HIVISION 2020

Guyana

National HIV Strategic Plan (2013-2020)

The Vision:

To eliminate HIV in Guyana

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The Goal

To reduce the social and economic impact of HIV and AIDS on individuals and communities and ultimately the development of the country, and overall strategic objectives of reducing the spread of HIV and improving the quality of life of PLHIV

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List of Acronyms	
ABC	Abstinence, Faithful and Condom Use
AHU	Adolescent Health Unit
AIDS	Acquired Immuno - Deficiency Syndrome
AIS	AIDS Indicator Survey
ANC	Ante Natal Clinic
ART	Antiretroviral Treatment
ARV	Antiretroviral
BBSS	Biological Behavioural Surveillance Survey
BSS	Behavioral Surveillance Survey
CARICOM	Behaviour Change Communication
CBOs	Community Based Organisations
CDC	Centers for Disease Control
CRIS	Country Response Information System
CRSF	Caribbean Regional Strategic Framework
CSO	Civil Society Organisations
CSW	Commercial Sex Workers
CTX	Co- trimaxazole
DCC	Department of Disease Control
DHS	Demographic Health Survey
DOTS	Direct Observed Treatment Short - Course
DPT3	Diptheria, Pertussis and tetanus
EFR	Enhanced Financial Reporting
eMTCT	eliminating of Mother to Child Transmission
FBO	Faith Based Organisation
FCSW	Female Commercial Sex Worker
FSW	Female Sex Worker
FY	Fiscal Year
G+	Guyanese Network of People Living with HIV and AIDS
GBV	Gender Based Violence
GDP	Gross Domestic Product
GFATM	The Global Fund against AIDS ,TB and Malaria
GHARP	Guyana HIV Prevention and Reproductive Programme
GIPA	Greater Involvement of People with AIDS
GMC	General Medical Council
GoG	Government of Guyana
GPRS	Guyana Poverty Reduction Strategy
HAART	Highly Active Anti - Retroviral Treatment
HAPSAT	HIV AIDS programme Sustainability Analysis Tool.
HBC	Home Based Care
HCW	Health Care Workers
HDI	Human Development Index

HESU	Health Education Sciences Unit
HFLE	Health and Family Life Education
HIES	Household Income and Expenditure Survey
HIV	Human Immuno Deficiency Virus
HPC	Home and Palliative Care
HPV	Human Papilloma Virus
HR	Human resources
ICT	Information, Communication and Technology
IEC	Information, Education, Communication
ILO	International Labour Organisation
INH	Isoniazide
KPAHR	Key Populations at Higher Risk
L &D	Labour and Deliver
LM	Line Ministry
LMIS	Logistic Management Information System
M&E	Monitoring and Evaluation
MAA	Ministry of Amerindian Affairs
MARPS	Most at Risk Populations
MCH	Maternal and Child Health
MCYS	Ministry of Culture, Youth and Sport
MDGs	Millennium Development Goals
MERG	Monitoring and Evaluation Reference Group
MHSSS	Ministry of Human Services and Social Security
MISU	Management Information System Unit
MMU	Material Management Unit
MOE	Ministry of Education
MOH	Ministry of Health
MOHA	Ministry of Home Affairs
MOHSS	Ministry of Health and Social Services
MOLGRD	Ministry of Local Government and Regional Development
MOLHS&SS	Ministry of Labour, Human Services and Social Security
MSM	Men who have Sex with Men
MTCT	Mother to Child Transmission
NAPS	National AIDS Programme
NASA	National AIDS Spending Assessment
NBB	National Blood Bank
NBTS	National Blood Transfusion Services
NCC	Network for Community Commitment
NCD	Non Communicable Disease
NCTC	National Care and Treatment Centre
NDS	National Development Strategy
NGO	Non Governmental Organisation
NHS	National Health Strategy

NPHRL	National Public Health Reference Laboratory
NSP	National Strategic Plan
NTP	National Tuberculosis Control Programme
ODA	Official Development Assistance
OI	Opportunistic Infection
OVCs	Orphans and Vulnerable Children
PAHO	Pan American Health Organisation
PEP	Post Exposure Prophylaxis
PEPFAR	President's Emergency Fund for AIDS Relief
PHC	Primary Health Care
PITC	Provider - Initiated Testing and Counseling
PLACE	Priorities for Local AIDS Control Efforts
PLHIV	Person Living with HIV
PMTCT	Prevention of Mother To Child Transmission
PMS	Patient Monitoring System
PrEP	Pre - Exposure Prophylaxis
PWP	Prevention with Positives
QoC	Quality of Care
RHS	Regional Health Services
S & D	Stigma and Discrimination
SCM	Supply Chain Management
SCMS	Supply Chain Management System
SI	Strategic Information
SPSS	Statistical Package for the Social Sciences
SRH	Sexual and Reproductive Health
STIs	Sexually Transmitted Infections
SVA	Single Visit Approach
SW	Sex Worker
TB	Tuberculosis
UA	Universal Access
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session.
UNICEF	United Nations Children's Fund
USAID	US Agency for International Development
VCT	Voluntary Counseling and Testing
VIA	Visual Inspection with Acetic Acid
WHO	World Health Organisation

Foreword

A National HIV Strategic Plan should provide clarity on how to achieve results, recognizing that results can only be achieved through a multi-sectoral approach.

As the Minister of Health, I reaffirm the multi-stakeholder inclusion of government, civil society, the private sector and key populations in governance, planning and implementation of Guyana's National HIV Strategic Plan 2013 to 2020: **HIVision2020.**

Accountability for this National HIV Strategic Plan and its implementation resides within the National AIDS Programme Secretariat of the Ministry of Health that has authority to demand accountability and drive multi-stakeholder Collaboration through functioning mechanisms defined in this Strategic Plan.

HIVision2020 is fully aligned with both our national development and health sector strategies. In this time of limited resources, prioritization will be critical for good resource allocation. Guyana is committed to continuously identify capacity gaps and build capacity of multiple stakeholders to develop and implement strategies and implementation plans, with appropriate support from our development partners.

HIVison2020 is underpinned by the principles of Human Rights, Gender Equality, Inclusiveness, Accountability, Value for Money and Sustainability.
I wish to call on all Guyanese and all our friends and partners to jointly make the vision of "Zero New HIV Infections, Zero Discrimination and Zero AIDS-Related Deaths" come true.

Dr. Bheri Ramsaran
Minister of Health
Guyana.
February 2013

Acknowledgements

Guyana's successes in the combating the HIV epidemic is well established locally and further afield. Significant progress is made in testing with many Guyanese knowing their HIV status. Less new infections are reported than previously. Fewer babies are born HIV positive and Guyana is on its way to achieving the elimination of Mother to Child Transmission. People Living with HIV are accessing high quality HIV care with the best antiretroviral regimen, living longer and healthier lives. Indeed, Guyana has stabilised the HIV epidemic and has begun its reversal, clearly on its way of getting to "Zero".

The National Response has been truly a multisectoral one and all partners and stakeholders rallied around this important public health and developmental issue. Guyana has been fortunate with the level of support received thus far from funding agencies. Special thanks to the President Emergency Fund for AIDS Relief (PEPFAR), the Global Fund Against AIDS, Tuberculosis and Malaria, the World Bank, the Canadian International Development Agency and all other donors whose resources have allowed Guyana to downgrade this epidemic from an emergency to a response where HIV is now a chronic disease and sustainability is of the highest priority. Special thanks to our technical partners, UNAIDS, PAHO, UNICEF and the entire UN family. The technical guidance provided was important in ensuring that our response was aligned to the epidemic and that our resources were achieving maximum impact. We are deeply appreciative to Civil Society Organisations, Community Based Organisations, the private sector, the faith community, people living with HIV, and communities of key populations at higher risk, for your unwavering advocacy and guidance. Your contributions take the response into the communities reaching the most vulnerable and impacting of their lives in significant way. I am deeply grateful to all of the agencies and individuals who have contributed to the development of the HIVision2020. Thanks to the Minister of Health, Dr. Bheri Ramsaran and the Steering Committee, for their leadership in the development process of this document.

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Executive Summary

The aim **of HIVision2020** the new National Strategic Plan for HIV of Guyana **2013-2020** is to fully fund Guyana's HIV response through country ownership and shared responsibility, to put knowledge, experience, lessons learnt and innovation forward to make effective programme decisions and to invest resources wisely to obtain optimal results for all the people of Guyana. ***It is designed to place Guyana on a trajectory to eliminate HIV.*** This strategic plan succeeds the previous plan of 2007 -2011 and addresses the issues and challenges of the epidemic in Guyana today. This plan takes into consideration the priorities for national development and specifically for the prevention and control of HIV, the regional priorities as guided by the Caribbean Regional Strategic Framework (CRSF) and the international commitments to the Political Declaration on HIV and AIDS and the Millennium Development Goals (MDGs).

The development of the HIVision 2020 was led by a steering committee, chaired by the Minister of Health and involved a wide cross section of stakeholders. The steering committee was supported by technical working groups for each priority area. Information for the development of the HIVision 2020 was gathered through desk review, key informant interviews, national consultations and focus groups with key populations at higher risk.

Situation Analysis

Since the first reported case of AIDS in 1987, there has been a progressive increase in the number of reported cases over the years. A cumulative total of 9,598 cases of HIV and 2,439 cases of AIDS were reported to the Ministry of Health for the period 2003-2012. The most recent estimation exercise conducted for 2011 revealed HIV prevalence among adults 15-49 years of 1.1% (Spectrum/EPP 4.47). This represented a decrease from 2.4% in 2004 and 1.2% in 2009 (UNAIDS Estimates). HIV prevalence among pregnant women was maintained around 1% between 2009 and 2011. Mother to child transmission of HIV continues to decline with the absolute number of babies being infected reducing each year. In 2011, 5 babies were born positive and the Mother to Child Transmission (MTCT) rate was 2.5%. HIV prevalence among blood donors has also remained below one percent in the last five years, moving from 0.5% in 2008 to 0.3% in 2012. The 2009 Biologic Behavioral Surveillance Survey (BBSS) showed a sharp decrease (38%) in the HIV prevalence among female sex workers (FSWs), from 26.6%

(BBSS, 2005) to 16.6% (BBSS, 2009). In contrast only a slight decrease was observed among MSM, from 21.2% (BBSS, 2005) to 19.4% (BBSS, 2009).

The male to female ratio for HIV cases has been fluctuating over the past four years. While HIV appears to have initially been most prevalent among males, data indicates that there are an increasing number of women becoming infected.

Whilst there are variations within the specific age groups, consistently more than three quarters of HIV cases are reported in the combined age group of 20-49, which is considered the productive workforce. Notable increases were observed among the age-groups 15-19 and 20-24 (in and out of school youth) in 2010 but there was a marked reduction in cases within these cohorts in 2011.

Among Guyana's 10 administrative regions, Region 4 continues to account for the largest proportion of notified HIV cases; reaching over 70% by 2011. There have been fluctuations across the other regions over the past six years. However, the coastal regions (2, 3, 5, 6 and part of 10) have stood out in terms of the proportion of reported HIV cases which may be attributed mainly to the better access of the prevention programme in these regions as compared to the hinterland regions where there are challenges as a consequent of the difficult terrain associated with these locations. Preliminary mortality data for 2010 show the proportion of all deaths attributable to AIDS steadily declining from 9.5% in 2002 to 3.2% in 2010.

The Response

Preventing new HIV infections has been a mainstay of the National Response and this is outlined in the "Guyana National HIV Prevention Principles, Standards and Guidelines, 2010." This stipulates and guarantees that the minimum standards required in achieving HIV prevention are being met and maintained nationwide. In scaling up HIV prevention, an intensified prevention programme had been implemented and includes access to Voluntary Counseling and Testing (VCT); Prevention of Mother to Child Transmission (PMTCT); comprehensive Sexually Transmitted Infection (STI) services and Information, Education and Communication (IEC) on Stigma and Discrimination (S&D) reduction and HIV prevention-related issues. Importantly, targeted interventions were scaled up to impact on some of the Key populations at Higher Risk, particularly the Men who have sex with men (MSM) and the Female Commercial Sex Worker (FCSW) populations, now termed Key Populations at Higher Risks.

The national care and treatment programme has expanded over the past four years with a steady annual increase of persons enrolled into treatment and managed according to national guidelines. Monitoring of Quality of Care (QoC) introduced in the last five years through the HEALTQUAL initiative and Client Satisfaction Survey (CSS) showed ongoing improvement in this area. Success was noted in the provision of nutritional and psycho-social support provided to persons infected and affected with HIV (PLHIVs). Referrals between TB treatment sites and Antiretroviral (ARV) treatment sites have been strengthened with the integration of tuberculin skin testing in the package of services provided at Antiretroviral Treatment (ART) sites. There has been high uptake of HIV testing among the TB patients and a steady increase in the proportions of TB/HIV co-infected patients being treated for both diseases simultaneously.

In order to understand the epidemic and effectively develop and implement programmes that achieve universal access to prevention, treatment, care and support, Guyana has put in place systems of surveillance, research, and monitoring and evaluation which provided essential information on the progress in responding to the HIV. These have been guided by a National M&E Plan and an Operational Plan. Several studies were undertaken and included the Biological /and Behavioral Surveillance Surveys (BSS and BBSS) for the MSM, FCSW, In School Youth (ISY), Out of School Youth (OSY), and the Armed Forces.

Some of the main challenges being faced by the HIV response remain:- attrition rate of health workers; continued existence of some degrees of stigma and discrimination; limited understanding of the epidemic in key populations at higher risk; the relative inadequacy of cohesive data collection system; limited access to services in remote areas; inadequate infection control in the health sector; social factors impacting negatively on treatment outcomes; and the transition of HIV as a chronic disease and the evolving nature of the global economic and political architecture which demands greater focus be placed on the understanding of the financial requirements of the National Response..

HIVision2020

The new strategic plan with its ***vision of eliminating HIV in Guyana*** has outlined the goal, guiding principles and strategic objectives to achieve this and to honour Guyana's commitment "To achieve Zero new HIV Infections, Zero Discrimination and Zero AIDS-related Deaths" by 2015. The ***goal is to reduce the social and economic impact of HIV and AIDS on individuals and communities and ultimately the development of the country, and the***

overall strategic objectives of reducing the spread of HIV and improving the quality of life of PLHIV

Several factors will influence HIVision2020 and include but not limited to the importance of continued political commitment; the fact that there is definitive evidence that treatment is prevention and therefore the need to refocus on consolidating the gains made in the treatment programme; the emergence of HIV as a chronic disease and no longer an emergency; HIV must continue to be based on Human Rights with equity in the provision of culturally appropriate services: and the global financial constrains and the need therefore for shared responsibility.

HIVision2020 includes, strong prioritised, strategic statements of how effective country ownership, commitment and actions, will bring about better control of the epidemic in Guyana, while scaling up the integration of HIV into the health sector and improving access to care and treatment to all in need.

HIVision2020 will be guided by several key principles ensuring that the HIV response is coordinated; that there is rights based approach to the response: that there is equity in services with consideration for the local and cultural contexts, and the response is strategic and based on evidence.

The Strategic Plan will address the HIV response using the social determinants of public health as its foundation. **HIVision2020** strives to achieve a more targeted and strategic approach to investment in the response to the HIV epidemic in Guyana that will yield long-term dividends. This approach will monitor the mobilization of resources and efforts made to maximize scaling up of the response and health systems strengthening.

Stigma and Discrimination and Human Resource issues are considered cross cutting and are addressed throughout the document in all priority areas.

Priority Areas

HIVision2020 encompasses five priority areas that will be the focus for implementation from 2013-2020. These areas provide strategic objectives and the expected and intermediate results that will determine the activities to be undertaken during the period. Built into Guyana's

HIVision2020, will be M&E framework to measure its progress of implementation. This, with the support of operational plans will provide markers of progress along the life of the plan.

1. Coordination

Aligned to the principles of the three ones, **HIVision2020** adheres to the principle of "*one* overarching coordination mechanism of the national HIV response," One agreed programme that serves to align all partners and stakeholders working jointly to accomplish the results of the National Strategic Plan2013 to 2020. With the changing dynamics of the HIV epidemic and its response, a review of the current coordinating mechanisms, its roles and responsibilities is critical in ensuring that this remains relevant and current. In facilitating the effective functioning of the coordinating agencies, all technical working groups will be strengthened and supported in their effective functioning. The Coordination Committees will ensure continued strategic engagement of the donors, technical agencies and developmental partners and Civil Society Organisations. The coordination of civil society organisations, non-health line Ministries, the business and the faith community, the PLHIV will be essential elements in this NSP2013-2020

2. Prevention

To achieve zero new HIV infections, zero discrimination and zero AIDS-related deaths, **HIVision2020** will facilitate an enabling social, economic, legal and institutional environment for unhindered HIV prevention for all, including support to community initiatives for prevention of HIV and mitigation of its impact. Established programmes will be expanded with a focus on universal access and quality of care. These programmes will include PMTCT, Blood Screening, HIV testing and Orphans and Vulnerable Children (OVC). An intensified focus would be placed on addressing the epidemic at its core; among key populations at higher risks. These will include MSM, SW, prisoners and communities linked to these populations. The youth and women identified as priority groups for action will also be targeted in significant ways and information will be gathered on the migrant populations (miners and loggers) and adjacent communities to understand their vulnerabilities with accompanying strategic programming. Linked to strategic Information, key populations will continue to be defined through Modes of Transmission Studies (MOT). Overarching to these populations, behaviours and vulnerabilities will be addressed to reduce the risk for HIV and to increase their protective factors.

3. Treatment, Care and Support

The goal is to improve the quality of life and reduce morbidity and mortality for PLHIV. While, the overall aim of this priority area is to strengthen the health system to create the conditions necessary for universal access through the simplification of high-quality treatment and improve the efficiency and effectiveness of treatment and care delivery, the long term goal is to transform the response of programmes from an emergency phase to long-term sustainability. Through **HIVision2020**, appropriate and equitable health care will be provided to PLHIV. The treatment programme, a critical component of HIV prevention will ensure universal access to Antiretroviral (ARV) therapy. First and Second line therapy for adults will continue and strategies for third line therapy would be put in place. Adherence, loss to follow up and drop rates negatively affecting treatment outcomes will be strategically addressed. TB/HIV co-infection would be priortised with strategic actions focused on reducing TB/HIV comorbidity and mortality. HIVision2020 will ensure that the idiosyncrasies of dealing with the adolescents, the ageing HIV population and key populations at higher risk (MSM, SW, prisoners) and other priority groups are addressed. Care services will be expanded to ensure that chronic diseases are integrated within the HIV management. Nutritional and psychosocial and other forms of support to PLHIVs and their families will be increased and, importantly, to enable the PLHIV to become economically independent. In order to enhance and facilitate the availability and use of real time information, the Health Information System would be strengthened.

4. Integration

The gains attained by the Guyana HIV programme over the past decade have the potential to benefit key areas beyond HIV. HIV is closely linked and interconnected with a wide range of health and public health issues such as: prevention, early diagnosis and treatment of STI; maternal, newborn and child health; sexual and reproductive health, and blood safety. **HIVision2020**, therefore, brings about the necessary integration at both the coordination and the implementation level, of HIV with other national primary health care and public health programmes. Inherent with integration at the *coordination* level, is strengthening of the health system while results of integration at the *implementation* level are reflected as improved and sustained care, treatment, support and prevention outcomes.

5. Strategic Information

The goal of this priority area is to strengthen HIV and AIDS Surveillance, Monitoring and Evaluation Systems, and Research towards the use of strategic information for decision-making. Guyana has made tremendous strides in collecting, generating, analysing, disseminating and using relevant data. **HIVision2020** supports the strengthening of capacity to translate data into strategic information, to be used as the basis for action. **HIVision2020** supports the National Programme to optimally measure the results of its efforts in reducing the incidence of HIV and its social and economic impact. To this end, the National AIDS Programme will continue to coordinate and manage its HIV-related M&E functions, technically supported by the Monitoring and Evaluation Reference Group (MERG). The strategies will be guided by an HIV M&E Plan and will hinge on maintaining proficient and stable M&E capabilities at the central level and supporting same at the regional and facility levels.

The strengthening actions identified for the current strategic period will be guided by the twelve essential components of a functional M&E System.

Chapter 1: Introduction

HIVision2020 is designed to place Guyana on a trajectory to eliminate HIV. This strategic plan succeeds the previous plan of 2007 -2011 and addresses the issues and challenges of the epidemic in Guyana today. The priority areas of focus are: Coordination, Prevention, Care, Treatment and Support, Integration and Strategic Information. The plan was developed through extensive consultations with the key stakeholders from government and non-government sectors and agencies, civil society organizations, the private sector, the faith community, PLHIV, members of key populations at higher risk, MSM and FCSW. The goal of the NSP 2013 – 2020 is "To reduce the social and economic impact of HIV and AIDS on individuals and communities and ultimately the development of the country."

The Government of Guyana (GoG) has declared from the inception of the local epidemic that HIV and AIDS is a National Priority. The GoG has demonstrated through its local response, regional and international commitments to an accelerated, comprehensive, multi-sector, multi-level approach, achievable through a well-coordinated partnership with local, regional, international, technical and others partners and all stakeholders.

The National HIV and AIDS Programme therefore find its basis in a number of national, regional and international frameworks. The National Strategic Plan 2013-2020 (**HIVision2020**) takes into consideration the priorities for national development and specifically for the prevention and control of HIV, the regional priorities as guided by the Caribbean Regional Strategic Framework (CRSF) and the international commitments to the Political Declaration on HIV and AIDS and the Millennium Development Goals (MDGs).

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Guyana is a Caribbean Country and functions within the context of CARICOM. The HIVision2020 has therefore considered in its development the CRSF 2008-2012, at the same time recognizing its time limitations. The HIVision2020 considered that the CRSF supports national level programmes which are based on multi-sectoral approaches within the priority areas as follows (1) An enabling environment that fosters universal access to HIV and AIDS prevention, treatment, care, and support services; (2) An expanded and coordinated intersectoral response to the HIV/AIDS epidemic; (3)Prevention of HIV transmission; (4)

Treatment, care, and support; (5)Capacity development for HIV/AIDS services; and (6)Monitoring, evaluation and research.

At the Global Level, Guyana has committed to the declaration of Commitment on HIV and AIDS, "Global Crisis, Global Action" in June 2001. The pillars of this declaration served as an integral tool in guiding the national response. More recently in June 2011, Guyana once more endorsed the Political Declaration of HIV and AIDS: Intensifying Our Efforts to Eliminate HIV and AIDS.

1.1 Country Profile – Social Context

Guyana has a population of 751,223, according to the last population census of 2002. The sex ratio indicates that males narrowly outnumber females - with 50.1% of the population being male and 49.9% female. The four main nationality sub-groups of Guyana are East Indians comprising the largest proportion of the population (43.5%); followed by persons of African heritage (30.2%). The third are those of Mixed Heritage (16.7%), while the Amerindians are fourth with 9.2%.

The single largest religious group is the Hindus, whose membership represents almost 28% of the population. The largest Christian religious group is the Pentecostal faith (16.8%). With an increase within the Pentecostal religious groups, the Anglican and Roman Catholic churches have experienced a decrease within those populations, which currently represents approximately 7% and 8% of the population respectively. Muslims account for 7% of the population.

In education, at the national and regional levels, gross enrolment rates at the primary level exceed 100% with net enrolment ratios topping 96%. Access to secondary education is also on the rise with more than 65% of that cohort being enrolled. Reduction in overcrowding, introduction of nutrition programmes, and implementation of other support programmes extended to students in difficult situations may have contributed to the increased access in secondary education particularly in rural coastal and hinterland areas.

Poverty, particularly extreme poverty, in Guyana declined substantively during 1992 to 1999, when growth rates averaged 5.6% per annum. Throughout the first half of the new decade however, growth slowed and with it, the rate of poverty reduction also declined. The 2006 Household Income and Expenditure Survey (HIES) measured moderate poverty at 36.1% of the population while 18.6% of the population continued to live in extreme poverty, that is, on less

US$1.25 per day. Despite the initial slowdown in the reduction in poverty early in the decade, Guyana is still on track to meet the Millennium Development Goal of halving poverty by 2015.

Approximately 28% of Guyanese live in urban areas with a poverty rate is 18.7%, which is about half the national average and significantly lower than the Millennium Development target of 21.6%. Six out of ten people live in rural coastal areas and they register a poverty rate slightly above the national average, at 37%. In the rural interior region where Amerindians are concentrated, three out of four people are poor. Considering the respective population shares, more than 62% of indigent Guyanese live in the rural coastal regions, 22.6% live in the rural interior regions, and 14.7% live in urban areas. In all three areas, except the rural interior, there have been significant improvements in poverty rates since 1992.

Reported HIV cases increased from 400 cases in 2001 to 1356 in 2006. A decline was observed in 2008 where 959 cases were reported. AIDS reported cases decreased from 435 in 2001 to less than 24 in 2008, indicating the benefits of the investment by the Government and its partners in providing care and treatment with Anti-Retroviral (ARV) medication in responding to the HIV epidemic. Prevalence for HIV as measured by ante-natal testing done in 1995 and three serial Ante Natal Clinic (ANC) surveys in 2000, 2004 and 2006 indicates steady decline from 5.6% (2000) to 1.5% (2006). HIV remains concentrated in the more populated urbanized Regions (4 and 10) and less prevalent in the hinterland Regions of 1, 7, 8 and 9. Other diseases such as tuberculosis and malaria also showed marked declines.

1.2 Economic Context

Guyana's economy continues to show resilience in spite of the global financial crises and downturn in the global economy. While most economies in the region contracted during the crisis years (2008-2009) the economy in 2008 and 2009 generated an average growth rate of 4.6%. In 2011, growth was estimated at 4.8% of Gross Domestic Product (GDP), up from 3.4% in 2010 and 3.3% in 2009 (World Bank). The Guyanese economy based largely on agriculture and extractive industries, was mainly affected by the global crisis through the sectors where foreign income is generated.

Guyana is ranked as a medium development country and in 2010 was ranked 117 (out of 187 countries) on the Human Development Index (HDI). This ranking is based on a GDP per capita of US$2,948; life expectancy at birth of 69.9 years; and a 96.5% adult literacy rate (Human

Development Report, 2006). Guyana's GDP is approximately US$2.23 billion a year (World Bank 2010).

1.3 Rationale

The reduction of HIV and AIDS is a critical component in the Guyana Poverty Reduction Strategy (GPRS) Programme, recognizing the social and economic impact of communicable diseases including HIV and AIDS and other STIs. The GPRS identifies priority areas for action and includes (i) increasing access to voluntary counseling and testing services in all regions; (ii) expanding the programme for reduction of mother-to-child transmission to all regions (iii) improving and expanding the availability of services for diagnosis, treatment and care of HIV and other STIs; (iv) increasing access to condoms; and (v) increasing school programs on sexual and reproductive health.[1]

Designed in 1993, the National Development Strategy (NDS) provides a framework for sustainable growth and poverty reduction in Guyana over a 25-year period. The NDS endorses the objectives of the health sector to increase the healthy status for all Guyanese and to reduce health disparities among social groups. Moreover, there is specific reference to addressing the incidence of HIV and AIDS and STIs considering the impact on the productivity of individuals, the population as a whole, and the social development impact of the economy, and the nation. While the **HIVision2020** plan is focused on the HIV related MDGs, it is cognizant that all of the MDGs are interrelated and progress in one goal potentially supports progress in others and more growth in overall health and national development.

Combating major communicable diseases including HIV and AIDS is a major priority of the Ministry of Health, and is also reflected in the National Health Strategy 2008-2012 (NHS). The Strategy places emphasis on prevention efforts and treatment, care and support services being fully integrated into the health services delivery system and social services provided by both the government and non-governmental sectors.

[1] The Guyana Poverty Reduction Strategy Paper

1.4 Process for the development of HIVision2020

The development of **HIVision2020** was completed through a national consultative process led by the National Strategic Plan Steering Committee. This committee was chaired by the Minister of Health and comprised of representatives from CSO, PLHIV, donors and technical partners, Non Health Line Ministries and other key stakeholders.

This overall development was guided by a number of activities and included input from a wide cross section of stakeholders including:

1. Governmental Sectors
2. Non- governmental organizations
3. Civil Society Organizations
4. Service Providers
5. Members of Key Populations at Higher Risk
6. Developmental Partners
7. The Private Sector
8. Policy Makers

The process for the development of HIVision 2020 included the following:

1. A comprehensive review of the previous National HIV strategic Plan NSP) 2007-2011 laid the foundation and commenced the process of development of HIVision2020. The review of the NSP 2007-2011 was conducted with the main objectives of determining the degree of implementation of the plan and to identify any gaps in implementation. A structured questionnaire was administered to 34 key stakeholders not only on the review of the NSP 2007- 2011 but importantly on defining priority areas for action in the new HIVision 2020.

- Review of Key documents including but not limited to NAPS annual reports 2007, 2008, 2009, 2010 and 2011.
- The Universal Access and UNGASS reports,
- Annual reports for PMTCT, Blood Banking, National TB and other relevant departments.
- Report of the midterm review of the NSP and the end of term review

2. WHO strategy, UNAIDS strategy, UNESCO strategy and a number of other key Strategic Directions were considered by the National Steering Committee in meetings and feedback on the various drafts of the document.
3. Consultations with stakeholders in smaller targeted sessions were held on many occasions with the following committees as they served as the technical working and writing group:-

- NSP Steering Committee.
- Coordination working group
- National Prevention Reference Group
- National Care and Treatment Technical Working Group
- Monitoring and Evaluation Reference Group

4. Four national consultations were convened to provide stakeholders with an opportunity to identify priority areas and provide feedback on the content of the NSP. This allowed for several drafts to be reviewed before the final draft was completed.
5. Written submissions on the HIVision were received from several organizations and were considered in the various iterations of the document.
6. Feedback from all of these processes were reviewed and considered in the document.
7. The final document was submitted to and approved by the Minister of Health.

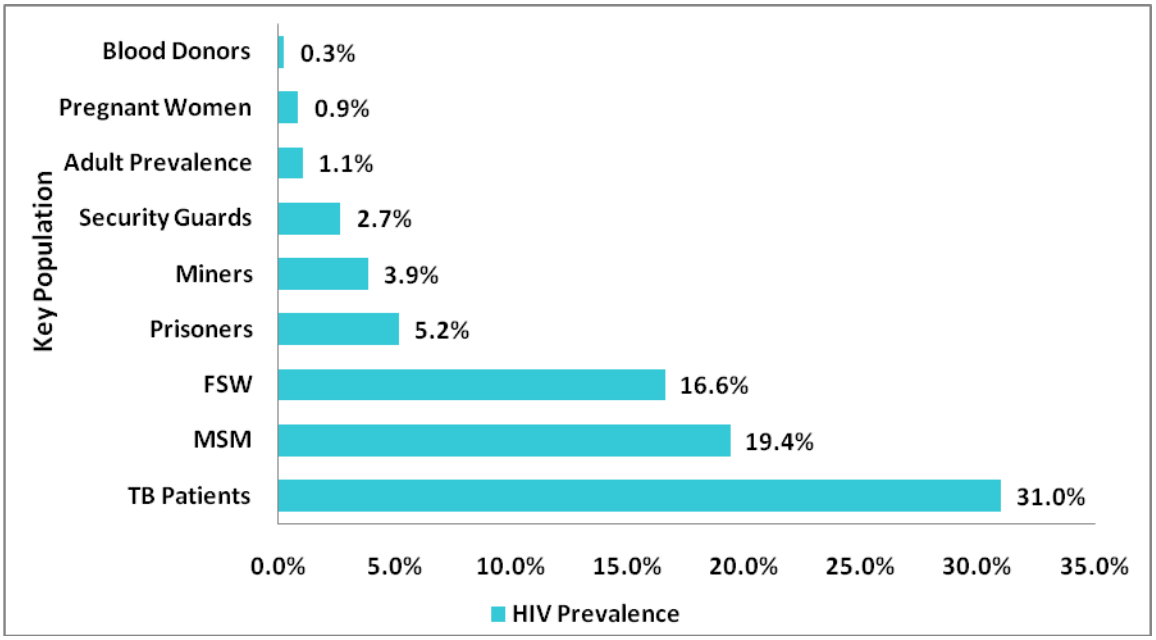
Chapter 2: The Status of the Epidemic in Guyana

Adult HIV Prevalence has been on a steady decline over the past eight years. The most recent estimation exercise conducted for 2011 revealed HIV prevalence among adults 15-49 of 1.1% (Spectrum/EPP 4.47). This represented a decrease from 2.4% in 2004 and 1.2% in 2009 (UNAIDS Estimates).

According to the Prevention of Mother to Child Transmission (PMTCT) programme data, HIV prevalence among pregnant women was maintained around 1% between 2009 and 2011. Fewer babies are being born infected with HIV as Mother to Child Transmission of HIV continues to decline. In 2011 the transmission rate was 2.5 % or 5 babies infected out of 201 HIV positive women who delivered. HIV prevalence among blood donors has been maintained below 0.5% between 2009-12.

The 2009 Biologic Behavioural Surveillance Survey (BBSS) showed a sharp decrease (38%) in the HIV prevalence among female sex workers (FSWs), from 26.6% (BBSS, 2005) to 16.6% (BBSS, 2009). In contrast only a slight decrease was observed among MSM, from 21.2% (BBSS, 2005) to 19.4% (BBSS, 2009). Figure 1 shows the most recent prevalence rates among key populations.

Figure1: HIV Prevalence among various populations



Year of prevalence: ***2012:*** *TB patients, Blood donors,* ***2011****: Pregnant women, Adult Prevalence;* ***2009****: FSW and MSM;* ***2004****: Security Guards and* ***2003:*** *Prisoners, Miners*

There is a pattern of decreasing prevalence among key populations (Table 1). The significant increase in the proportion of voluntary blood donors and improved screening of potential donors is the catalyst to the decreasing pattern observed among this group. The trend over the last eight years shows that the co-infection prevalence among TB-HIV patients is decreasing. In 2012 however, there was a notable increase in co-infection among TB patients.

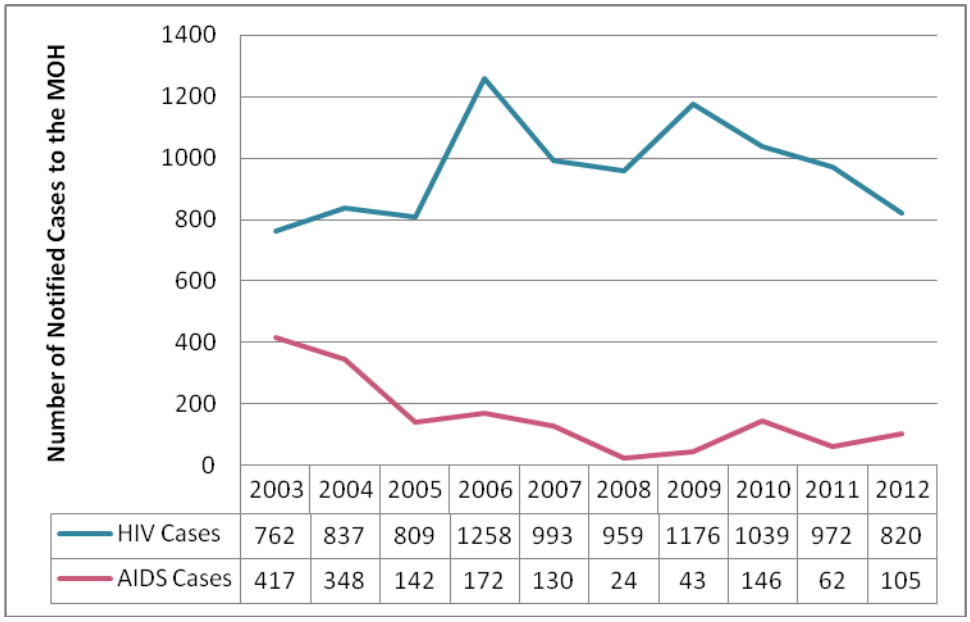
Table 1: HIV Prevalence among Key Populations in Guyana

POPULATION	SEX	YEAR	PREVALENCE	SOURCE
Pregnant Women	Female	2004	2.3%	ANC surveys
		2006	1.6%	
Pregnant Women	Female	2008	1.2	PMTCT Programme Reports
		2009	1.1	
		2010	1.0	
		2011	0.9	
Blood Donors	All	2008	0.5	Blood Bank Programme Reports
		2009	0.2	
		2010	0.2	
		2011	0.1	
		2012	0.3	
Sex Workers	Female	1997	45.0	Special Survey
		2005	26.6	BBSS
		2009	16.6	BBSS
MSM	Male	2005	21.3	BBSS
		2009	19.4	BBSS
TB Patients	All	2008	22.0	Chest Clinic Records
		2009	28.0	
		2010	26.0	
		2011	23.4	
		2012	31.0	
Miners	Male	2000	6.5	Special Survey -One mine study
		2003	3.9	Special Survey- 22 mine study
Security Guards	All	2008	2.7	BBSS
Prisoners	All	2008	5.2	BBSS

Source: National AIDS Programme Secretariat, 2011

Since the first reported case of AIDS in 1987, there has been a progressive increase in the number of reported cases over the years. A cumulative total of 9,598 cases of HIV and 2,439 cases of AIDS were reported to the Ministry of Health for the period 2003-2012. The number of new AIDS cases has declined by 25% at the end of the last 10 years. (Figure 2).

Figure 2: Annual Cases of HIV and AIDS, 2003-2012



2.1 Sex Distribution of HIV and AIDS Cases

The male to female ratio for HIV cases has been fluctuating over the past four years. While HIV appears to have initially been most prevalent among males, data indicates that there are an increasing number of women becoming infected. By 2003, the annual number of reported cases of HIV was higher among females and continued until 2008 when the male female ratio was 0.9. The situation was again reversed in 2010-2012 when more females were diagnosed with HIV, with a male to female ratio remaining below 1.0 for these three years (Table 2).

Table 2: Trends in Reported Cases of HIV and AIDS by Sex, 2008-12

CLASSIFICATION		2008	2009	2010	2011	2012
HIV	Male	446	600	449	432	393
	Female	490	567	547	517	424
	Unknown	23	9	43	23	3
	Total	**959**	**1,176**	**1,039**	**972**	**820**

	Sex Ratio	0.9	1.1	0.8	0.8	0.9
AIDS	Male	14	21	86	41	61
	Female	8	21	58	21	42
	Unknown	2	1	2	0	2
	Total	**24**	**43**	**146**	**62**	**105**
	Sex Ratio	1.8	1	1.5	2	1.5
TOTAL HIV &AIDS		**983**	**1,219**	**1,185**	**1,034**	**925**

Source: Ministry of Health Statistics Unit and NAPS

2.2 Age Distribution of HIV Cases

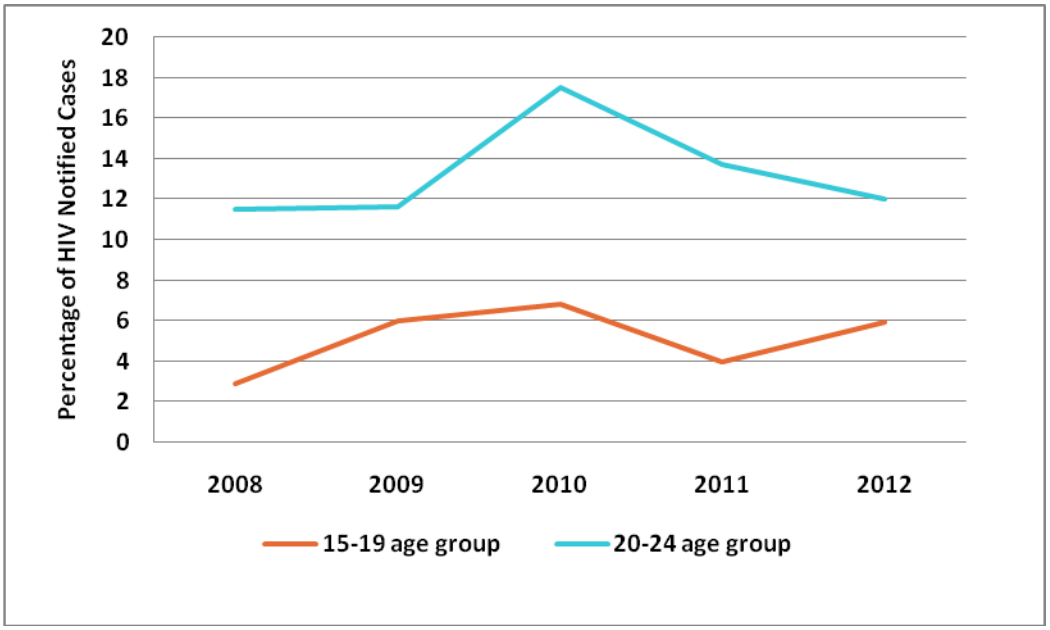
Whilst there are variations within the specific age groups, consistently more than three quarters of HIV cases are reported in the combined age group of 20-49, which is considered the productive workforce. Notable increases were observed among the age-groups 15-19 and 20-24 (in and out of school youth) in 2010, but there was a marked reduction in cases within these cohorts in 2011. There was also an increase in cases among the 30-34 age group in 2010 and 2011. The highest proportion of reported cases of HIV has been occurring in the 30-34 age-group (Table 3).

Table 3: Distribution of HIV Cases by Age-group 2008 – 2012

Age Group	2008	2009	2010	2011	2012
Under 1	0	1	1	4	3
1—4	5	9	5	5	10
5—14	15	14	9	9	11
15-19	28	71	71	39	48
20-24	110	136	182	133	98
25-29	166	161	133	129	125
30-34	173	204	193	176	139
35-39	157	198	142	148	141
40-44	106	143	124	112	91
45-49	70	105	68	83	55
50-54	48	48	42	55	41
55-59	21	30	27	40	22
60+	33	25	21	21	21
Unknown	27	31	21	18	15
Total	**959**	**1176**	**1,039**	**972**	**820**

The reported cases of HIV remained relatively stable for most of the recorded years at approximately 5% for the 15-19 age group and 12% in the 20-24 age group, however within both age groups there was an increase in 2010 at 7% and 18% respectively (Figure 3).

Figure 3: Proportion of HIV Cases among Youth, 2008 – 2012



2.3 Spatial Distribution of HIV and AIDS

Guyana is divided into 10 Regions (numbered 1-10) and among these, Region 4 continues to account for the largest proportion of notified HIV cases; reaching over 70% by 2011. There have been fluctuations across the other regions over the past six years. However, the coastal regions (2, 3, 5, 6 and part of 10) have stood out in terms of the proportion of reported HIV cases which may be attributed mainly to the better access of the prevention programme in these regions as compared to the hinterland regions where there are challenges as a consequent of the difficult terrain associated with these locations (Table 4).

Table 4: Proportion of HIV Cases by Region 2008 – 2012

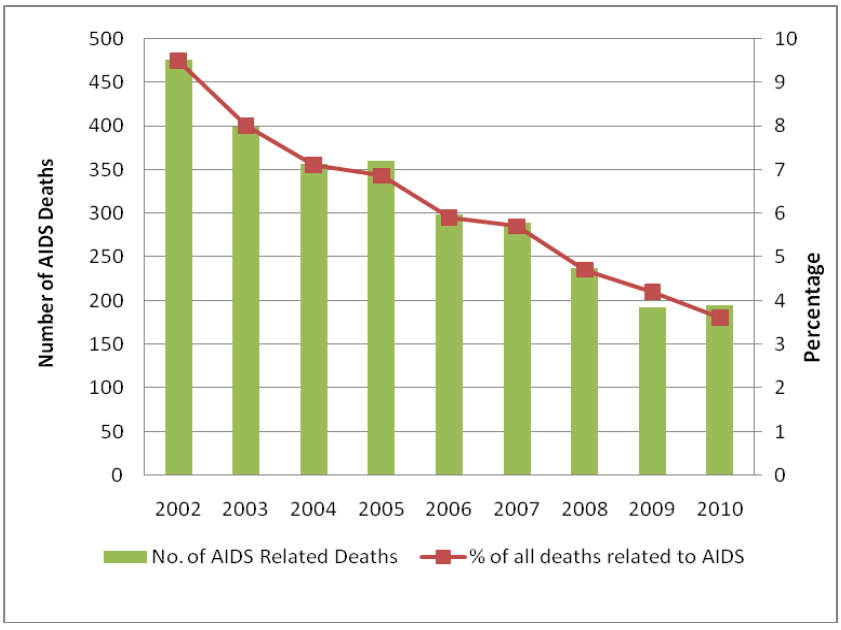
Region	Total population	% pop	2008	2009	2010	2011	2012
Region 1	24,275	3.2	0.5	0.9	0.6	0.8	1.5

Region 2	49,253	6.6	3.9	2.6	1.3	2.7	2.2
Region 3	103,061	13.7	8.3	10.6	10.7	9.0	15.9
Region4	310,320	41.3	59.1	56.3	71.5	70.8	63.3
Region 5	52,428	7.0	1.7	2.7	2.6	2.8	2.7
Region 6	123,695	16.6	9.7	9.9	7.4	4.9	6.0
Region 7	17,597	2.3	1.6	2.5	1.6	1.1	1.2
Region 8	10,095	1.3	0.1	0.5	0.3	0.4	0.4
Region 9	19,387	2.6	0.3	0.0	0.3	0.1	0.4
Region 10	41,112	5.5	3.7	3.1	2.5	4.1	2.1
Unknown	0	0.0	11.2	10.8	1.3	3.3	4.5
Total	**751,223**	**100**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

2.4 AIDS-Related Mortality

The proportion of all deaths attributable to AIDS has declined from 9.5% in 2002 to 4.7% in 2008 and 4.2% in 2009. The actual number of AIDS-related deaths has also generally declined (Figure 4). According to the Ministry of Health's 2008 Statistical Bulletin, AIDS-related deaths have been among the top ten causes of deaths in Guyana, ranking at number 5 in 2006 and moving to number 6 at the end of 2008.

Figure 4: Annual Number and Proportion of AIDS-Related Deaths



**2010 data is still preliminary*

Chapter 3: HIV Financing

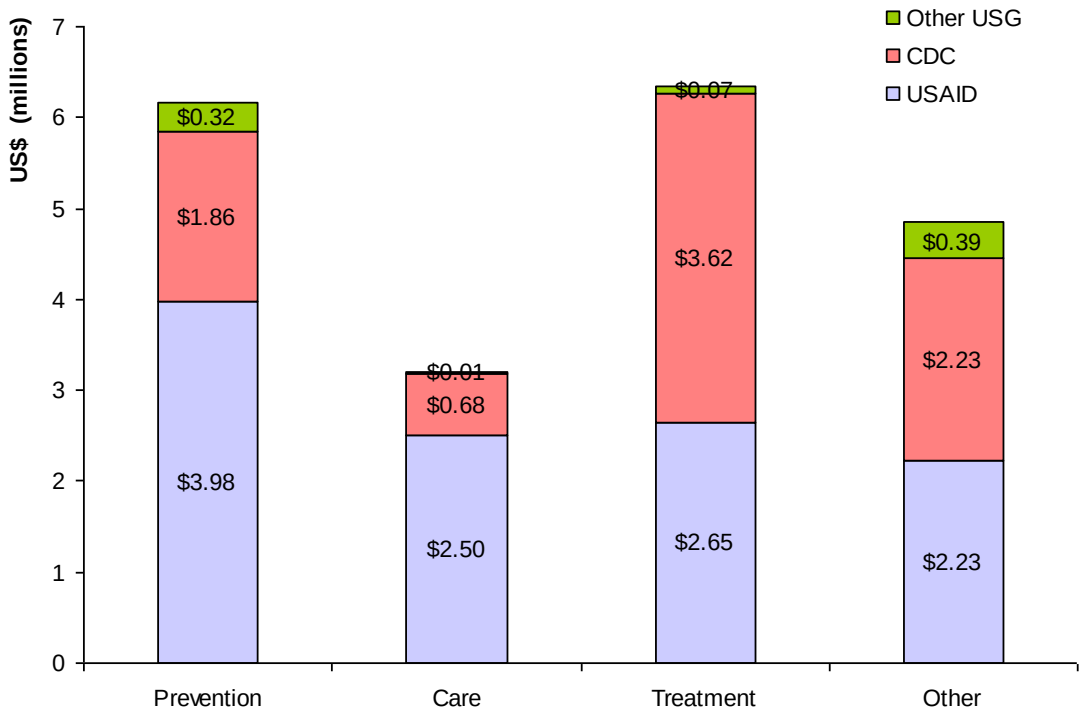
Over the years, Guyana has benefited from a significant amount of donor funding, primarily from the World Bank, the President's Emergency Fund for AIDS Relief (PEPFAR) programme and the Global Fund for AIDS, Tuberculosis and Malaria (GFATM). The major sources of HIV funding at the conclusion of the NSP 2007-2011 were the Global Fund and PEPFAR. At the end of 2012, Guyana's HIV budget was estimated at US$29 million with PEPFAR providing approximately 65%, while 25% was provided by the Global Fund. It is unclear as to the future projections of the PEPFAR contribution to the HIV budget; however it is anticipated to decrease over the years.

The Global Fund has granted preliminary approval for six years of funding totalling US$16,157,119 in the first phase covering the period of March 2010 to March 2013. The Global Fund Project has performed well and has been invited to submit a continuation application for phase two of the Grant for a maximum ceiling funding of US$ 23, 981,116 covering the period of April 2013 to March 2016. While this is the maximum funding ceiling, the actual approved sums for phase 2 would only be known at the conclusion of the proposal review.

Based on the information garnered during the HIV and AIDS Programme Sustainability Analysis Tool (HAPSAT) exercise, it is evident that Guyana's annual HIV budget is projected to decrease over a five year period as much as 55%, with the transition of services being gradually undertaken by the GoG. The projected GoG contribution is expected to increase by at least 61%, from US$2.3 million in 2010 to US$3.7 million in 2015.

In fiscal year (FY) 2009 (October 2008 to September 2009), PEPFAR allocated 31% of its funding to treatment, 30% to prevention, and 16% to care. The amount of U.S. government funding allocated through the United States Agency for International Development (USAID) was 55%, while 41% was distributed through the Centers for Disease Control (CDC). In FY 2009, CDC invested US$3.6 million on HIV AND AIDS treatment in Guyana, whereas USAID allocated $2.6 million; however, USAID was the main financial agent for prevention and care in 2009 (Figure 6).

Figure 5: USA Government's HIV Budget for Fiscal Year 2009, by Agency and Service Category



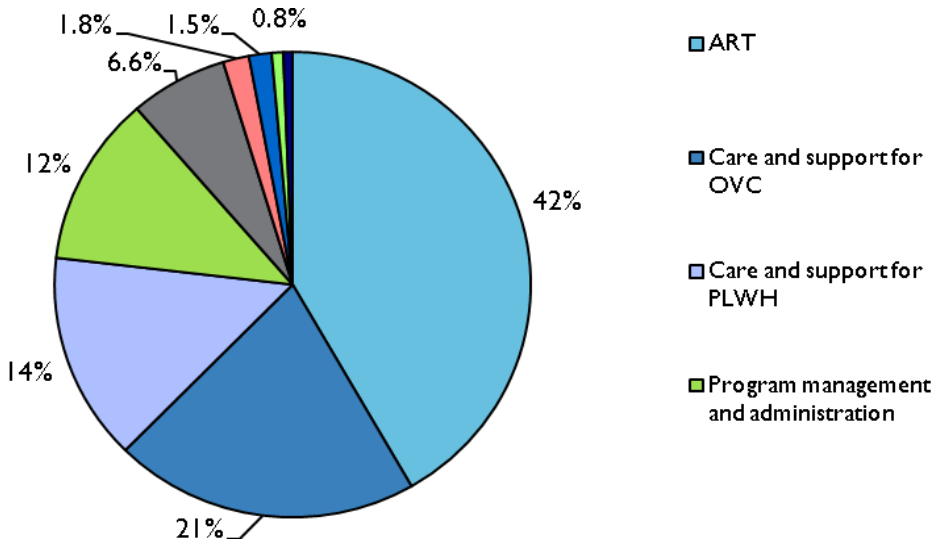
Source: (PEPFAR)

Guyana's AIDS program, with the MoH as principal recipient, received US$24.5 million from the Global Fund from the first disbursement in 2005 through March 2011. Approximately US$7.3 million was budgeted for 2010, increasing to US$8.4 million in 2011, and peaking at US$10.4 million in 2014. The Global Fund is from four different grants with the primary grant being the Round 3 HIV grant. The other three grants include health system strengthening (Round 8 grant) and two TB grants (Rounds 3 and 8). Guyana's Rolling Continuation Channel (RCC) proposal for March 2010 to March 2016 includes US$14 million through March 2013. Depending on grant performance and funding availability, the country is expected to apply for an additional estimated US$27 million through March 2016 from the Global Fund.(Country Coordinating Mechanism Guyana 2009).

Global Fund expenditure data from March 2008 to April 2009 revealed that 42% of the funding of the Round 3 HIV grant was invested in Antiretroviral medications (ART), 21% was allocated for care and support of Orphans and Vulnerable Children (OVC), 14% for care and support of People Living with HIV (PLHIV), and 8.1% was spent on Behaviour Change Communications (BCC), mainly on mass media. Round 3 HIV grant budget for 2010–2016 reduced the

treatment, care and support allocation from 75% of the total funds in 2008 to 47% of the total funds. Prevention is increased from 9% to 35%. The second largest Global Fund investment in Guyana's HIV response is the health system strengthening which is the Round 8 grant of US$10 million for 2010–2014, but was discontinued after phase 1. Two TB grants (Rounds 3 and 8) allocated US$610,000 for HIV/TB activities between 2009 and 2015 (Figure 9), (Country Coordinating Mechanism Guyana 2008b); 2009 Enhanced Financial Reporting (EFR) of Global Fund grant (GYA-405-G03-T).

Figure 6: Expenditure of Global Fund Financing by Service Delivery Areas, April 2008' March 2009



Source: 2009 EFR of Global Fund grant GYA-304-G01-H

Chapter 4: The Response Analysis

At the conclusion of the National HIV Strategic Plan 2007-2011, the end of term review was conducted to determine the degree of its implementation, provide a clear understanding of the HIV situation in Guyana at the end of 2011, and to describe lessons learnt and document best practices. One of the main reasons for this exercise was to inform the new strategic plan; **HIVision2020.**

4.1 Coordination

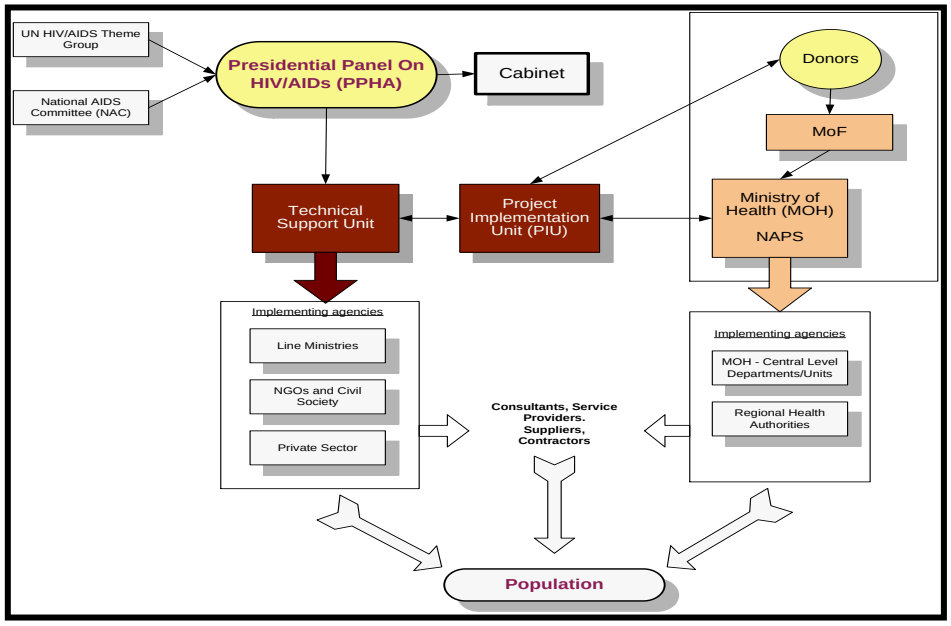
In 2004, in order to strengthen the implementation and coordination of the multi-sectorial response on HIV/AIDS, the Presidential Commission on HIV and AIDS(PCHA) under the aegis of the Office of the President was established. The commission is chaired by His Excellency, the President of Guyana. The composition of the PCHA include key Ministries, the Attorney General, the Chair of the United Nations Theme group (UNTG) on HIV/AIDS, and the Head of the Presidential Secretariat.

The GOG response to HIV/AIDS is supported by the activities of numerous NGOs, CBOs, FBOs, the private sector, and civic organizations. The primary responsibility of the PCHA is to coordinate, oversee, and support the national response to HIV/AIDS. Key functions of the PCHA include the following:

- Supporting the implementation of the National Strategic Plan;
- Mobilising multi-sector support for the national response;
- Coordinating, preparing and assisting in the implementation of the line ministries' work programme;
- Advising the Cabinet on HIV/AIDS policies and strategies;
- Mobilizing resources (national and international) for HIV/AIDS programming;
- Presenting annual and quarterly reports on the progress of the national response;

The Ministry of Health continued to play a pivotal role with the National AIDS Programme Secretariat by providing technical leadership for the response and the Project Implementation Unit, coordinating the fiduciary arrangements for donor funded projects and serving as the Secretariat to the PCHA. Non Health, Line Ministries continued to implement work place programmes and Civil Society Organisations impacted at the community levels reaching the difficult populations. People living with HIV were actively engaged in policy, decision making and implementation of programmes.

Figure 7: Coordinating Mechanism for the HIV response



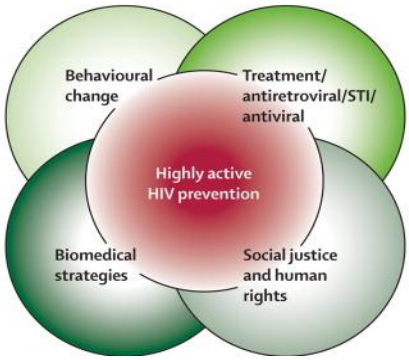
The roles of the HIV coordinating mechanisms were strengthened with the National Programme building capacity in leadership and public health among key cadres. The multi-sectoral response was rolled out to key Line Ministries of Government, impacting specific constituents and increasing the number of civil society and community-based organisations engaged in reaching the most-at -risk populations. The National Programme adhered to the “Three Ones” principles and international, regional and national reporting commitments which were derived from stakeholder consultative midterm and end of term review processes.

Findings from focus group sessions and key informant interviews, suggest that access to HIV prevention, care and treatment services is limited for the indigenous populations and the mobile

communities of Administrative Regions 1, 7, 8 and 9. This indicates that more work needs to be done in those areas of the country. Education of in-school youth, through Health and Family Life Education (HFLE) is currently on-going, through the Ministry of Education. However, there is a need to scale up and intensify this program. Specifically in the area of legislation and policy, the National HIV Policy was revised and draft HIV legislation was crafted and is currently under review. Attempts to collect incidents of criminalization of HIV for willful transmission were averted through active engagement of the Guyana National Assembly. Coordination of national sectors has been achieved; however, there is a need for regular AIDS-spending assessments to be conducted and for better coordination of donor resources.

Attrition of health workers, largely due to migration, both internal and external, continues to affect implementation. This issue affects not only the HIV response, but also the wider health sector. In recognition of this, the Ministry has developed a human resources strategy, and strides were made to increase the number of health care workers. More nurses are being trained than in previous years. The scholarship programme with the Cuban Government has resulted (during the period 2008-2011) in more than 100 trained medical doctors serving the Government of Guyana for a five-year contractual period. Medexes (Physician Assistants) were also trained, and are also on five-year contracts. Additionally, postgraduate and specialty programmes were developed by Guyana's tertiary clinical institution, the Georgetown Public Hospital Corporation, in the areas of surgery and emergency medicine, among others, in collaboration with the University of Guyana.

4.2 Intensifying prevention efforts



Preventing new HIV infections has been a mainstay of the National Response and this is outlined in the "Guyana National HIV Prevention Principles, Standards and Guidelines, 2010. This stipulates and guarantees that the minimum standards required in achieving HIV prevention are being met and maintained nationwide. In scaling up HIV prevention, an intensified prevention programme has been implemented and includes access to Voluntary Counseling and Testing (VCT); PMTCT; comprehensive STI services; distribution of free condoms; and Information, Education and Communication (IEC) on HIV prevention-related issues. Specific

youth prevention programmes are being conducted by the Ministries of Education and Culture, Youth and Sports, various NGOs, and the MOH Adolescent Health Unit. These include the establishment of Youth Friendly Spaces throughout the country and implementation of the Health and Family Life Education (HFLE) as a curriculum subject in over fifty secondary schools.

4.3 Knowledge and Behaviour

Data suggests that there are high levels of correct knowledge on HIV and prevention transmission in Guyana. Compared to 2005, knowledge levels on the four safe sexual behaviours: abstaining from sex, being faithful, reducing the number of sexual partners, and consistent and correct condom use, remained consistent with slight decreases. Notably, in 2009 Demographic Health Survey (DHS), fewer men and women perceived abstinence as a means to reduce the risk of being infected by HIV than they had in 2005 AIDS Indicator Survey (AIS). This can be interpreted as increased understanding of the determinants of HIV prevention beyond the traditional ”ABC” (Abstinence, Be Faithful and Consist and Correct Condom use) which is also articulated in the ‘Guyana National HIV Prevention Principles’ highlighting the importance of combination prevention.

Examination of the trend of three sexual behaviors (ABC) further reveals no significant changes. A notable change was the percentage of sexually active males (12.8) who had two or more sex partners in the past 12 months compared to 9.4% in 2005. Overall, the levels of reported safe sex are high. Among sexually active females, 1.8% reported having two or more partners in the past 12 months. Among males this proportion was much higher, yet 71.5 % reported using condoms when they last engaged in higher-risk intercourse (with a non-marital, non-cohabiting partner).

The promotion of consistent condom use was an integral part of the HIV Strategy. This strategy has been supported through the free distribution of male and female condoms. Male condoms are also made available at a lower cost through non-traditional outlets. Over 10.5 million condoms have been distributed for the period 2007 - 2011 across the ten administrative regions.

The 2009 Bio Behavioural Sero Survey (BBSS 2009) reveals that a high percentage of respondents (average 90%) felt that consistent condom use can prevent HIV transmission. However, this belief does not appear to translate into behaviour where among the groups

surveyed, an average of 50% reported *consistently* using a condom with their regular partners and 65% with clients/paying partners. Consistent condom use among youth, especially those in school (age 15-19) was alarmingly low, reporting at 47.7% with regular partners and 39.3% with transactional partners (BSS 2009)

Sexual behaviour among youth, in terms of condom use and the low average age of sexual debut, is characterized as high risk. Contrastingly there is a widely held perception among young Guyanese of being low risk in becoming infected with HIV.

4.4 Reducing HIV-related Stigma and Discrimination

In tandem with increasing knowledge of HIV, is the need to promote accepting attitudes towards People living with HIV (PLHIV). HIV-related discrimination negatively affects uptake in the HIV care and treatment programme, and other HIV services. A comparison of the two rounds of the BBSS (2005 and 2009) indicates that the general attitude of the Guyanese population is accepting of PLHIV as part of the general society.

There is greater acceptance of PLHIV among out-of-school youth, while within the MSM and FSWs population, and to a lesser degree in-school youth there seem to be lower levels of tolerance. Continued support through the workplace programme and key agencies such as the Guyana Business Coalition on HIV and AIDS and the Guyana Faith-and-HIV Coalition will be critical to addressing this issue over the next few years.

4.5 Blood Screening

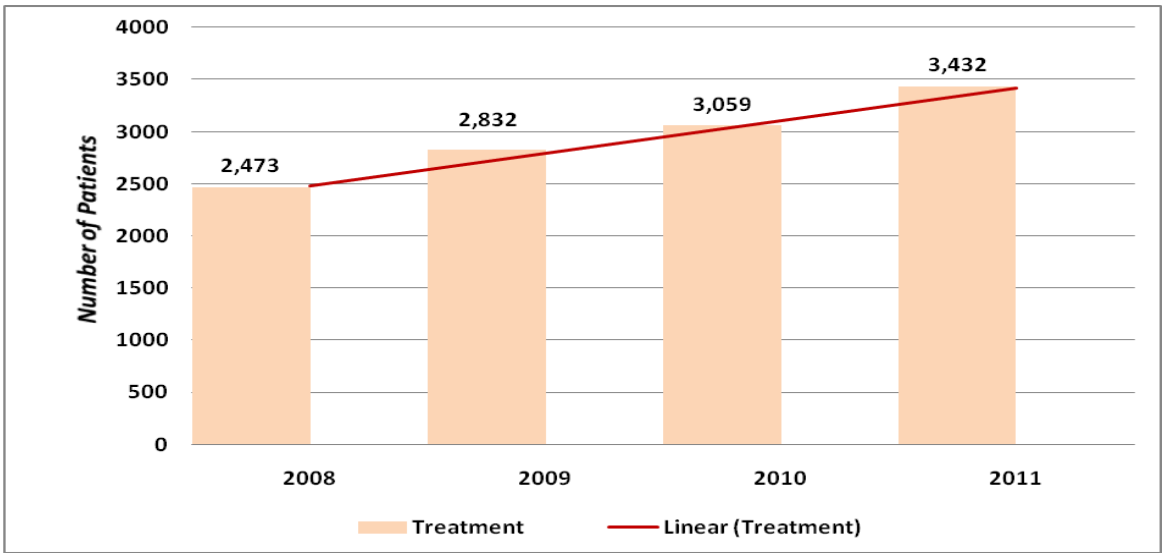
In line with the National Blood Safety Policy, 100% of donated blood is screened for infectious markers, including HIV, Hepatitis B and C. The proportion of persons testing positive for HIV among all persons screened was 0.2% in 2010 and 0.3% in 2012.There has been an increasing trend with regard to the proportion of voluntary blood donations over recent years, moving from 55% in 2008 to 90% in 2012.

The National Public Health Reference Laboratory (NPHRL) and the National Blood Transfusion Services have implemented a quality management programme that is managed by the Quality Assurance Department of the NPHRL. Both institutions operate in accordance with international standards ISO 15189 and Caribbean Blood Banking Standards respectively. Moreover, the NPHRL is certified with the Guyana Standard GYS170:2003 General requirements for the operation of a Laboratory.

4.6 Expansion of Treatment

The national care and treatment programme has expanded over the past four years with a steady annual increase of persons enrolled into treatment. At the end of 2011 there were 3,432 persons receiving ARVs, of which 3,231 (94.1%) were adults and 201 (5.9%) children. This represents 77% of the estimated HIV population in Guyana in 2011. Persons on second line treatment represent 10% of the adult patient population and 10% of the pediatric patient population. There are an additional 1,180 persons receiving pre-ART services (Figure 8).

Figure 8: Number of Persons Receiving Treatment, 2008 - 2011



Quality of HIV care and treatment services is important and is monitored and improved through the implementation of the patient monitoring system (PMS) and the HIV quality management programme, HEALTHQUAL, at all treatment sites.

4.7 Care & Support

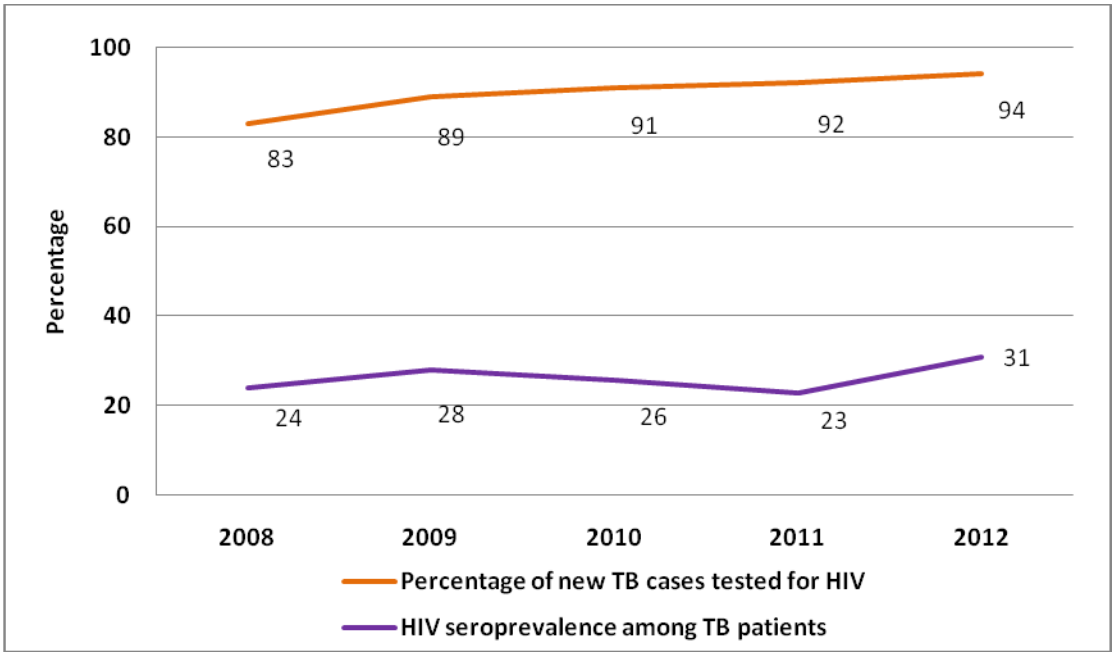
The national programme has recorded success in the nutritional and psycho-social support provided to persons infected and affected with HIV under the Home Based Care (HBC) and Food Bank initiatives. Enormous support has been received from the private sector and NGO community in sustaining these programmes. The number of beneficiaries of nutritional hampers has steadily increased, reaching 952 in 2007 to 4540 in 2011. The number of private sector agencies contributing to this initiative increased from 10 in 2007 to 30 in 2011. At the end of 2011 the private sector contribution accounted for 25% of the nutritional support through this initiative. Almost one thousand PLHIVs continue to access Home Base Care (HBC services) on an annual basis, with 1,189 new persons enrolled in HBC programme, at the end of 2011.

4.8 Collaborative TB/HIV management

HIV care and treatment in Guyana is provided through a network of 18 fixed care and treatments sites and one mobile unit which covers 4 hinterland regions of Guyana. The programme is standardized based on internationally recommended treatment guidelines that are periodically reviewed. HIV training for doctors, nurses and medexes is likewise standardized and follow the Guyana's National Care and Treatment Guidelines, last updated in 2011.

Between 2008- 2012 a total of 3,004 new TB cases were tested for HIV which represents 90% of the new TB cases. There were 799 TB/HIV co-infected cases over this period, representing an average of 26% HIV sero-prevalence among TB patients over the period. Figure 9 illustrates the increasing proportion of new TB cases tested for HIV with a reduction in TB/HIV co-infection recorded from 2009.

Figure 9: Percentage of New TB cases tested for HIV and HIV sero-prevalence among TB patients, 2008-12



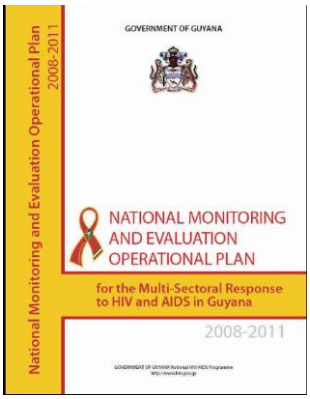
These trends are as a result of continued collaboration between the national HIV and TB programmes with a view towards expansion in screening for the two infections at all HIV

treatments sites and the TB clinic, reducing co-infection and ultimately a decline in TB/HIV related mortality. Referrals between TB treatment sites and ARV treatment sites have been strengthened with the integration of tuberculin skin testing in the package of services provided at ART sites. This is done by trained nurses, counselor-testers and Direct Observed Treatment Short-course (DOTS) workers.

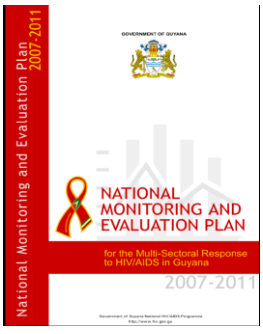
National guidelines for the management of TB and HIV co-infections are clearly established in the guidelines of the HIV programme and vice versa. The most recently revised guidelines (2010/2011) recommend early initiation of ARVs for patients being managed for TB. Some 88.4% of TB/HIV co-infected patients received ART during TB treatment in 2011.

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

4.9 Strategic Information



In order to understand the epidemic and effectively develop and implement programmes that achieve universal access to prevention, treatment, care and support, Guyana has put in place systems of surveillance, research, and monitoring and evaluation, which provide essential information on the progress in responding to HIV. A National HIV Monitoring & Evaluation (M&E) Plan and Operations Manual were developed to compliment the 2007-2011 HIV Strategy. These provided guidance throughout the past five years on all M&E related decisions and initiatives. Coordination and leadership were ensured through the NAPS M&E Unit.



Emphasis continued to be placed on improving the HIV surveillance system, which was initiated primarily at PMTCT and VCT sites. In 2011, the HIV Case Surveillance form was revised to meet the WHO new definition of HIV advanced cases. Clinical and surveillance staff was trained accordingly and the new surveillance system was successfully piloted. It is being rolled out at health facilities in a phased manner. This system is supported by an HIV surveillance database, established and functional at the central MoH.

The Ministry of Health has invested in human resource capacity to undertake research, conduct analyses, and disseminate findings. Training was conducted in areas such as basic research skills, advanced research skills, sampling methodologies, Epi-Info and Statistical Package for the Social Sciences (SPSS). This contributed to the successful implementation of the second round of BSS/BBSS among at risk groups. Several special studies, surveys, and operations research were conducted over the past five years, with the data generated being used to inform programme planning and resource allocation.

The Country Response Information System (CRIS) database is being implemented at the M&E Unit of NAPS as a national database for the HIV programme. There are a number of other primary databases for specific sub-programmes, including VCT, Care and Treatment, and Condom Distribution, which are housed at the NAPS and are routinely maintained by the Management Information System Unit, in the central Ministry of Health.

4.10 Summary of Achievements

Key achievements were noted in all areas of the HIV response over the last strategic plan. Selected key achievements as per the priority areas within the NSP2007-2011 are highlighted below.

Coordination

1. The Presidential Commission on HIV and AIDS coordinated the timely submission of key global reports and included the UN Country progress and the Universal Access Reports
2. Thirteen Non Health line Ministries implemented HIV work-plans and several integrated HIV within their sector budgets.
3. The Guyana Business Coalition on HIV and AIDS was established with a current membership of 45 major companies with HIV workplace policies and programmes.
4. The Guyana Faith Coalition on HIV and AIDS was established.
5. ILO Workplace policy adapted
6. The HIV policy revised.

Reducing New Infections

1. The Guyana Principles, Standards and Guidelines were developed and disseminated.

2. The Most at Risk Populations (MARPS) Guidelines developed and implemented.
3. HIV policy for health care facilities developed and training conducted at all HIV treatment sites for HCW.
4. CSOs engaged and implemented community based interventions targeting the MARPS.
5. Several BCC campaigns developed and disseminated and included campaigns on early HIV testing, correct and consistent condom use, STIs, adherence, TB/HIV, aimed at men and boys, women and girls among others.
6. Community opinion leaders were trained in S&D reduction.
7. HIV testing rolled out across the country at 78 testing sites with several hundreds of thousands HIV test conducted over the five years according to National Algorithm.
8. VCT guidelines and curriculum were revised and training done.
9. PMTCT services well integrated into ANC services with high uptake of HIV testing of pregnant women (>90%) and high coverage of ARV among the population (>90%).
10. Mother to Child transmission rates reduced over the years with a report of 2.5% at the end of 2012 (5 babies).
11. STI strategic Plan Developed 2011-2020 and implementation commenced.
12. All blood screened for HIV and other infectious markers.

Care, Treatment and Support.

1. Universal coverage for ARVs was achieved as reported in the two previous UNGASS reports
2. Access available to first and paediatric first and second line therapy.
3. Guidelines for the management of HIV infected adults and children developed with subsequent revisions.
4. A patient Monitoring System developed and rolled out at all treatment sites.
5. Quality of Care (QoC) system, HEALTHQUAL implemented and QoC monitored.
6. The National Public Health Institute housing the National Public Health Reference laboratory and the National Care and Treatment Center was established.
7. TB/HIV coordinating Committee established with progress made in TB/HIV collaborative work. High uptake of HIV testing among the TB population. INH prophylaxis now being offered at HIV treatment sites.
8. The NPHRL conducted specialised testing including CD 4, Viral load, DNA PCR, TB culture and others.

9. An electronic warehouse management system with inventory management was developed and implemented. The Logistics Management Information System was also developed and introduced through the health sector. A new warehouse was constructed.
10. The network of support groups across treatment sites functioned with an active membership of over 500 persons. Significant capacity building was done for PLHIVs.
11. The Food Bank provided nutritional support to more than 1500 persons on a monthly basis.
12. Home Base Care programme provided support to more than 1200 person per annum. HBC strategy was developed. Training manual was developed and used for the training of HCW.

Strategic Information

1. M&E plan and Operational Plan developed and rolled out. Target setting process completed.
2. M&E unit for the National AIDS programme defined and staffed.
3. Second round of BBSS conducted for MSM and FCSW.
4. Second round of BSS conducted for ISY, OSY and the police.
5. BBSS conducted for the armed forces.
6. First Client Satisfaction Survey Conducted.
7. HIV Notification to Surveillance revised and adapted from the WHO recommended case surveillance to include HIV, Advance Disease, AIDS, and AIDS death notifications.

4.11 Challenges

It is evident that Guyana's HIV and AIDS response has made progress over the years and more so over the implementation period of the previous NSP 2007-2011. Several challenges have been raised during the end of term review, some of which are highlighted below. In its continued effort of responding to HIV, **HIVision2020** articulates strategies to address these challenges.

- Attrition rate of health workers – This is largely due to migration, both internal and external and continues to affect implementation. Although efforts have been made to address this by the increased training of additional health care providers, it is still recognized as a challenge in the effective implementation and success of Guyana's national response to HIV.

- Stigma and Discrimination (S&D) – Although significant strides were made S&D continues to challenge the response. Health care workers were trained, thereby facilitating increased access to services among some Key Populations at Higher Risk and improved services to PLHIV in non- stigmatizing and non- discriminatory manner.
- Inadequate information on Key Populations at Higher risk- As the National programme aims to have a better understanding of the epidemic, it is evident that there are several populations with higher HIV prevalence (MSM and FCSW), engaging in higher risks behaviours placing them at a greater risk within an environment where there is inadequate legislative support. Improved understanding of these through further analyses including secondary data analysis, triangulation of data and other methodologies are needed. Still unknown for Key Populations at Higher Risk is the population size estimate which has become critical for programming. In addition to these populations, there is evidence to suggest that other populations could be determined as Key populations at higher Risk. It is therefore essential to gather information on the migrant populations (miners and loggers) and adjacent communities. The Modes of Transmission Study would more clearly define for Guyana the sources of infections and thus allow for better targeting of the response.
- Data Collection System-There is an absence of a cohesive data collection system to capture data through an electronic system. Most of the technical programme areas have stand alone data bases, however this creates many challenges. With such a system, there is the need for additional skilled human resource capacity. Currently the information collected is analyzed in a “silo” or stand alone manner.
- Access to services in remote areas, mainly the interior is not adequate in meeting the demands generated by the BCC program. HIV prevalence in the interior is low, however there are significant numbers of vulnerable groups within these areas including: miners, loggers, and the populations that live adjacent to these mines and forests. Infection Control in the health sector continues to be a challenge and, importantly, as it relates to TB control in the public, outpatient and inpatients settings. The relatively weak infection control practices are noted as one of the key contributing factors to the high level of TB/HIV co- infection rates.
- Social Issues impacting of treatment outcomes- Some PLHIVs are not adhering to treatment so there are issues of loss to follow-up, dropout rates and other patient monitoring challenges that impact the treatment outcomes and ultimately prevention.

- There is the need for comprehensive dialogue on the possibilities and provisions of third line therapy. The proportion of persons moving from first to second line therapy is within acceptable international standards; however there are persons who may be indicated for third line therapy. Drug resistant strains may emerge and the public health implications of primary transmission of drug resistant HIV are a reality.
- Guyana has a strong primary health care (PHC) system with a wide network of healthcare facilities and health care workers. Since HIV is now a Chronic disease, it is important that it is integrated into the PHC system, for the management of co morbidities associated with the ageing HIV population. Increase in life expectancy means that the need has arisen to comprehensively manage PLHIV for other chronic diseases such as diabetes, hypertension and other cardio vascular diseases. Children born with HIV in the earlier days of the epidemic are now growing up to be adolescents, teenagers and young adults.
- AIDS spending is affected by the evolving nature of the global economic and political architecture which demands greater focus be placed on the understanding of the financial requirements of the National Response. There needs to be better coordination and donors and regular National AIDS Pending Assessment (NASA) conducted.

Chapter 5: Achieving Global Targets

Globally countries are committed to achieving universal targets as set by UNAIDS and other global indicators for HIV by the year 2015. Targets as endorsed at the United Nations General Assembly Special Session on HIV and AIDS reiterate the need for a global response.

In June 2011, the member countries of the United Nations including Guyana committed to the new declaration of the United Nations General Assembly Political Declaration on HIV and AIDS. Within this declaration there are several targets aimed at the elimination of HIV by 2015.

These targets seek to focus countries on the key areas that need to be highlighted in their response to the HIV epidemic. Thus, within **HIVision2020** national targets have been aligned with Global targets and are reflected in the priority areas of:

Prevention: The prevention response will focus on the elimination of Mother to Child Transmission (MTCT), universal access to HIV Testing, greater involvement of civil society, NGOs and other sectors. The strategies will be based on human rights principles and incorporate issues of gender equality, address vulnerable populations as a priority and the elimination of stigma and discrimination through a multi-sectoral approach, engaging and training of stakeholders in reaching and addressing Key Populations at Higher Risks. The prevention effort will be evidence informed and culturally appropriate for the people of Guyana. The HIV Treatment programme will be strengthened to serve as a key pillar to prevention.

Care, treatment and support: The **HIVision2020** strategy will address treatment for PLHIV improving on access and equitable health care. This will be addressed through the integration of HIV treatment and care in the health system. The management of TB/HIV co-infection will be addressed in a structured way through the WHO 12 point policy to impact on TB/HIV morbidity and mortality, important in achieving the global targets.

Strategic Information: The **HIVision2020** articulates the need for the development of a research agenda and collaboration with key interest groups; the mobilization of resources for research, and the establishing of technical expertise within the Ministry of Health, other government and non-government institutions, the private sector and civil society to conduct relevant operational research and behavioural and impact evaluation studies through the

exploration of appropriate innovative means. This will address the parallel systems for HIV-related services and strengthen the integration of the AIDS response, additionally fulfilling reporting obligations to international and regional bodies and organizations.

Integration: The HIV programme has made significant strides in collaborating and working with other sectors, donors and partners in the response to HIV. Understanding that HIV as an epidemic is directly linked to other public health issues, the integration process in Guyana has been initiated and deemed a priority of the **HIVision2020**.

Guyana is committed to the achievement of the Universal access and Millennium Development Goals (MDGs) and more specifically Goal 6 "Combat HIV and AIDS, malaria, and other diseases" This is reiterated within **HIVision2020** as specific targets to be achieved by 2015. The specifics are:

- Have halted by 2015 and begun to reverse the spread of HIV and AIDS
- Achieve, by 2010, universal access to treatment for HIV and AIDS for all those who need it
- Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases.

Previous efforts are expected to be strengthened addressing the gaps and demands of prevention and scale up of treatment and care.

The universal goal of getting to Zero is another priority of the National AIDS Programme and Guyana has committed "To achieve Zero new HIV Infections, Zero Discrimination and Zero AIDS-related Deaths" by 2015. To achieve this, **HIVision2020** will facilitate an enabling social, economic, legal and institutional environment through integration and coordination, use of strategic information, scaling of prevention programmes and treatment, care and support programmes.

Further, **HIVision2020** is anchored in key national, regional and international frameworks and meant to be the benchmark on which the plan is to function. **HIVision2020** takes into consideration the priorities for national development and specifically for the prevention and control of HIV and the regional priorities as guided by the Caribbean Regional Strategic Framework (CRSF) among other international commitments.

HIVision2020 alignment with global targets for the HIV response, and elimination initiative goals will facilitate Guyana's achievement of the defined global goals of:

- **By 2015 reduce the sexual transmission of HIV, by 50%.**
- **By 2015 halt the spread and begin the reversal of HIV.**
- **By 2015 eliminate mother-to-child transmission of HIV, and substantially reduce AIDS-related maternal deaths.**
- **By 2015 reduce tuberculosis deaths in people living with HIV, by 50%.**
- **By 2015 all eligible persons will be on ARV treatment.**

Chapter 6: HIVision2020

Much progress was made over the years Guyana's response to HIV, and particularly over the life of the previous NSP for the period 2007-2011. 'HIVision2020' covers the period of 2013-2020 and offers excellent opportunities to build on the successes and achievements of the previous NSP and to address the challenges while utilizing the lessons learnt.

On its trajectory towards elimination of its HIV epidemic, Guyana has developed HIVision2020 which provides the opportunity for Guyana to eliminate stigma and discrimination (S&D) Mother to Child Transmission (PMTCT), and reduce morbidity and mortality associated with the disease.

Vision: The elimination of HIV in Guyana

To achieve the country's vision for HIV, in the year 2020, Guyana will reinforce its national HIV response, through an effective and efficient National HIV Strategic Plan, HIVision2020. This strategic plan provides a roadmap of the response to be implemented over a seven year period. HIVision2020 will be operationalised through detailed three year results-based implementation plans. The GoG is committed to the allocation of adequate resources to accomplish priority results. Additionally, a coordinated response of donors, partners and stakeholders through regularly scheduled donor and partners meetings will be achieved through robust management and accountability. This is expected to support harmonization and cost effective implementation of HIVision2020.

Goal

To reduce the social and economic impact of HIV and AIDS on individuals and communities and ultimately enhance the development of the country.

HIVision2020 includes, strong prioritised, strategic statements of how effective country ownership, commitment and actions, will bring about better control of the epidemic in Guyana, while scaling up the integration of HIV into the health sector and improving access to care and treatment to all in need.

Overall Strategic Objectives

1. To reduce the spread of HIV
2. To improve the quality of life of PLHIV.

Guiding Principles

HIVision2020 is guided by the following principles:

1. **Coordination:** HIV programming involves collaboration and strengthening of linkages with local, regional and international partners, as well as community-based organisations, the private sector, and key populations at higher risk for HIV;

2. **Rights Based Approach or Respect for Human Rights and Dignity:** HIV programming is based on 'Positive Health, Dignity and Prevention of people living with HIV; HIV programming is respectful of people's rights to privacy and confidentiality, considers human rights, gender, and diversity, and encourages environments free of stigma and discrimination;

3. HIV programming will adhere to the principle of the Greater Involvement of People Living with HIV (GIPA)

4. **Equity**: HIV programming is developed and delivered to ensure equitable access to all services regardless of age, gender, ethnicity, sexual orientation or any other demographic characteristics, and with additional consideration given to special populations at higher risk for HIV infection;

5. **Cultural Context**: HIV programming respects social, and cultural issues, and takes these into consideration;

6. **Integration:** HIV programming will, as much as possible and where appropriate, be integrated into primary healthcare and other relevant programmes to create synergies between services, to maximize efficiency, and to leverage the best possible health outcomes;

7. **Monitoring & Evaluation and the use of strategic Information:** HIV programming is guided by ongoing monitoring, evaluation, research, and adjustments are made where necessary, to ensure evidence-informed planning;

8. **Strategic Investment:** HIV programming is based on prioritisation, through a strategic investment framework that is intended to result in effective and efficient management of the Guyana national HIV response.

Factors Influencing HIVision2020

1) Political Commitment and Governance

There is a marked shift in commitment and attitude towards HIV in favor of strengthened integration into the wider public health and national development plans and agendas. To 'contextualise' HIV more clearly within country health and social development planning, the plan posits that the costs and expenditures for HIV must be part of the overall health system costs and expenditure, and other development programme resources. AIDS as a disease is a socio-economic burden, and for greater country ownership of HIV programming, including financing, HIV must be appropriately positioned within the overall Guyana context.

2) Treatment as Prevention

Globally there is an increased movement for prevention and treatment programmes' integration, based on effective service delivery and increasing scientific evidence of "treatment as prevention." Along with this, the capacity and capability of the Guyana health sector to manage such expanded and comprehensive programmes, has significantly increased. In an environment where greater allocation of resources and operational efficiencies are being demanded of all public and private service delivery, planning for HIV must identify service delivery systems, in all appropriate sectors, where minimal adjustments to the demands of the epidemic achieves maximum impact on the spread, management and mitigation of the epidemic.

3) HIV, the new Chronic Disease

More than thirty years into responding to the epidemic and with more than 6 million people on treatment around the world, HIV is no longer the emergency it once was. It is now a chronic condition, albeit still a complicated and expensive one, that should be

managed with a longer-term perspective. While AIDS is still classified by the World Health Organisation (WHO) as a 'communicable disease', much of the programmatic responses to treatment and care is similar to that of chronic non-communicable disease programmes. Addressing HIV as a chronic disease will require a different approach to directing and protecting longer-term investment in systems that will make the HIV response sustainable. These will need to be addressed as long-term, sustained social development programmes, if HIV is to be eliminated in Guyana.

4) Human Rights and Equity

There is a substantially heightened global solidarity in support of the human rights and service needs of those at higher risk for HIV infection. Now, more than ever, there is a greater demand to advocate for the needs of persons at risk and to address the wider issues of social justice and inequity. A major contributor of successful National Strategic Plans has been the explicit grounding of national HIV responses in a set of values of human rights, equity, gender justice, access, participation, and greater involvement of people living with and affected by HIV, among others. As national responses become more context-specific, less global, and more country-driven, it is important that these values are not lost. The fundamental adherence of national responses to principles of equity, engagement, involvement and inclusion must be respected and sustained.

5) Global Financial Constraints and Shared Responsibility

The global economic crisis has serious and far-reaching implications in many donor capitals: not only with respect to actual volume of Official Development Assistance (ODA), but more importantly in how it is delivered – with significantly greater emphasis on such issues as 'value for money' and 'cash on delivery'. Guyana must acquire new ways of thinking, planning and investing for its HIV national response. The present austere times will bring about the imperatives of 'informed demand', or 'managed demand', both leading to better prioritising of what should be funded first when resources are limited.

Chapter 7: HIVision2020 Priority Areas

To achieve its vision and goal HIVision2020 will be coordinated through five priority areas. Broad strategic objectives are defined for each priority area. Expected results with intermediate results are articulated using a result based management approach. An M&E framework is defined to monitor the implementation of the HIVision2020

Priority Area 1: Coordination

Strategic Objectives:

- Ensure a Coordinated Multi-sectoral Response
- Mainstream HIV services into the programmes and services provided by the Non Health, Line Ministries (LM)
- Create and strengthen strong and sustainable partnerships through increased collaboration with key stakeholders in the response
- Mobilise, Harmonise and Align resources to ensure efficient use of Sustainability of the Response

- Create a supportive environment that is based on a human rights foundation and facilitates the delivery of services.

Coordination has been and remains a key component of the multi-sectoral response to HIV. The large number of stakeholders involved in Guyana's programme has recognized the critical need in ensuring that the country has One Coordinating Mechanism, One National Strategic Plan and One Monitoring and Evaluation Plan, as it adheres to the Universal "Three Ones" Principles. At a local level, over time the number of stakeholders in the national response increased with the inclusion of a growing number of Civil Society Organisations, Community Based Organisations, the Faith and Business Communities and others. Adhering to the three One's principles, supports coordination and efficiency in managing the financial resources, technical assistance, implementation and monitoring and reporting efforts through joint planning efforts.

A significant component of the coordination functions is that there is high level capacity building that is adequate and relevant to leaders with the response. The strong political will and leadership at a central level will continue, and strategies will be implemented to strengthen ownership at the local levels within the health sector, such as the Regional Health Authorities. With the changing dynamics of the HIV epidemic and its response, a review of the current coordinating mechanisms, its roles and responsibilities is critical in ensuring that this remains relevant and current. In facilitating the effective functioning of the coordinating agencies, all technical working groups will be strengthened and supported in their effective functioning.

Key Line Ministries will be supported in their responses as their constituents are prioritised for action. They will be supported in the development and implementation of relevant strategies and in understanding of the internal impact of their sectors response and the wider HIV national response. The Coordination will ensure continued strategic engagement of the donors, technical agencies and developmental partners, and civil society Organisations. Critical to success of the strategies within the **HIVision2020**, is the adherence to the principle of Greater Involvement of People Living with HIV (GIPA Principle) and therefore close collaboration will be pursued with People Living with HIV (PLHIVs) through all available mechanisms and concerted efforts made at strengthening the G+ Plus Organisation.

The prediction of reduced financial resources over the coming years requires a proactive approach particularly from the Government of Guyana. This is essential in ensuring that the

important gains made in preventing new infections through effective VCT and PMTCT programmes, in treatment services with access to high quality simplified regimes among others, are not compromised, but rather sustained and scaled up as required. **HIVision2020** will continue to provide strong political commitment and country ownership to the response. Strategic partnership innovations will be explored with the local private sector. Existing agencies such as the Guyana Business Coalition and the Guyana Faith Coalition on HIV and AIDS will continue to be supported as their vast networks contribute to sustaining the gains, particularly in prevention. In this regards, new national coalitions will be formed. Government Ministries will incorporate HIV budgeting in their sector plans. The GoG, through the MoH will work strategically with all donors in developing and implementing efficient transition plans. This will create the space for the MoH to transition in an incremental fashion as the HIV response moves from an emergency response to one focused on sustainability. To support the coordination of the financial aspects of the response, a costing of the operational work-plans and regular National AIDS Spending Assessments will be conducted.

Priority Area 1: Coordination		
STRATEGIC OBJECTIVE	**EXPECTED RESULT**	**INTERMEDIATE RESULT**
1.1 Ensure a Coordinated Multi-sectoral Response	1.1.1. Enhanced functioning of the coordinating mechanisms for the multi-sectoral response	1.1.1.1 National leadership and ownership is inclusive and empowered
		1.1.1.2 Streamlined/reformed existing coordination systems, including improved support for their operations and functioning
		1.1.1.3. Accountability and oversight guaranteed
		1.1.1.4. Human Resource Management Strategy Implemented.
		1.1.1.5. Key reviews and evaluations conducted- economic and social impact of HIV, Interim review of the HIVision2020, NASA, Global AIDS Programme and others.
		1.1.1.6. Operational plan developed and HIVision2020 costed.
		1.1.1.7. Improved alignment and harmonization of work plans and indicators of development partners with national M&E framework and M&E plan
Lead Agencies: PCHA/ MOH/UNAIDS/PAHO/PEPFAR		

1.2 Mainstream HIV services into the programmes and services provided by the Non Health, Line Ministries (LM)	1.2.1. Improved capacity of LM to respond to HIV and AIDS	1.2.1.1 Increased knowledge and skills of relevant staff of LM to plan, design, implement and monitor HIV and AIDS programs/initiatives
		1.2.1.2 Strengthened LM networking and sharing
	1.2.2. Reduced stigma and discrimination in the LM and increased support for PLHIVs	1.2.2.1 HIV workplace policy adapted, implemented and monitored for LM
		1.2.2.2 PLHIV-friendly workplaces free from stigma and discrimination among LM promoted
	1.2.3. Integrated HIV response with the health response of the LM	1.2.3.1 Strengthened HIV prevention, care and treatment for the prison population
		1.2.3.2 HIV initiatives incorporated into LM sector-specific observances, other special events and opportunities
	1.2.4. Ensure efficiency and effectiveness of LM program	1.2.4.1 LM program impact evaluated
Lead Agencies: Relevant LM/MOH/ILO/UNAIDS/PEPFAR		
1.3 Create and strengthen strong and sustainable partnerships through increase coordination and collaboration with key stakeholders in the response	1.3.1. Strengthened Civil Society Organizations.	1.3.1.1 Increased knowledge and skills of relevant staff of CSOs to plan, design and implement HIV and AIDS programs/initiatives 1.3.1.2 Strengthened M&E of CSO programs and initiatives
		1.3.1.3 Strengthened CSO networking and sharing
		1.3.1.4 Improved support for implementation of CSO programs
		1.3.1.5 Improved support for CSO initiatives to reduce HIV and AIDS-related stigma and discrimination and to advocate on human rights and policy issues.
	1.3.2. Collaboration with existing National Coalitions to ensure optimal functioning and create new coalitions such as the Youth Coalition on HIV and AIDS	1.3.2.1 Optimal functioning of existing National Coalitions on HIV and AIDS such as G+, the Guyana Business Coalition on HIV and AIDS and the Guyana Faith Coalition on HIV and AIDS and the Network for Community Commitment (NCC)
		1.3.2.2 Creation of new Coalitions on HIV and AIDS supported such as the Youth Coalition on HIV and AIDS
		1.3.2.3 Strengthened networking and sharing by Coalitions on HIV and AIDS
		1.3.2.4 Strengthened M&E support for programs and initiatives of Coalitions on HIV and AIDS

	1.3.3. Collaboration with Guyana Network of People Living with HIV and AIDS (G+) to ensure the greater involvement of PLHIVs	1.3.3.1 Increased knowledge and skills of relevant members of G+ to plan, design and implement HIV and AIDS programs/initiatives
		1.3.3.2 Increased participation of G+ in coordination, decision making and implementation of national response
		1.3.3.3 Strengthened G+ networking and sharing
	1.3.4. Increased private sector participation in national response to HIV and AIDS	1.3.4.1 Strengthened Private/Public partnership in the HIV response.
		1.3.4.2 Standardized quality of prevention and services delivered to private sector businesses
		1.3.4.3 PLHIV-friendly workplaces free from stigma and discrimination among private sector businesses established
		1.3.4.4. Expanded coverage of Private sector agencies with HIV workplace policy adapted.
Lead Agencies: Guyana Private Sector/GBCHA/NCC/GFCHA/ MOH/ /ILO/ UNAIDS		
1.4 Mobilise, Harmonise and Align resources to ensure their efficient use and sustainability of the Response	1.4.1. Mechanisms to effectively oversee and manage the resources strengthened	1.4.1.1 Coordination and oversight mechanisms for funding support and other resources developed/strengthened
		1.4.1.2 Use of financial data for planning and resource mobilization increased
		1.4.1.3 Unified electronic platform for financial resources developed and utilised for information sharing and decision making
Lead Agencies: MoF/MoH, Donor Agencies, Technical Partners, Private Sector.		
1.5 Create a supportive environment that is based on a human rights foundation and facilitates the delivery of services	1.5.1. The Legal and Policy Environment supports the rights of PLHIV and vulnerable groups strengthened	1.5.1.1 Strengthened Legislative and policy mechanisms and frameworks to reduce discrimination and human rights violation against PLHIV and other vulnerable groups, and support effective responses to the epidemic
Lead Agencies: Ministry of Legal Affairs/MOH/UNAIDS/G+Plus/CSOs.		

Priority Area 2: Prevention

Strategic Objectives:

- Decrease stigma and discrimination across all sectors
- Reduce sexual transmission among Key Populations at Higher Risk
- Reduce sexual transmission among other targeted groups
- Reduce the vulnerability of OVCs to HIV
- Promote behaviour change through mass media and reinforcement activities
- Increase access to condoms and lubricants
- Ensure universal access to HIV Testing Services
- Eliminate Mother to Child Transmission of HIV
- Reduce the risk for HIV transmission in medical settings
- Ensure safe and adequate blood supply

To achieve zero new HIV infections, zero discrimination and zero AIDS-related Deaths, **HIVision2020** will facilitate an enabling social, economic, legal and institutional environment for unhindered HIV prevention for all, including support to community initiatives for prevention of HIV and mitigation of its impact. Activities aligned to the NSP will promote better understanding of HIV infection and generate greater awareness about the nature of its transmission, facilitating the promotion and adoption of safer sexual practices for HIV prevention.

This will necessitate decentralisation and strengthening of HIV prevention programme management and technical capabilities at the local levels; both in the public and private sectors, and in leading NGOs participating in the Programme, with adequate financial and administrative delegation of responsibilities.

Programmes that are designed to achieve HIV prevention will be intensified and made stronger for maximum reach to all; particularly the *'Key Populations at Higher Risk'*. These populations are defined in this strategy as populations at higher risk of HIV exposure which refers to those most likely to be exposed to HIV or to transmit it due to either the number of partners that they have or the type of higher risk sex that they engage in. In Guyana's context these key populations include people living with HIV, men who have sex with men, transgender persons,

sex workers and their clients, Prisoners, miners and loggers. Key populations at higher risk would be targeted in ensuring that the key prevention package defined would we delivered to those populations. These include peer education and outreach; risk-reduction counseling and skills building, promotion; demonstration and distribution of male and female latex condoms and water based lubricants; screening and treatment for drugs and alcohol abuse; voluntary counselling and testing; STI screening and treatment; HIV care and treatment and reproductive health services (MARPS Guidelines 2012)

'Other Targeted Populations' will receive intensified focus in this strategy and are defined as those persons who are placed at elevated risk for HIV infection due to their sexual risk behaviours and other behaviors that could lead to high risk sexual behaviours such as violence, substance use. Other Targeted Populations include In-School-Youths, Out-of-School Youths, seronegative partners in serodiscordant couples, women and girls.

Additionally, *'Adjacent Populations'* will receive heightened focus and is defined as the communities in close geographic proximity to Key Populations where high risk behaviours take place.

Stigma and discrimination, homophobia, gender inequality, violence against women and other HIV related abuses of human rights are placed high on the agenda, as related injustices discourage people from seeking the information and services that will protect them from HIV infection, from adapting safe behaviours and from accessing HIV care and treatment services. Advancing human rights and particularly the context of HIV, the rights of People Living with HIV, Key Populations at Higher Risk, Youth, women and girls could mean ending HIV stigma and discrimination and therefore increased access to HIV services.

An intensified multi-sectoral approach to HIV has seen progress made in the area of protection for Orphans and Vulnerable Children (OVCs). Access to information, education and life skills tools to reduce their risk and vulnerability will continue to be pursued. These initiatives will go beyond our traditional support to include more broadly the private sector and the CSOs community, families and the community as a whole, to care for, ensure their protection and social justice..

Key in **HIVision2020** is the elimination of mother-to-child transmission of HIV (eMTCT). This continues to be a gateway for HIV prevention, treatment, care, and support services for affected families. An effective eMTCT programme facilitates universal access to testing, prophylaxis and treatment for all reproductive Guyanese mother *and* father. This will be supported with the provision of ARVs and other necessary interventions to protect infants from becoming infected with HIV. Option B Plus would be rolled out nationally ensuring the eMTCT and also contributing the treatment as prevention.

Guyana recognizes the effectiveness of condom use in preventing the transmission of HIV and will continue to be an HIV prevention intervention. Both male and female condoms will receive enhanced promotion with increased access to the hinterland regions and to Key Populations at Higher Risk.

HIV Testing through the Voluntary Counselling and Testing programme remains a major gateway to HIV prevention. VCT would ensure that every Guyanese know their HIV status. Equally important, strategies and approaches will be put in place to ensure that Key Populations at Higher Risk receive timely and regular counselling and testing in a confidential manner. The gap between testing and entry into treatment would be strengthened facilitating a timely entry and access to ARVS for those persons testing positive. A renewed focus will be on integrating VCT with PMTCT utilizing the Provider Initiated Testing and Counselling (PITC) approach.

With the expansion of VCT services, enhanced finding and treatment for STI with greater focus on Key Populations at Higher Risk especially in the hinterland and hard to reach communities will more robustly be addressed. Please refer to the Guyana Sexually Transmitted Infections Strategic and Monitoring and Evaluation Plan 2011-2020 for further guidance.

Ensuring the maintenance of safe blood supply will be of paramount importance. Prevention of HIV transmission through transfusion with contaminated blood is a key component of HIV prevention. The past five years has seen a steady increase in voluntary blood donation. All blood (100%) is screened for infectious markers such as HIV and other STIs. The development of a Blood Banking Strategy to effectively roll out enhancement of regional recruitment, screening and testing processes of all blood collected from non-remunerated blood donors while ensuring that adequate safe blood is available to all those in need will be a major priority of the prevention front.

Reducing the risk of HIV transmission in medical settings with updated guidelines and standard operating procedures on universal precautions such as those for post exposure prophylaxis will also see enhanced focus.

For this, every HIV prevention practitioner will be expected to contribute to the elimination of HIV, by ensuring that activities and services for HIV prevention meet national standards. The recommended National HIV Prevention Guidelines will be the guiding document and will provide direction in achieving and maintaining these standards.

Align this with the guiding principles HIVision2020 takes into consideration that all biomedical interventions such as ART, PrEP with ARVs, post-exposure prophylaxis (PEP), and treatment of sexually transmitted infections must have behavioural components. Although still unavailable, in the future, microbicides and/or an HIV vaccine could become additional important interventions.

PRIORITY AREA NO 2: PREVENTION		
STRATEGIC OBJECTIVE	**EXPECTED RESULTS**	**INTERMEDIATE RESULTS**
2.1 Decrease stigma and discrimination across all sectors	2.1.1 Advocate for a legal environment that protects the rights of people living with and affected HIV	2.1.1.1 Greater coordination between law, justice and health and other sectors
		2.1.1.2 Parliamentarians, police, judges, justice ministry officials have evidence-based information on HIV and AIDS and are adequately trained
		2.1.1.3. Mechanism defined, implemented and monitored to address
	2.1.2 Decreased misconceptions and discriminatory behaviors	2.1.2.1 Improved support for community including faith based/workplace-based education and advocacy regarding human rights of MSM, SW transgender people, PLHIV, and other targeted populations
		2.1.2.2 National stigma and discrimination policy on disclosure and related issues on HIV, STI and TB and other updated and monitored
	2.1.3 Increased knowledge and access to prevention products and services	2.1.3.1 Ensured equitable access to needs-responsive health services for Key Populations at Higher Risk- MSM, FCSW, Miners and Loggers Prisoners and other targeted populations- Clients of sex workers, Youth and Women.

		2.1.3.2. Prevention packages defined and reviewed for all populations
		2.1.3.3. Quality of prevention services maintained at the highest level and monitored regularly.
		2.1.3.4 Collaboration with all stakeholders maintained in ensuring access to prevention services.
Lead Agencies: MoH, Ministry of Legal Affairs/PEPFAR/UNAIDS/ILO/CSO/G+		
2.2 Reduce sexual transmission among Key Populations at Higher Risk	2.2.1 Reduced sexual transmission of HIV infection with a focus on key populations at higher risk and their partners through reduced partner change and number, increased condom use, and increase access to screening and treatment services	2.2.1.1 Programs targeting Key Populations at Higher Risk and other sub-populations coordinated
		2.2.1.2 Protective behaviors reinforced and risky behaviors discouraged through behavior change interventions for Key Populations at Higher Risk
		2.2.1.3 Expanded HIV prevention services and programs for Key populations at Higher Risk and other vulnerable populations
		2.2.1.4 Strategy developed for Key Populations at Higher Risk
	2.2.2 Reduce the risk of HIV transmission through Positive , Health, Dignity & Prevention strategies reduced	2.2.2.1 Guidelines for secondary prevention (Positive Health, Dignity & Prevention) disseminated and used
Lead Agencies MoH/PEPFAR/G+/UNAIDS/UNFPA/CSOs		
2.3 Reduce sexual transmission among other targeted populations	2.3.1 Reduce Harmful gender norms that increase the risk of HIV transmission such as those that facilitate gender-based violence; alcohol abuse mitigated	2.3.1.1 Harmful male norms reversed through greater advocacy and collaboration, focused education including engendering a culture of safety and respect, engagement of men as allies, and greater focus on healthy protective norms
		2.3.1.2 Increased knowledge and awareness on domestic violence, alcohol/drug abuse, resources and options available
		2.3.1.3 Increased public/community knowledge and awareness about alcohol/drug abuse, domestic violence, and improved community response to Women and Girls, Gender Based Violence and the abuse of children

		2.3.1.4 Greater linkages with Ministry of Human Services and FBOs to address gender norms established
	2.3.2 Empower young people to protect themselves from HIV and other STIs	2.3.2.1 Initiation of sexual debut delayed, number of sexual partners reduced and other safer sex practices increased among youth through Comprehensive Sexuality Education
		2.3.2.2 Inter-Ministerial Collaboration with Ministry of Education to expand the implementation of the HFLE in secondary schools continued
		2.3.2.3 Healthy sexual behaviors maintained, risky sexual behaviors reduced , and harmful norms modified among youth via peer education and outreach
		2.3.2.4 Young people's access to comprehensive HIV and STI information and to promote behaviour change through new technologies and communication channels including the internet, social networking and youth media improved
		2.3.2.5 Young people's access to comprehensive HIV prevention services such as VCT, STI screening and treatment, male and female condoms, improved with *Safe Spaces* created for the youth to access these services established
	2.3.3 Behaviour change reinforcement activities on HIV/ AIDS and STIs among Men and Boys implemented	2.3.3.1 Initiation of sexual debut delayed, number of sexual partners reduced and other safer sex practices increased among men and boys through Comprehensive Sexuality Education
		2.3.3.2 Healthy sexual behaviors maintained, risky sexual behaviors reduced , and harmful norms modified among men and boys through peer education and outreach, engendering a culture of safety and respect, engagement of men and boys as allies, and greater focus on healthy protective norms
		2.3.3.3 Access and quality of sexual and reproductive health services for men and boys improved

		2.3.3.4 Greater Collaboration with Ministry of Human Services, CSOs and other stakeholders to address men empowerment to promote healthy lifestyles
Lead Agencies : MOH/MoLHSS/MCYS/MOE/LMCSOs/PEPFAR/UNESCO/UNICEF/CSOs		
2.4 Reduce the vulnerability of OVCs to HIV	2.4.1 Increased protection of OVCs	2.4.1.1 Strong and adequate legislative framework to protect children from abuse enforced
		2.4.1.2 Health workers, teachers, police, social workers, and others who interact with children equipped to respond to child protection issues including for children who are *Differently Able*
		2.4.1.3 Access to non-discriminatory care and basic social services provided in an environment that fosters the health, self-respect, education and dignity of the child
Lead Agencies: MOH/MoLHS&SS/MOE/UNICEF		
2.5 Promote behaviour change through mass media and reinforcement activities	2.5.1 Enhanced community mobilization with emphasis on combination prevention	2.5.1.1 Intensified access to the types of interventions that best suit the needs of Key Populations at Higher Risk and other targeted populations and the general population
		2.5.1.2 Healthy sexual behaviors maintained, risky sexual behaviors reduced , and harmful norms modified in the general population and Key Populations at higher Rosk at community level through peer education and outreach
Lead Agencies: MOH/PEPFAR/UNAIDS/UNFPA/CSOs		
2.6 Increase access to male and female condoms and lubricants	2.6.1 Comprehensive condom and lubricant distribution strategy developed	2.6.1.1 Increased availability, accessibility, acceptability, and use of male & female condoms plus lubricants among Key Populations at Higher Risks, other targeted populations and the general population
		2.6.1.2 Condom social marketing campaigns targeted at Key Populations at Higher Risk and the general population developed, implemented and monitored
		2.6.1.3 Comprehensive condom and lubricant distribution strategy developed
Lead Agencies: MOH/PEPFAR/UNFPA/CSO		

2.7 Ensure universal access to HIV services	2.7.1 VCT/PITC services integrated into the PMTCT and Primary Health care services	2.7.1.1 Improved access to quality HIV counseling and testing services countrywide (including the Hinterlands, hard to reach populations and Key Populations at Higher Risk), through innovate strategies to reach those populations
		2.7.1.2 PITC/VCT/PMTCT operational strategy developed with priority on the integration of VCT into primary health care
		2.7.1.3 Reinforced capacity of health care providers and others to provide quality HIV counseling and testing services
		2.7.1.4 Quality of Counseling (VCTQUAL) and testing maintained at the highest level.
		2.7.1.5. Data and evidence used in decision making.
		2.7.1.6 Collaboration maintained with the treatment programme in resulting referral into HIV management
		2.7.1.7 VCT guidelines, protocols, SOPs reviewed and updated.
	2.7.2 Key Populations at Higher Risk access HIV testing	2.7.2.1 Strategies implemented for increased HIV testing among Key Populations at higher risk and other targeted populations.
		2.7.2.2 CSO and member of the Key populations engaged in reaching the Key populations at Higher Risk
		2.7.2.3 Targeted HIV testing through mobile outreaches in safe spaces at appropriate times for key populations at higher risk.
Lead Agencies: MOH/PEPFAR/Private Sector/CSOs		
2.8 Eliminate Mother to Child Transmission of HIV	2.8.1 Risk of HIV infection among women of child-bearing age reduced through primary prevention	2.8.1.1 Knowledge of HIV transmission widespread and major misconceptions reduced among women of child-bearing age
		2.8.1.2 Availability and access to HIV prevention and comprehensive sexual reproductive health services and programs improved for women of child-bearing age, particularly women and men at higher risk for HIV
	2.8.2 PMTCT program Scaled up and Option	2.8.2.1 Expanded access to HIV counseling and testing for all pregnant

	B plus rolled out nationally	women
		2.8.2.2 All HIV+ pregnant women identified and provided with ARVs to prevent vertical transmission of HIV, for their own health and prevention of new infections (treatment as prevention)
		2.8.2.3 Universal access to comprehensive sexual reproductive health care for HIV+ pregnant women, including family planning
		2.8.2.4 Risk of vertical transmission of HIV reduced through ARV intervention and supplementary infant feeding
		2.8.2.5 HIV/AIDS-related morbidity and mortality decreased and the quality of life improved among HIV+ mothers and their HIV+ infants through treatment and care, including ART
		2.8.2.6 Established and strengthened support and referral systems for PMTCT
		2.8.2.7 Strengthened PMTCT service delivery and functioning
Lead Agencies: MOH/PEPFAR/Private Sector		
2.9 Reduce the risk for HIV transmission in medical settings	2.9.1 Guidelines on universal precautions disseminated and used	2.9.1.1 Universal Precautions Guidelines used to implement program to reduce the risk of HIV transmission in medical settings
		2.9.1.2 Guidelines on sexual assault and needle stick injuries in developed and disseminated and used
Lead Agencies: MOH/CDC/PAHO		
2.10 Ensure safe and adequate blood supply	2.10.1 Improved screening of donors and testing processes	2.10.1.1 Strengthened coordination of blood banking services
		2.10.1.2 Improved capacity of human resources through a structured training and education program
		2.10.1.3 Comprehensive quality assurance system, covering the entire transfusion process from donor recruitment, blood collection, production of blood components, testing, storage, transport, and maintenance of the cold chain, to transfusion to the patient
		2.10.1.4 National Blood Banking Strategy review, updated, implemented and monitored

	2.10.2 Participation of voluntary, non-remunerated blood donors increased	2.10.2.1 Increased blood collections from voluntary, non-remunerated blood donors

Priority Area 3: Care, Treatment, and Support

Strategic Objectives:

- Ensure timely access to quality ARVs and other related pharmaceuticals and commodities.
- Expand access to antiretroviral therapy through decentralization while strengthening the NCTC as the centre of excellence.
- Decrease the burden of tuberculosis through the integration of TB and HIV services in accordance with the WHO 12 point interim policy
- Reduce the burden of Opportunistic Infections (OIs)
- Strengthen Management of HIV and co-morbidites for special populations
- Expand and Strengthen the holistic approach towards HIV management inclusive of chronic illness, home and palliative, Family Planning Services and mental health
- Expand access to support services for People Infected and Affected by HIV
- Increase access to quality Laboratory services

The overall aim of this priority area is to strengthen the health system to create the conditions necessary for universal access through the simplification of high-quality treatment and improve the efficiency and effectiveness of treatment and care delivery, transforming the response of programmes from an emergency phase to long-term sustainability.

HIVision2020 ensures the provision of care and support to people living with HIV, through the protection and promotion of their human rights, including the right to access health care, and the right to mobilise support of non-governmental organisations (NGOs), Community Based Organisations (CBOs), and communities of faith. The **HIVision202**0 will continue to provide appropriate and equitable health care to HIV-infected people. To maximise this, attention will be drawn to compelling public health rationale for overcoming stigmatization and discrimination.

The decline in HIV-related morbidity and mortality reflect the enormous progress made in HIV service provision since the introduction of antiretroviral therapy in 2002. The scale up the HIV prevention response and HIV testing coupled with an effective treatment programme resulting in persons living with the disease longer would demand an increase in the provision of HIV treatment. Considering the reducing financial donor support it will be of critical importance in the future, that an intensified focus be placed on appropriate evidence based interventions and service-delivery approaches to provide optimal high quality treatment.

The HIVision2020 will promote and optimise programme links between HIV and other key priority health areas which is crucial for leveraging broader health outcomes through the maintenance of treatment 2.0 principles.

The HIVison2020 will embrace the mounting scientific evidence which demonstrates a strong link between expanding access to HAART and reducing the transmission of HIV. The continued modernization of the supply management system will contribute to the uninterrupted supplies of antiretroviral and other medicines. **HIVision202**0 will ensure a comprehensive dialogue on the possibilities of third line therapy and would be guided by evidence inclusive of the results of HIV Drug Resistance Surveys.

In addition to the ART programme, Pre Exposure Prophylaxis and the management of serodiscordant couples will be important variables in comprehensively addressing treatment as prevention.

With the advancements made in HIV management, people who are infected with HIV are living longer, and HIV has now emerged as a chronic disease. An increase in life expectancy means that the need has arisen to comprehensively manage PLHIV for other chronic diseases such as diabetes, hypertension and other cardio vascular diseases. Children born with HIV in the earlier days of the epidemic are now growing up to be adolescents, teenagers and young adults. **HIVision2020** addresses this population and makes provisions for enhancing the quality of life. Inclusive of this holistic approach is the community home and palliative care, nutritional, psychosocial, economic and other forms of support involving all stakeholders.

The gap between testing and entry in to treatment will be bridged. Issues of loss to follow up, poor adherence to clinical and medication appointments and others that can impact the treatment outcomes and ultimately prevention are being addressed.

Tuberculosis a public health issue has reemerged with the HIV epidemic. TB constitutes the majority opportunistic infections and is the leading cause of mortality among the HIV population. The National Tuberculosis Control Programme and the National AIDS Programme Secretariat are involved in a number of collaborative activities and notable achievements were made. However with the significant burden of the TB/HIV co infection epidemic, the HIVision2020 will address TB and HIV in accordance with the WHO 12 point interim policy of collaborative activities, and would seek to facilitate programme coordination and resource management, particularly the management of human resources through task shifting, cross training and other mechanisms. Further joint TB and HIV services will ensure alignment of programme deliverables, synchronicity between guidelines, training curriculum, standard operating procedures and coordinated referral between services. There would be an increase in operations research as the programme to use all evidence in impacting on the TB/HIV mortality rates.

The National Public Health Laboratory will continue lead in the provision of high quality Laboratory services for optimal monitoring of persons living with the disease inclusive of the diagnosis for the opportunistic infections and other co morbidities.

Priority Area 3- Treatment, Care and Support		
STRATEGIC OBJECTIVE	**EXPECTED RESULT**	**INTERMEDIATE RESULT**
3.1 Ensure timely access to quality ARVs and other related pharmaceutical and commodities.	3.1.1 Efficient National Supply Chain Management (SCM)and Logistics Management Information System for ARVS and other commodities	3.1.1.1 LMIS and national SCM at all levels of the health care system supported, strengthened and coordinated
		3.1.1.2 Established inter-agency Collaboration mechanisms to coordinate LMIS/SCM activities.
		3.1.1.3 Functional Procurement Oversight Committee to support a coordinated procurement plan among donors among joint development partners and other stakeholders.
		3.1.1.4 Capacity built for forecasting , procurement and supply management
		3.1.1.5 Warehousing, distribution and management of ARVs and other health commodities at MMU and Regional Hubs supported and strengthened.
		3.1.1.5. Quality of the LMIS, procurement systems and the National SCM at all levels of the health care system maintained.

		3.1.1.6 Compliance to national and donor specific procurement regulations and policy for all commodities and supplies
	3.1.2 High Quality ARVs and related pharmaceuticals available	3.1.2.1 Food and Drug Department functions optimally.
		3.1.2.2 ARVs and related pharmaceutical registrations maintained in compliance with International Standards.
		3.1.2.3 Qualitative and Quantitative analyses for all ARVS and related commodities conducted.
		3.1.2.4 Pharmocovigilance maintained.
		3.1.2.5 Referral linkages between the National Food and Drug Department and Regional and other reference like institutions functional
Lead Agencies- MOH/PEPFAR/PAHO		
3.2 Expand access to antiretroviral therapy through decentralization while strengthening the NCTC as the centre of excellence	3.2.1 Expanded Access to HIV management	3.2.1.1. HIV ART programme decentralised and integrated into PHC
		3.2.1.2. Capacity built among healthcare workers including the roll out of Integrated management of Adult and Child hood Illnesses (IMAI and IMCI)
		3.2.1.3 Heightened public awareness through sustained and active programmes focusing on stigma and discrimination reduction.
		3.2.1.4 Linkages between HIV testing and referral into treatment strengthened
		3.2.1.5 Adherence to ART maximized
		3.2.1.6 Robust system in place to ensure reduce loss to follow up and retention in care.
	3.2.2 Effective and evidence based HIV treatment delivered	3.2.2.1 HIV management guidelines regularly updated based on evidence and include new guidance on ARVs, management of OIs, Laboratory monitoring and others
		3.2.2.2 Operations research conducted
		3.2.2.3 Continuous quality improvement thorough HEALTHQUAL and consumer advisory mechanisms institutionalised.
	3.2.3 Maintain and Strengthen the NCTC as a centre of excellence.	3.2.3.1 Multidisciplinary, highly trained and experienced staff functions at the NCTC
		3.2.3.2 NCTC constitutes an integral component and leads the HIV clinical Training and mentoring programme for all categories of HCW
		3.2.3.3 Collaboration with specialized teaching institution supported

		3.2.3.4 Specialized clinical research led by NCTC
		3.2.3.5 Technical support and supervision oversight to regional treatment sites provided.
		3.2.3.6 Technical leadership provided in the areas of new technology and science such as third line therapy, microbicides, pre-exposure prophylaxis, management and serodiscordant couples.
Lead Agencies: MOH/PEPFAR/PAHO		
3.3. Decrease the burden of tuberculosis through the integration of TB and HIV services in accordance with the WHO 12 point interim policy	3.3.1 Strengthened existing mechanisms for coordination and joint planning between TB and HIV programmes.	3.3.1.1 National TB/HIV Coordinating Committee functional
		3.3.1.2 Planning, monitoring and evaluation and surveillance systems for TB and HIV integrated
	3.3.2 Reduced burden of TB in people living with HIV through the "Three I's" principle	3.3.2.1 TB infection Control in Health Care and Congregate Settings adequate.
		3.3.2.2 INH prophylaxis to all TB/HIV patients with TB infection.
		3.3.2.3 TB case findings intensified through TB screening and diagnosis
	3.3.3 Reduced burden of HIV in people living with TB	3.3.3.1 Expanded HIV testing and counseling for all TB patients
		3.3.3.2 HIV prevention methods introduced among TB patients
		3.3.3.3 Co-trimaxazole preventative therapy for all presumptive tuberculosis cases and all Tuberculosis patients according to national protocols and guidelines introduced
		3.3.3.4 Antiretroviral therapy for all patients with TB and HIV introduced as early as possible and according to national protocols and guidelines and delivered by trained health care workers and by DOT HAART.
		3.3.3.5 TB/HIV management supported by optimal Laboratory diagnostics including new technologies such as gene Xpert and point of care testing.

Lead Agencies: MOH/PAHO/PEPFAR/MOHA/MAA/ MHSSS/CSO		
3.4. Reduce the burden of Opportunistic Infections (OIs)	3.4.1 Strengthened Management of OIs.	3.4.1.1. Guidelines, SOP and other relevant technical guidances updated regularly to incorporate new evidence.
		3.4.1.2. Capacity built for diagnosis and management of Opportunistic Infections.
		3.4.1 3 Access to medicines for the management of Opportunistic Infections maintained
		3.4.1.4 National Cervical Cancer Policy guides the implementation of Cervical cancer screening, diagnosis and treatment.
		3.4.1.5 Monitoring, Evaluation, Research and Surveillance of Opportunistic Infections enhanced.
Lead Agencies: MOH/PAHO/PEPFAR/MOHA/MAA/ MHSSS/CSO		
3.5.Strenghten Management of HIV and co-morbidities for special populations	3.5.1 Strengthen HIV management among specific populations- Key Populations at Higher Risk (MSM, SW, Prisoners, Mobile and migrant populations) , Adolescents and the Ageing Populations	3.5.1.1.Consideration of particular needs for special populations addressed in National policies, guidelines protocols and all policy and strategic directions
		3.5.1.2 Stigma and Discrimination reduced, facilitating access to HIV to key populations
		3.5.1.3. National Guidelines and protocol reviewed and revised to address the emergency of Chronic Diseases and Other related health issues among the ageing population with HIV.
Lead Agencies: MOH/PEPFAR/PAHO		
3.6. Expand and Strengthen the holistic approach towards HIV management inclusive of chronic illness, home and palliative, Family Planning Services and	3.6.1 Expanded and strengthen access to Home and Palliative Care	3.6.1.1 Home and Palliative care strategy, guidelines and protocol reviewed and revised.
		3.6.1.2 Strengthen and expanded capacity of CSOs, CBOs and families of PLHIVs to provide HPC
		3.4.2.2. National HPC programme coordinated.
		3.6.1.3 The network and capacity of HPC service providers including volunteers.
		3.6.1.4 Chronic Illness, Family Planning, Mental health and other services incorporated into HPC

mental health		
Lead Agencies: MOH/PEPFAR/CSO		
3.7.Expand access to support services for People Infected and Affected by HIV	3.7.1 Psychosocial support to people living with HIV strengthened	3.7.1.1 Capacity of multi disciplinary team (particularly social workers) built to address social, economic and psychosocial issues among all PLHIVs with consideration for the key populations at higher risk as a specific sub population.
		3.7.1.2. Capacity of PLHIVs built to address quality of care issues(Consumer Advisory Group)
		3.7.1.3 Mechanisms for referral within and between agencies remain current and robust.
		3.7.1.4 Protocols for psycho social support developed, implemented and evaluated and will include issues of disclosure, self stigma, adherence, economic empowerment and others.
		3.7.1.5.Network of Support Groups Functional
		3.7.1.6. Revise, Review and implement PWP framework to reflect evidence based guidance.
	3.7.2 Established comprehensive nutritional Programme for PLHIVs	3.7.2.1 Partnership and Collaboration on nutrition initiatives enhanced.
		3.7.2.2 National Nutritional Strategy Policies and Guidelines approved and implemented and evaluated
		3.7.2.3 System for nutritional education and Counseling and referral developed, implemented and evaluated.
		3.7.2.4 Information Systems for nutritional support robust and relevant. 3.7.2.5 Capacity of Health Care workers built in Nutrition and HIV
	3.7.3 Economic Independence of PLHIVs attained	3.7.3.1 Mechanisms for evaluating, facilitating and referring PLHIVs for employments in place. 3.7.3.2. PLHIVs benefit from targeted skills building with appropriate levels of micro financing support.
Lead Agencies: MOH/MHSSS/PEPFAR/CSO/Private Sector		
3.8 Increase access to quality	3.8.1 Strengthen the capacity of	3.8.1.1. National Laboratory Strategy implemented and monitored.

Laboratory services	Laboratory services to provide accurate and timely monitoring for HIV and opportunistic infections (testing for drug susceptibility and resistance, STIs, cervical cancer and others)	3.8.1.2. Laboratory Services in compliance with National approved standards.
		3.8.1.3 Policies, guidelines, protocol, standard operating procedures approved and implemented
		3.8.1.4. Availability of infrastructure (physical, logistics, equipment and consumables human resources, transportation network and all others) for efficient Laboratory services.
		3.8.1.5. Qualified and trained staff provide Laboratory services
		3.8.1.6. Internal and external Quality controls and assurance implemented.
		3.8.1.7 Decentralization Laboratory services strengthened
		3.8.1.8 Laboratory- Epi Surveillance developed and functional
	3.8.2 Maintain the National Public Health Reference Laboratory as the Center of Laboratory Excellence	3.8.2.1 NPHRL maintains National Standards of Certification and acquires and maintains International certification
		3.8.2.2 Specialized testing conducted at the NPHRL
		3.8.2.3 NPHRL constitutes and integral part of the institutional architecture for Laboratory training
		3.8.2.4 NPHRL monitors and reports on Laboratory Standards and Quality Assurance for National Laboratory services
		3.8.2.5 Laboratory components of research led by the NPHRL
		3.8.2.6 New Laboratory technologies piloted and introduced at the NPHRL. Including any point of care testing
		3.8.2.7 Technical support and oversight to network of regional and district Laboratories provided
		3.8.2.8 Referral linkages maintained with Regional and International Laboratories
Lead Agencies: **MOH/NPHRL/RHS/PEPFAR/PAHO/**		

Priority Area 4: Integration

Strategic objectives:

- Integrate the management of HIV with non communicable and chronic diseases.
- Integrate HIV services with the Sexual and Reproductive Health and Rights.
- Deliver quality health services inclusive of HIV through a highly qualified cadre of Human Resources.
- Strengthen Linkages between HIV and maternal, newborn and Child health Services.
- Integrate HIV Behavior Change Communication within overall Health Promotion and Communication.

The gains attained by the Guyana HIV programme over the past decade have the potential to benefit key areas beyond HIV. HIV is closely linked and interconnected with a wide range of health and public health issues such as: prevention, early diagnosis and treatment of STI; TB control; maternal, newborn and child health and Sexual and Reproductive Health (SRH). There are also cross-cutting and interdependent issues within the health sector such as human resources development, health communication, strategic information, research, and health financing that once well integrated with the systems could yield better results.

HIVision2020, therefore, brings about the necessary integration at both the coordination and the implementation level, of HIV with other national primary health care and public health programmes.

Inherent with integration at the *coordination* level, is strengthening of the health system. The key pillars of the WHO defined health systems building blocks are addressed under the purview in **HIVision2020**, to include good governance, leadership and the health workforce. Results of integration at the *implementation* level are reflected as improved and sustained care, treatment, support and prevention outcomes.

Guyana HAPSAT assessment conducted in July 2011 recommended that funding for cross-cutting issues will facilitate the integration of HIV services into the general health care and social services and would result in cost savings. A precise national HIV response, as guided by **HIVision2020** will facilitate the retention of current sources of funding. Local and external sources of funding will be mobilised for sustaining, expanding and intensifying activities that result in successful outcomes. **HIVision2020** will be efficient and effective in supporting transition to financial sustainability, while external funding will be harmonized and aligned to support domestic funding mechanisms.

HIVision2020 will integrate HIV services in a number of key areas making the HIV response more comprehensive and sustainable.

As a results of the advances made in the management, HIV has now emerged as a chronic disease requiring the management of cardio vascular diseases, hypertension, cancer, diabetes among associated conditions.

Many lessons were learnt and systems were strengthen over the years of the HIV response and would be applied to the models of managing non-communicable diseases, for example, the affected populations would be mobilized and the broader community would be engaged in advocacy and service delivery such as outreaches to communities, including workplaces. The successful multi-sectoral approach to the HIV response would be utilized in the continued promotion of HIV care, treatment and support services as well as for chronic non communicable diseases.

The Non Communicable Disease programmes would cover common health complications of people living with HIV, including conditions associated with ageing, oral health, poor nutrition and sanitation, mental health disorder and as well issues related to long-term antiretroviral therapy.

The integration of sexual and reproductive health and HIV, particularly HIV prevention has great benefits to the individual, to the community and the health system. HIVision2020 in integrating SRH services will seek to prevent unwanted pregnancies, HIV and other sexually transmitted Infections. Behaviours that persons adapt during their adolescent years have significant implications for their future health and therefore the HIVision2020 will focus on addressing

sexual and reproductive health among this population recognizing also the diversity of the group and the significant challenges in accessing information and services for a variety of reasons. The role of the school system in dealing with the adolescents is prioritised.

An enabling environment for the accessibility and delivery of the services would be strengthened. Particular emphasis would be placed in establishment of mechanisms such as youth friendly services to ensure the provision of HIV Prevention, counselling and testing services as well as STI screening, family planning including education and availability of contraception and condoms, cancer screening and other sexual and reproductive health issues.

Closely linked to the SRH, HIVision2020 will address the important public health issues of gender based violence, sexual violence and sexual coercion.

A qualified health force is required to deliver quality health services. HIVision2020 will see HIV education integrated at all levels of training. Specific focus would be placed on training of health care workers through the Health Education Sciences Unit (HESU) of the Ministry. This would be done through the leadership of the HESU and in collaboration with other academic institutions both locally and internationally in ensuring that curriculum is updated regularly and that new programmes are developed and implemented. The HESU in collaboration with other agencies such as Georgetown Public Hospital Corporation and the University of Guyana will ensure that training remains relevant including higher levels of training such as post graduate level.

The further integration of HIV services into the ANC services, will facilitate Guyana achieving the 2012 MDGs of eliminating mother to child transmission of HIV and substantially reducing AIDS related maternal deaths by 2015 and similarly a reduction in the AIDS related child mortality. This approach of integration has yielded significant positive outcomes as the programme reports an average of over 90% coverage for HIV testing among the population for HIV testing as well as for ARV among all women tested positive. Further integration into the core package of interventions for maternal, new born and child health is critical as the programme expands it reach and scope.

The strengthened integration of the elimination of the vertical transmission of HIV infection into the ANC services provides a foundation to deliver a continuum of care and a package of antenatal, maternal and child health and reproductive health services. This approach would

ensure that women access not only antenatal services, but also would ensure that services to manage STI, unwanted pregnancies, sexual violence and others are available. Integral to the PMTCT programme and to Sexual and Reproductive Health Services is male involvement. The enhanced integration will facilitate male involvement, whilst maintaining and scaling up of HIV testing, couples counselling, treatment or prophylaxis with ARVS, and management of the exposed infant. The ANC programme would continue to strengthen its data collection. The ANC survey conducted would include additional STI pathogens such as Hepatitis B and operations research would be conducted to determine other baselines such as gonorrhea and Chlamydia and ultimately to guide more efficient and effective implementation.

The Ministry of Health currently has a mixed model in delivering health promotion and health communication. In this regards, several parallel programmes exist that support disease specific health promotion in a fragmented fashion. The NAPS, NTP, Department of Chronic Diseases and AHU are clear examples of such parallel programmes. These departments have built relatively strong disease specific health communication programmes and have the expertise to transfer to a wider MoH effort in streamlining Health communication.

It is anticipated that the integration of the services would facilitate the development of a wider MoH strategy and better coordination. Additionally with the integration, work planning and monitoring would be more streamlined.

PRIORITY AREA No 4: INTEGRATION		
STRATEGIC OBJECTIVE	**EXPECTED RESULT**	**INTERMEDIATE RESULT**
4.1 Integrate the management of HIV with non communicable and chronic diseases	4.1.1 Efficient coordination of HIV and Chronic Diseases.	4.1.1.1 HIV Prevention and treatment adequately addressed in the Chronic Disease Strategy.
		4.1.1.2 Strengthened integrated management of adult illnesses within the Primary Health care setting with adequate referral services.
		4.1.1.3 Chronic disease management integrated into HIV community and clinical training modules.
		4.1.1.4 HIV prevention and screening incorporated within Chronic Disease screening
		4.1.1.5 Integrate the monitoring of Quality of Care for Chronic Diseases within the HIV HEALTHQUAL system
Lead Agencies: MOH/PAHO/PEPFAR		

4.2 Integrate HIV services with the Sexual and Reproductive Health and Rights Services	4.2.1 An enabling environment and effective coordination for the access of SRH and HIV services	4.2.1.1 SRH policy including access to HIV counseling and testing for adolescents and access to SRH services among the in-school population developed, implemented and monitored
		4.2.1.2 SRH included in all appropriate policy and strategic documents such as the National Health Strategy, Adolescent Health Strategy, Teenage Pregnancy Strategy and Health and Well Being Strategy and others.
		4.2.1.3 Teenage pregnancy strategy and all other SRH related strategies developed, implemented, monitored and evaluated.
		4.2.1.4 SRH services coordinated
	4.2.2 Access to quality sexual and reproductive health services for all persons in need and with a special focus on adolescents increased.	4.2.2.1 High quality, evidence based information on sexual and reproductive health disseminated
		4.2.2.2 Capacity built for health care workers in addressing the needs of the specific population sexual and reproductive health.
		4.2.2.3 High quality SRH services provided on a timely, non judgmental manner and in a friendly environment - STI screening and treatment, HIV counseling and testing, Family Planning, Contraceptives and Condoms.
		4.2.2.4 Strengthened Youth Friendly Health services with a focus on adolescents and youth
		4.2.2.5 Cervical Cancer Prevention And treatment Programmes expanded, monitored and evaluated including the HPV vaccination programme and the Visual Inspection with Acetic Acid (VIA) using the Single Visit Approach (SVA)
	4.2.3 Sexual and Reproductive Health in schools addressed	4.2.3.1 Sexual and reproductive health in school based policies promoted.
		4.2.3.2 Capacity built among the administrative and teaching staff on SRH issues
		4.2.3.3 Health and family Life Education for all schools strengthened and monitored, including curriculum review and pre and in service training
	4.2.4 Sexual Violence including Gender Base Violence in the context of SRH services addressed	4.2.4.1 Reviewed and updated National strategy on Sexual Violence and GBV
		4.2.4.2 GBV and sexual violence programmes strengthened through multi-stakeholder coordination.
		4.2.4.3 Prophylactic measures accessible on a timely manner for cases of sexual assault- HIV post exposure Prophylaxis, STI prophylaxis, Emergency Contraception.
Lead Agencies: MoE/MOH/PEPFAR/MCYS/MHSSS/UNICEF/UNFPA/ PAHO		

4.3 Deliver quality health services inclusive of HIV through a highly qualified cadre of Human Resources	4.3.1 Coordinated training of health care workers	4.3.1.1 Established functional technical working group on training.
		4.3.1.2 Compendium of all curricula and its functional status established.
		4.3.1.3 Data base of all persons trained by predefined categories- professional health worker categories, by technical thematic areas developed.
		4.3.1.4 Linkages with other health care professional development agencies such as Regional and International Universities and training institutions in mentorship and training established
		4.3.1.5 University of Guyana and other training institutions regularly updated curriculum including the integration on HIV onto infectious diseases modules and others
	4.3.2 Capacity of the health care workers at pre service, in-service and postgraduate levels strengthened	4.3.2.1 Assessed training needs of the Health Sector – clinical, programmatic and leadership and public health.
		4.3.2.2 Training curricula – pre service and in-service reviewed and updated as required.
		4.3.2.3 Capacity built for the trainers on training methodologies and techniques.
		4.3.2.4 Reviewed, Implemented and Monitored the Training Strategy for the Health Sector.
		4.3.2.5 Collaborated with University and academic institutions and key stakeholders in the development, implementation and monitoring of a higher education and Post Graduate Training Plan.
Lead Agencies: MOH/UG/GPHC/PAHO/PEPFAR		
4.4 Strengthen Linkages between HIV and maternal, newborn and Child health Services	4.4.1 Efficient coordination of the ANC and HIV services	4.4.1.1 The National Oversight Committee for ANC and PMTCT functioning efficiently
		4.4.1.2 HIV integrated with the ANC policy directions.
		4.4.1.3 Interdepartmental collaboration strengthened to facilitate better integration and delivery of services particularly to the hinterland regions (hard to reach populations)
		4.4.1.4 Reviewed and updated curriculum to ensure the inclusion of HIV , and to incorporate new evidence
		4.4.1.5 Built capacity of healthcare workers to deliver high quality care through training and monitor the delivery of services and care provided.
	4.4.2 Provided High Quality Antenatal, Perinatal and postnatal services	4.4.2.1 Health care workers in the delivery of antenatal services trained to provide HIV services including HIV counseling and testing, integrated management of childhood illnesses, management of syphilis, on protocols for Dry Blood Spots, counseling (infant

	including the provision of HIV services	feeding practices) for and management of the HIV exposed infant and others
		4.4.2.1 Safe mother-hood approaches integrated with the PMTCT programme.
		4.2.2.3 Functional referral system for persons testing HIV positive to HIV treatment.
		4.4.2.4 Vaccination schedules for HIV exposed and infected children reviewed and updates regularly.
		4.4.2.5 Operations research to inform further integration of services conducted
Lead Agencies: MOH/PAHO/UNICEF		
4.5 Integrate HIV Behavior Change Communication (BCC)within overall Health Promotion and Communication	4.5.1 Coordinated Behavior Change Communication within the Ministry of Health	4.5.1.1 Review conducted on Health Communications within the Ministry of Health to integrate HIV BCC
		4.5.1.2 Finalised Health Communication Strategy, implemented and monitored.
		4.5.1.3 Mechanism defined and functional for the coordination of health communications within the departments of MoH, technical partners and other stakeholders
		4.5.1.4 Developed, implemented and monitored a comprehensive work-plan on health communication that will include HIV with all stakeholders.
		4.5.1.5 Capacity built of HR on health communication strategies
		4.5.1.6 Effectiveness of specific health promotion and health communication initiatives evaluated.
Lead Agencies: MOH/PAHO/UNICEF/UNIADS		

Priority Area 5: Strategic Information

Strategic Objectives:

- To improve the management and coordination of Strategic Information
- To ensure systematic capacity building initiatives to improve the quality of strategic information
- To perform HIV and AIDS related research and special studies.
- To Strengthen Strategic Information Systems to improve HIV Programme Management, Surveillance, Monitoring and Reporting

Strategic information is fundamental to the formulation and delivery of effective HIV programmes. Guyana has made tremendous strides in collecting, generating, analysing, disseminating and using relevant data. **HIVision2020** supports the strengthening of capacity to translate data into strategic information, as evidence for action. The system that will be in place to monitor progress of **HIVision2020** implementation, and the operational plans, requires that staff and resources carry out four major functions: 1) implementing an early alert system allowing for the timely collection, synthesis and use of information to respond quickly to emerging epidemics; 2) careful data analysis to develop policy scenarios and resource projections to guide decision-making; 3) periodical evaluation of results of the current response and recommendations to improve them; and 4) engaging policy-and decision makers in ways that promote improvements to current programmes, based on evidence.

HIVision2020 supports the National Programme to optimally measure the results of its efforts in reducing the incidence of HIV and its social and economic impact. Such results are also important to show effectiveness and accountability. To this end, the NAPS will continue to coordinate and manage its HIV-related M&E functions, technically supported by the Monitoring and Evaluation Reference Group (MERG). The NSP also calls for developing a research agenda in Collaboration with key interest groups; mobilising resources for research, and establishing the technical expertise within the Ministry of Health, other government and non-government institutions, the private sector and in civil society to conduct relevant operational research and behavioural and impact evaluation studies. It is envisaged that HIV related

research activities will take on a stronger biological component to include more comprehensive screening for STI and opportunistic infections such as TB.

Over the medium term, enhancing HIV-related strategic information will also involve institutionalizing M&E functions and responsibilities at the regional and facility levels and ensuring there is ownership and use of data for improving the response at the local level. These strategies will be guided by an HIV M&E Plan and will hinge on maintaining proficient and stable M&E capabilities at the central level.

Of critical importance also is the modernization of the HIV data collection, reporting and M&E systems which will involve the eventual transformation of stand-alone information and data sources, whether paper-based or electronic, into updated and standardized formats and electronic systems that can link sub programmes and track patients and clients as they are moved through the continuum of HIV services. All ICT related activities including the development of the HIV electronic systems, procurement and deployment of networking and communication infrastructure, hardware and software at the regional and facility levels and overall maintenance of the system at the national level will be led and technically supported by the Ministry of Health Management Information Systems (MIS) Unit in Collaboration with the NAPS.

Priority Area 5- Strategic Information		
STRATEGIC OBJECTIVE	**EXPECTED RESULTS**	**INTERMEDIATE RESULTS**
5.1 To improve the management and coordination of Strategic Information	5.1.1 Evaluated the SI System/process to determine linkages, gaps and to improve the overall functioning of the M&E system	5.1.1.1 SI processes and procedures assessed and evaluated
	5.1.2 Coordination of Strategic Information initiatives	5.1.2.1 Ensured M&E leadership and advocacy 5.1.2.2 Monitoring and Evaluation Reference Group functional

	5.1.3 Integrated and Standardized HIV/AIDS data collection Systems	5.1.3.1 Increased capacity to monitor, evaluate, and report on process, outcomes, and impact of HIV/AIDS programs and interventions 5.1.3.2 Costed National M&E plan developed
	5.1.4 Strategic Information disseminated and used	5.1.4.1 SI available and used for evidence-based planning and programming at national and sub-national levels
Lead Agencies: MOH/UNAIDS/PAHO/USAID		
5.2 To ensure systematic capacity building initiatives to improve the quality of strategic information	5.2.1 HIV/AIDS surveillance and M&E system strengthened	5.2.1.1 Improved quality of surveillance data being collected
		5.2.1.2 Guidelines and protocols for HIV surveillance developed
		5.2.1.3 Routine data quality assessments conducted
	5.2.2 Human resource capacity in HIV/AIDS Surveillance and M&E developed	5.2.2.1 Strengthened human resource capacity to strategically collect and use information for program accountability and improvement
Lead Agencies: MOH/PEPFAR		
5.3 To perform HIV/AIDS related Research and special studies	5.3.1 Research Agenda developed and supported	5.3.1.1 Research and evaluation agenda developed
		5.3.1.2 Conducted HIV/AIDS risk assessments, behavioral and biological surveys for different vulnerable populations
		5.3.1.3 Operations and facility level research conducted
		5.3.1.4 Sound scientific evidence garnered to develop tools and strategies to improve existing or develop new promising interventions and tools
		5.3.1.5 Research findings translated into national initiatives for implementation to improve HIV/AIDS activities, interventions and programs
	5.3.2 Provision of Human resource capacity building in conducting research	5.3.2.1 Conducted assessments of available research skills
		5.3.2.2 Local expertise and capacity to conduct research activities developed
Lead Agencies: MOH /UNAIDS/ PEPFAR/UG		
5.4 To Strengthen Strategic Information Systems to improve HIV programme Management ,	5.4.1Support the creation of a robust, sustainable and governance system for the coordination of Strategic Information activities	5.4.1.1 HMIS expanded to improve data collection, analysis, use and dissemination.
		5.4.1.2 Infrastructure support for expansion of Surveillance and M&E at National and Regional Levels through electronic systems supported.

Surveillance, Monitoring and Reporting	5.4.2. Connectivity and access to shared resources improved.	5.4.2.1National guidelines on systems and tools for National HMIS revised and disseminated.
		5.4.2.2 Data confidentiality, use and dissemination policy developed and disseminated.
		5.4.2.3 Network at National and Regional Levels established and interconnected.
	5.4.3 Medical records and Management Reporting Systems in Health care facilities (hospitals and health centers) improved.	5.4.3.1HR capacity built for the operation and maintenance of networks and management information systems.
		5.4.3.2 Development of the Electronic Health Information System scaled up.
		5.4.3.3 ICT infrastructure Improved.
Lead Agencies: Ministry of Health/PEPFAR/ PAHO		

Chapter 8: Monitoring & Evaluation

In line with the three ones principles **HIVision2020** will have a national Monitoring and Evaluation Framework that guides the National Strategic Plan 20132020.

The objectives of the M&E framework are:

- To provide accurate and timely information to policy makers and programme planners.
- To monitor and report on core and additional indicators for impact, outcomes, outputs and inputs of the national HIV AND AIDS programme.

The strengthening actions identified for the current strategic period will be guided by the twelve essential components of a functional M&E System. The components of the M&E frameworks will guide strategies that support an effective system and ensure that data is timely and accurate supporting information on the status of the epidemic, appropriate response, monitoring of the national programme and multi-sectoral response, and ultimately assess the effectiveness of Guyana's National response to HIV.

Below is a graphical representation of the M&E twelve components that will support the **HIVision2020** plan**.**

M&E Framework for HIVision2020					
	Indicator	**Data Source**	**Indicator Origin**	**Baseline**	
				Year	**Value**
	Impact				
1.	HIV prevalence among Key Populations SWs MSM	BBSS 2009	GARPR	2011	 16.6% 19.4%
2.	HIV Prevalence among pregnant women	ANC Survey; PMTCT Programme Records	National	2011	0.9
3.	Percentage of all deaths attributable to AIDS	Surveillance Programme Report	National	2010 (preliminary)	3.6
4.	Percentage of infants born to HIV infected mothers who are infected	PMTCT Programme Records	UA	2011	2.5
5.	Percentage of adults and children with HIV still alive and known to be on treatment after initiating treatment: 12 months 24 months 60 months	ART Programme Records	UA	2011	 80.4 NA NA
	Coordination				

M&E Framework for HIVision2020					
	Indicator	**Data Source**	**Indicator Origin**	**Baseline**	
				Year	**Value**
6.	Domestic and international AIDS spending by categories and financing sources	NASA	UNGASS	NA	NA
7.	National Commitments and Policy Instruments (prevention, treatment, care and support, human rights, civil society involvement, gender, workplace programmes, stigma and discrimination and monitoring and evaluation)	Key informant interviews	UNGASS	2011	Completed
	Prevention				
8.	Percentage of young women and men aged 15-24 who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconception about HIV transmission	DHS	UNGASS	2009	51.1
9.	Percent of persons aged 15-49 expressing accepting attitudes towards people with HIV and AIDS	DHS	National	2011	21.3
10.	Percentage of adults aged 15-49 who have had more than one sexual partner in the past 12 months who report the use of a condom during their last intercourse: Females Males	DHS	UNGASS	2009	 NA 65.4
11.	Number of women and men aged 15 and older who received HIV testing and	VCT and PMTCT Programme Records	UA	2012	63,853

M&E Framework for HIVision2020					
	Indicator	**Data Source**	**Indicator Origin**	**Baseline**	
				Year	**Value**
	counseling in the last 12 months and know their results				
12.	Percentage of Key Populations with active syphilis: SWs MSM	BBSS	UA	NA	NA
13.	Percentage of Key Populations who have received an HIV test in the past 12 months and know their results: FSWs MSM	BBSS	UNGASS	2009	 83.9 72.3
14.	Number of new persons within key populations who were reached with HIV prevention programmes: FSW MSM	Monthly NGO Records	National	2012	 909 722
15.	Percentage of sex workers reporting the use of a condom with their most recent client	BBSS	UNGASS	2009	94.2
16.	Percentage of men reporting the use of a condom the last time they had anal	BBSS	UNGASS	2009	

M&E Framework for HIVision2020					
	Indicator	**Data Source**	**Indicator Origin**	**Baseline**	
				Year	**Value**
	sex with a male partner: Regular Partner Non-regular Partner Commercial Partner				 79.5 75.0 84.0
17.	Percentage of HIV-positive pregnant women who received anti-retrovirals to reduce the risk of mother-to-child transmission	UNAIDS Estimate; PMTCT Programme Records	UNGASS	2011	73.4
18.	Percentage of pregnant women attending antenatal care (ANC) whose male partner was tested for HIV	PMTCT Programme Records	UA	2011	8.9
19.	Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth	NPHRL Programme Records	UNGASS	2011	34.1
20.	Percentage of infants born to HIV infected women receiving antiretroviral (ARV) prophylaxis to reduce the risk of early mother to child transmission	PMTCT Programme Records	UA	2011	97.5
21.	Percentage of infants born to HIV infected women started on co-trimoxazole (CTX) prophylaxis within two months of birth	PMTCT Programme Records	UA	2011	58.2
22.	Number and Percentage of patients with STI at STI sentinel sites who are appropriately diagnosed, treated and counseled	STI Programme records	National	2012	731
23.	Number of condoms distributed by	CHANNEL	National	2011	2,761,981

M&E Framework for HIVision2020					
	Indicator	**Data Source**	**Indicator Origin**	**Baseline**	
				Year	**Value**
	the public and private sector in the past 12 months	CHANNEL Database; Private Sector Reports			
24.	Percentage of transfused blood unit in the public and private sector in the last 12 months that had been adequately screened for HIV according to national guidelines	National Blood Bank Programme Records	National	2011	100%
25.	Percentage of passed proficiency testing for infectious markers: HIV VDRL HepB HepC HTLV	NBTS Proficiency testing reports	National	Oct-Dec 2012	 100% 100% 100% 100% 100%
26.	No. of Persons receiving Post exposure Prophylaxis (PEP)	PEP Programme Records	UNAIDS Indicator registry	2012	40
27.	Current school attendance among orphans and non-orphans aged 10-14	-	UNGASS	-	NA
Care, Treatment and Support					

M&E Framework for HIVision2020					
	Indicator	**Data Source**	**Indicator Origin**	**Baseline**	
				Year	**Value**
28.	Percentage of eligible adults and children currently receiving antiretroviral therapy		UNGASS	2011	77.2
29.	Percentage of adults and children enrolled in HIV care and eligible for co-trimoxazole (CTX) prophylaxis (according to national guidelines) currently receiving CTX prophylaxis	HEALTHQUAL Audit	UA	June 2011	78
30.	Number of persons receiving HPC following National Standards	HBC Programme Records	National	2012	1,236
31.	Number of new PLHIV receiving nutritional hampers through the Food Bank programme	Food Bank Referrals	Programme Data	2012	1,087
32.	HIV Prevalence among TB Patients	TB Programme Records		2012	31
33.	Percentage of registered TB patients tested for HIV	TB Programme Records	National	2012	94
34.	Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV	WHO Estimates; Programme Data	UNGASS	2011	67.5
35.	Percentage of adults and children newly enrolled in HIV care starting isoniazed preventive therapy	Pre-ART Programme Records	UA	NA	NA
36.	Percentage of adults and children enrolled in HIV care who had TB status assessed and recorded during their last visit	HEALTHQUAL	UA	June 2011	94
37.	Proportion of all deaths attributed to TB	MOH Statistical Report	MDG	2010 (preliminary)	1.6

M&E Framework for HIVision2020					
	Indicator	**Data Source**	**Indicator Origin**	**Baseline**	
				Year	**Value**
		Integration			
38.	Percentage of women accessing antenatal care (ANC) services who were tested for syphilis at first ANC visit	MCH Programme Records	UA	2010	87.9 (includes testing beyond first visit)
39.	Percentage of antenatal care attendees positive for syphilis who received treatment	MCH Programme Records	UA	NA	NA
40.	Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15	DHS	UNGASS	2009	13.6
		Strategic Information			
41.	Number of persons trained in Strategic Information (M&E, surveillance, research, statistical analysis)	Training Registration sheets	National	2011	66

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96	Ms	Olenda Griffith	Representative	Hope Foundation
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102	Ms	Patrice LaFleur.	Country Representative	UNFPA, Guyana
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106	Ms	Preeta Saywack	Surveillance Officer	MoH
107	Dr	Ravi Homenauth	Health Qual Officer	NAPS/MoH
108	Dr	Ravindra Swammy	STI coordinator (former)	NAPS/MoH
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115	Ms	Rose Mortley	Assistant Secretary	Guyana Trade Union Congress
116	Dr	Ruben Del Pardo	Country Director(Former)	UNAIDS, Guyana.
117	Ms	Rushell Perry	Social Services Officer	Red Cross, Guyana.
118	Dr	Ruth Ramos	Director	NTCT
119	Dr	San San Min	Lead Resident Advisor	SCMS.
120	Ms	Sarah Insanally.	Director	Planning Unit, MoH
121	Ms	Schemel Patrick	MSMO	GBCHA
122	Mr	Sean Wilson	Project Coordinator	ILO, Guyana
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124	Ms	Shamane Granger	Reporter	Kaieteur News
125	Dr	Shamdeo Persaud	Chief Medical Officer	Ministry of Health.
126	Ms	Shanta Samuels	Reporter	NCN
127	Dr	Shanti Singh	Programme Manager	NAPS/MoH
128	Dr	Shauna Scotland	STI coordinator (former)	NAPS/MoH
129	Ms	Shaundell Shipley	MARPS Coordinator	GHARP II
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131	Mr	Somdatt Ramessar	Food Bank Manager	NAPS/MoH
132	Dr	Sonia Alexander	Independent Consultant	
133	Ms	Sophia Brewer	PEPFAR Coordinator	US Embassy, Guyana
134	Ms	Sophie Collier	Data Analyst	NAPS/MoH
135	Mr	Stan Gouveia	Project Director	Friends Across Differences
136	Mr	Suvendra Bipiah	Quality Assurance Officer	National Blood Transfusion Services
137	Ms	Suzanne French	Ex Director	GBCHA
138	Ms	Suzette Harald	Monitoring & Evaluation Officer	NAPS/MoH
139	Ms	Teresa Gaime	Deputy Director	Child Protection Agency
140	Mr	Trevor McIntosh	VCT Regional Supervisor and Quality Assurance Manager(forem),	NAPS/MoH
141	Mr	Trevor Thomas	Permanent Secretary	Ministry of Human services and Social Security
142	Ms	V. Wilson	Member	PYARG
143	Ms	Vaajiyah Azeeze	Industrial Nurse	Guyana Geology & Mines
144	Ms	Vashti Hinds	Care and Support Officer.	GHARP II
145	Dr	Vishwa Mahadeo.	Chief Executive Office	Berbice Regional Health Authority
146	Mr	Whitney Persaud	Reporter	GNNL
147	Members of the FCSW Community-19 persons.			
148	Members of the MSM Community- 26 persons			
149	Members of the PLHIV Community – 24 persons			

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