&E system were undertaken to inform actions for improvement;
6. Establishment of a Monitoring and Evaluation Reference Group;
7. Comprehensive guidelines were developed to monitor the contribution of CSOs and Line Ministries to the national response;
8. Strong donor commitment to strengthen the national M&E system;
9. Data generated over the last few years have been used to inform strategy and programme development; and
10. Several special studies were conducted that include the Biological and Behavioural Surveillance Survey(2005), AIS (2005), ANC Survey (2006), PMTCT Uptake Study (2005), Service Provision Assessment (SPA) (2005), and the BBSS among prisoners (2007). These surveys provided valuable baseline data and were also used to guide the establishment of national targets.

All respondents of the 2007 NCPI unanimously agreed that the M&E plan was endorsed by key partners and that it was developed in consultation with civil society, including PLHIV. However, there was significant variance in opinion as it relates to whether all key partners have aligned and harmonised their M&E requirements (including indicators) with the national M&E plan. Responses varied from “YES”, all partners have harmonised, to “NO”, not all partners have. Fifty percent (50%) of interviewees across sectors agree that most partners have harmonised and aligned their M&E requirements with the national M&E plan. Seventy five (75%) percent of respondents agree that the national M&E plan includes the following:

1. A data collection and analysis strategy;
2. Behavioural surveillance;
3. HIV surveillance; and
4. A well defined standardised set of indicators.

Fifty percent (50%) of respondents agreed that the national M&E plan contain guidelines on tools for data collection. Seventy-five percent (75%) of respondents agreed that the national plan does not contain data dissemination and use strategy, and there were significantly mixed responses in relation to whether a strategy for assessing quality and accuracy of data existed. It was noted, however, that the NAPS network is emerging as a valuable source for data sharing. Most respondents were aware of the effort to make the national M&E plan operational and noted that such a plan will soon be developed to address some of the existing M&E gaps and challenges. All respondents agreed that there is no budget for the M&E plan. However, several donor-funded projects have M&E budgets which need to be consolidated and linked to national M&E plan.

Seventy-five percent (75%) of respondents believed that the national M&E network is fledgling or “in progress” however all respondents were aware of the officers or staff in the department. It was noted by a majority of respondents that more work is needed in building the capacity of the unit. Respondents cited the development of the national M&E operational plan as an opportunity to address issues such as, roles and responsibilities, relationship to partners and data flows. All respondents agreed that there is no formalised mechanism in place to ensure that all major implementing partners submit M&E data/reports to the national M&E unit for review and consideration in the country’s national reports. However, it was noted that most major implementing partners regularly share data with NAPS on progress and challenges in implementing country plans.

All respondents agreed that there is a national M&E working group. However, fifty percent (50%) noted that the working group meets irregularly and on an as needed basis. Seventy-five percent reported that there was no civil society representation, including PLHIV in the national working group. The M&E unit does not currently manage a central national database. Seventy-five percent of respondents said that there is a functional (regularly reporting data from health facilities) health information system and that Guyana publishes at least once a year an M&E report on HIV, including HIV surveillance data.

All respondents agreed that there is a moderately high use of M&E data in planning and implementation of the national HIV response. Examples of this include:

- Regular feedback meetings among PMTCT managers
- Data is used by development partners for forecasting and development of work-plans for future years
- National BCC strategy was designed based on findings of the BSS
- GHARP used Health and Family Life Education and BSS data for designing the in-school youth prevention programme.

The key M&E challenges include:

1. Additional personnel required to effectively fulfil all M&E needs;
2. Roles and responsibilities for M&E are not clearly defined;
3. Limited capacity for M&E centrally and within the various regions;
4. There is no comprehensive national workplan for M&E;
5. Lack of consolidated M&E budget;

6. Data flow is currently not streamlined to allow NAPS to be a functional clearinghouse of all HIV data;
7. Lack of data quality protocols; and
8. Lack of a structured communication and data dissemination plan.

All of the gaps identified above will be specifically addressed in an operational plan which is being prepared to facilitate the implementation of the National M&E Plan. The operational plan is expected to be completed by the end of the first quarter of 2008.

ANNEXES

Annex 1

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
 - Labour Yes
 - Foreign Affairs Yes
 - Others No
 - Civil Society Organisations Yes
 - People living with HIV Yes
 - Private sector Yes
 - United Nations Organisations 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, UN agencies, bilateral agencies and NGOs.
- 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.

Date: _____

Signature: _____

ANNEX 2

National Composite Policy Index Questionnaire (through CRIS) National composite Policy Index – 2007

Country: Republic of Guyana

Name of the National AIDS Committee officer in charge: Dr. Shanti Singh-Anthony, M.D., M.P.H.

Signed by: _____

Address: Hadfield Street & College Road, Wortmanville, Georgetown, Guyana

Tel: (592) 227-8683 or (592) 226-5371

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E-mail: ssinghanthony@yahoo.com

Date: 29th January 2008

Report of National Composite Policy Index Questionnaire
See email attachment

ANNEX 3

National Return Forms for programme, knowledge, behaviour and impact indicators (through CRIS)