Guyana

Operational Plan Report

FY 2013

Note: Italicized sections of narrative text indicate that the content was not submitted in the Lite COP year, but was derived from the previous Full COP year. This includes data in Technical Area Narratives, and Mechanism Overview and Budget Code narratives from continued mechanisms.

Operating Unit Overview

OU Executive Summary

COUNTRY CONTEXT

EPIDEMIOLOGY

Since the first reported case of AIDS in Guyana in 1987, the HIV epidemic has been a significant threat to health and development in Guyana, with an estimated 6,200 adults and children living with HIV at the end of 2011. Guyana's HIV epidemic is categorized as a low level generalized epidemic. Statistics at the end of 2011 show HIV prevalence among the general population steadily decreasing, from 2.4% in 2004 to 1.1% in 2011. This equates to an estimated 5,900 adults living with HIV, a considerable burden for a population of less than one million. Similarly, prevalence among pregnant women decreased from 2.3% in 2004 to 1.0% at the end of 2011. Although general population prevalence may be low, surveillance data for key populations from both the 2005 and 2009 Biological and Behavioral (BBSS) studies reveals a concentrated epidemic among high-risk populations, including men who have sex with men (MSM) (21.2%, 2005; 19.4%, 2009) and female commercial sex workers (FCSWs) (26.6%, 2005; 16.6%, 2009). A 2011 surveillance study among members of the military revealed a low HIV prevalence (0.2%), but the prevalence of other sexually transmitted infections (STIs) was significant (21.4%).

Similar to the trend in HIV prevalence, the percentage of deaths attributable to HIV/AIDS and the estimated number of new HIV infections have also declined. In 2009, 4.2% of all deaths in Guyana were attributable to HIV/AIDS, a reduction from 9.5% in 2002. New HIV infections were fewer than 1,000 in 2002, and in 2011 estimates projected the number of new infections to be fewer than 200.

The rapid scale-up of the HIV response saw increases in the numbers tested, reached and treated. In 2011, of the estimated 4,444 adults and children in need of anti-retroviral treatment (ART), 77.2% were receiving it. Among women who gave birth in the two years preceding the 2009 Demographic and Health Survey (DHS), almost eight in ten were offered and accepted an HIV test during antenatal care and 75% received their test results.

Despite advances and expansion of HIV services, more than 25 years after the first reported case of AIDS in Guyana, HIV/AIDS remains the leading cause of death among 25-44 year-olds, as of 2009. While HIV services have expanded across the country, many gaps still exist. The 2009 DHS reported almost universal knowledge of AIDS in Guyana and that almost nine in ten women and men knew where to get an HIV test; however, only 53% of women and 38% of men age 15-49 had ever been tested for HIV.

STATUS OF NATIONAL RESPONSE

Guyana has made significant strides in addressing and monitoring its HIV epidemic. Sustaining this momentum as external donor resources contract will be critical in ensuring an adequate response to the public health and socio-economic challenges that HIV presents. The Government of Guyana (GOG) is currently finalizing its new national HIV strategy, HIVision2020, shaped by a series of consultative reviews with government, civil society, private sector, and target populations, such as MSM, FCSWs, and people living with HIV/AIDS (PLHIVs). HIVision2020 delineates five priority areas for guiding the HIV/AIDS program in Guyana in the coming years: Coordination; Prevention, Care, Treatment and Support; Integration of HIV into Other Services; and Strategic Information. The aims of HIVision2020 are to “fully fund Guyana’s HIV response through country ownership and shared responsibility; to put knowledge, experience, lessons learned and innovation forward to make effective program decisions and life-saving choices; and to invest resources wisely to obtain optimal results for all Guyanese.”

Guyana’s National AIDS Program remains heavily dependent on PEPFAR and Global Fund support, which threatens the long-term sustainability of the response. PEPFAR and the Global Fund represent the two largest sources of support, accounting for greater than 80% of the total investment in HIV/AIDS, with UN agencies and PANCAP providing limited funding and technical assistance (TA). Partnerships with the private sector help support counseling and testing, mass media activities, and the National Food Bank program, which is managed by the National AIDS Program Secretariat (NAPS). New opportunities may emerge as a result of the influx of foreign investment in the exploration and development of natural resource reserves in Guyana, but this potential sector has yet to be fully understood and incorporated into the overall strategy, and in some instances, development of natural resources contributes to transient conditions that facilitate spread of the disease. Another key element of the transition to a more financially sustainable country program is the role of civil society in the overall health system. Capitalizing on the critical role of non-governmental organizations (NGOs) in supporting the national response will require addressing their longer-term sustainability, defining roles and responsibilities as complementary to facility-based providers, and ensuring their place in stakeholder dialogues.

While HIVision2020 recognizes that external funding for HIV is likely to decline significantly over the next five years, the overall strategic response in terms of prioritization and streamlining of service areas to absorb these changes has thus far been inadequate. The U.S. Government team does recognize, however, a more coordinated effort on the part of the government over the past year to analyze and program for a greater host nation financial contribution and remains committed to working in partnership to ensure a successful transition.

HOW THE USG FITS INTO THE NATIONAL RESPONSE

PEPFAR's support continues to be a significant contributor to the progress Guyana has made in addressing its HIV/AIDS epidemic. PEPFAR together with the NAPS and other stakeholders has contributed to increased voluntary counseling and testing (VCT) and prevention of mother to child transmission (PMTCT) service coverage; and improved uptake and access to life saving drugs, laboratory services and enrollment in care and treatment programs. PEPFAR and NAPS have also worked together to build and implement tools and systems to help monitor the progression of the HIV epidemic.

The PEPFAR program will continue to support the areas of prevention, care and support, treatment, and health systems strengthening and ensure that activities are aligned and complimentary to HIVision2020. As PEPFAR transitions from direct support to technical assistance activities, shared responsibility and science-guided investments will be critical components in PEPFAR's portfolio for ensuring sustainability of the Guyana HIV response.

Improving HIV service access and uptake among key populations will remain a priority, and PEPFAR will continue to support and promote targeted, evidence-based interventions for populations at greater risk, taking services and the response to where the epidemic lies. PEPFAR will increase its focus on eliminating stigma and discrimination against PLHIV and key populations and will continue to support civil society as a partner in the HIV response. As civil society in Guyana is a significant provider of services to key populations, continued PEPFAR support to NGOs is critical to ensuring adequate and quality services are delivered to MSM and commercial sex workers (CSWs). PEPFAR will also play a stronger role in donor coordination and in ensuring wider stakeholder involvement in the HIV response.

OTHER CONTEXTUAL FACTORS

Guyana's new national poverty reduction strategy for 2011-2015 lists HIV/AIDS sixth in terms of national development priorities, but high levels of poverty increase vulnerability to disease and create barriers to reaching and caring for those affected by HIV/AIDS. An estimated 36% of the population lives in moderate poverty, and 18% lives in extreme poverty. Without strong policies and political leadership to prioritize health, including HIV/AIDS, the gains made through investments by the United States and other stakeholders could be lost to competing priorities.

Though not unique among Caribbean countries, Guyana is the only country in South America that criminalizes homosexual behavior. This increases the susceptibility of MSM to stigma and discrimination, which cuts across all program areas, impeding prevention, treatment, and care efforts.

Guyana's geography and undeveloped transportation infrastructure diminish access to health services for populations, including remote interior communities and mining and logging camps. Additionally, high attrition rates of trained healthcare workers within the health sector continue to negatively impact efforts to expand capacity for service delivery and strengthen systems. Guyana has a very high rate of emigration of tertiary-educated people which must be addressed if the investments made to the health system are to have long-term impact.

The 2011 Guyana national elections saw the reelection of the ruling political party. However, for the first time, the government does not have a majority in Parliament, with the combined opposition holding a one-seat advantage. This presents new opportunities and challenges for governance. For example, the split government has led to frequent deadlocks and disagreement over budget priorities. The elections also resulted in ministerial changes, with the appointment of new ministers of government and permanent secretaries in several of the ministries, including in the Ministry of Health (MOH).

PEPFAR FOCUS in 2013

The PEPFAR Interagency Team completed two exercises in 2012, which along with the recommendations of the FY 2013 funding letter, influenced the program's focus for 2013. As part of the annual portfolio review process, the team piloted the Efficiencies Project model, which included U.S. Government staff, implementing partners, and Government of Guyana in portfolio presentations and discussions. The team also used the review to engage partners in earnest dialogue on transition of the PEPFAR country program in what was one of the first of numerous meetings on transition in 2013.

The team continues to build on priorities outlined in the FY 2013 funding letter, namely continuing to strengthen the focus on key populations, especially MSM and CSWs, and revaluating the PEPFAR response to human resources for health (HRH) challenges in the country. Advancing the transition from dialogue to responsible action will require taking on these challenging issues, including human resource integration and the sustainability of NGOs as part of the national response.

HRH challenges go beyond the realm of HIV--and even health--but addressing this is essential for sustainability of the HIV response. HRH was a common theme during transition discussions, and an essential priority area for the program will be to address these in a more systematic capacity across program areas. For PEPFAR-funded positions, the updated transition plan will detail whether and how these have been absorbed within the national program.

While migration of health staff continues to be an issue, additional challenges include a lack of performance-based and incentive-driven strategies, leading to frequent staff turnover. Transition review

meetings have already identified the need to institute an HRH Working group, and the U.S. Government will support this action item in 2013. Addressing these challenges within the health system requires a longer-term approach and must involve other relevant ministries, including the Public Service Ministry and Ministry of Finance (MOF). The U.S. team will refocus its HRH portfolio in 2014 based on national consultations with the government and other donors to establish a more appropriate technical assistance approach for HRH.

NGOs in Guyana play a significant role in the provision of HIV services, especially among most at risk populations (MARPS), but remain heavily if not solely dependent on PEPFAR and, to a lesser degree, Global Fund financial support. To ensure HIV community services continue to reach MARPs, serious consultation and guidance will be needed to explore funding diversity and opportunities for NGOs to ensure they remain financially stable. While PEPFAR recognizes that transition is essential for certain aspects of the portfolio in the short- to medium-term, the funding trajectory for civil society is less certain and requires a longer-term strategy to address a multitude of factors including and beyond financing.

Another critical component of the national response is a well functioning monitoring and evaluation (M&E) system. PEPFAR will continue to provide support to ensure that the required systems and capacities are in place at the country level for continuous monitoring of the HIV epidemic and program. Support will also be required to align the PEPFAR M&E framework with the transition plan, shifting from direct service indicators to appropriate technical assistance indicators that better reflect the nature of the support. Benchmarks and strategies to monitor and evaluate the progress of the transition are also required.

PROGRESS AND FUTURE

The PEPFAR Guyana team in 2012 developed a detailed five-year plan to guide its transition. COP 2013 supports the continuous implementation and refinement of the transition strategy, which details how the program will transfer successful and critical PEPFAR activities to the government, the private sector, and other donors.

The PEPFAR Team took several actions to support increased country ownership during 2012. Several of these involved building in country recommendations to PEPFAR review and planning processes. During the 2012 PEPFAR Portfolio Review, the Government of Guyana, civil society, and public sector partners participated in presentations and discussions on programming and transition of areas of the portfolio away from PEPFAR support. A joint U.S.-Guyana Transition Committee was formed to lead the process of shared transition planning. Focal meetings with governmental and non-governmental partners on procurement and logistics management and PMTCT further supported transition planning.

The Country Team shared the detailed five-year PEPFAR Transition Plan with the government in 2012 and coordinated with the MOF to support line ministries in their responses to this document, detailing implications for the national budget for 2013 and 2014. U.S. Government staff took part in budget hearings in 2012 that were called by MOF to discuss the PEPFAR transition and develop a coordinated approach to gathering information on the financial implications of the plan. As MOF is more fully cognizant of donor resource allocation for the country, it is better able to plan collectively for its health programs, including HIV. PEPFAR is supporting improved planning by including MOF in transition meetings and actively sharing information to assist MOH and MOF in making timely budget decisions.

The United States will continue the process of finalizing the timeline for transferring activities to the government or other donors, with specific benchmarks; and supporting the coordination/review body to review policies and activities for sustaining essential HIV/AIDS programming as PEPFAR resources become more concentrated on technical assistance activities.

The PEPFAR Team also coordinated a series of review meetings on the transition plan, one for each of the four program areas, with implementing partners and other key stakeholders, to identify transition challenges, ensure full ownership of the transition plan, and ensure understanding of details in the plan, including timeframes and financial responsibilities. The team is using this information to update the transition plan and present this to partners in March 2013. Review meetings were also used to construct an action list, which will support the development of a transition agenda for 2013. Action items include working with MOH to create working groups on procurement and logistics and HRH.

Another important aspect of supporting increased country ownership in 2012 was through increased U.S. staff engagement with host country counterparts through one-on-one dialogue and participation on technical working groups. U.S. staff continued and increased their participation on national technical working groups (TWGs), for example the Monitoring and Evaluation Reference Group (MERG). As the team addresses challenging transition and sustainability issues, it will identify and work closely with issue champions within the government and civil society who can help lead this dialogue. The team will pursue opportunities to support the improved functioning of national technical working groups as a way to build and promote local technical leadership for the national response.

In 2013 the PEPFAR Team will continue to engage the host country on these fronts and identify additional opportunities to support the dual goals of transition and country ownership. The team has recognized the importance of involving the MOF as a key partner in transition and sustainability discussions and negotiations and will continue to pursue this as a strategic action. The 2012 portfolio review model will be repeated in 2013 with substantial host country participation.

The trajectory for FY 2014 and beyond will include continued progress in transitioning key support to the government as detailed in the transition plan. As mentioned above, challenges remain in ensuring that the transition progresses as planned. The topic of transition itself creates numerous challenges, as it affects the people dedicated to the HIV response, whether U.S. staff, PEPFAR-supported NGOs, or government partners. Not all activities will continue to be funded by PEPFAR, and this uncertainty brings with it the possibility that staff will begin to exit, destabilizing already fragile programs that are transitioning from PEPFAR to host country financial support. A key action for 2014 and beyond will be to continue communicating with country partners regularly on transition progress and ensuring their active participation in planning for transition.

While the transition plan is the guiding document, it does not hold all the answers to the multitude of challenges that have been already identified and those that are yet to be uncovered. The team must continue to document these challenges and communicate at the country level and to OGAC and to seek out assistance in building the team's capacity to both lead and function within a changing program. The team sees this support as critical to the overall transition of the Guyana PEPFAR program.

PROGRAM OVERVIEW

TREATMENT

The MOH, with PEPFAR support, has successfully scaled up HIV treatment services across the country, resulting in improved access to treatment and a steadily declining AIDS mortality rate. An estimated 77% of PLHIV who are in need of treatment are currently receiving it. While there have been marked successes, challenges to the treatment program exist, including late enrollment in C&S, gender disparities in 12-month survival rates, and high TB-HIV co-infection rates.

PEPFAR-supported HIV treatment includes direct clinical services provided at three centrally located facilities in Region 4, funding of a medical mobile van for provision of supportive supervision in remote regions, training of healthcare workers in treatment and management, and procurement of laboratory reagents and commodities, first and second line pediatric antiretrovirals (ARVs) and second line adult ARVs.

PEPFAR will continue its collaboration with donors, particularly Global Fund, and MOH to implement a phase transition plan that increases country ownership of treatment services. Priorities for transition for COP 13 are PEPFAR support for the medical mobile van and procurement of lab reagents and commodities. PEPFAR supports a private clinic facility that serves approximately 35% of all PLHIV enrolled in care and treatment and provides an important alternative for clients who choose not to access

services at public facilities. For COP 13, there will be increased emphasis on capacity building and task-shifting to reduce overall cost at this site, improving the likelihood of country ownership and financing.

Significant sustainability issues will need to be addressed to enable a successful transition of HIV treatment services provided by PEPFAR-supported private facilities. PEPFAR funding is currently the major contributor to these operations and transition will have to be implemented over an extended period of time, allowing careful monitoring to ensure that access and the quality of treatment services are not compromised in the process.

CARE AND SUPPORT

Care services are provided for people living with HIV/AIDS (PLHA) and orphans and vulnerable children (OVC), mainly through 16 public and private health sites and a network of community- and faith-based organizations. PEPFAR's contribution to the national strategy supports five categories of essential care and support (C&S) services to all people infected or affected by HIV/AIDS as outline in the PEPFAR guidance: clinical care, psychological care, spiritual care, social services, and prevention for PLHA.

PEPFAR-supported activities succeeded in reaching a significant proportion of the estimated 6,200 adults and children living with HIV, providing 6,082 eligible adults and children affected and infected with HIV with care services in FY 12. Over 80 family members of PLHA were equipped with the knowledge and skills to care for sick family members, and approximately 127 persons benefitted from entrepreneurial skills training.

In October 2012, members of the PEPFAR Adult C&S Technical Workgroup participated in the C&S portfolio review. Major findings included: inadequate coordination of programs at the community level; inconsistent (bi-directional) referrals between facility and community based HIV care, support and treatment, including supportive supervision and record keeping of the referral process; insufficient attention to key social issues; identifying the "ideal package and cost" of care and support services; limited involvement of PLHIV support networks, with weak male involvement; and, challenges with uptake of pediatric services.

In FY 2013, PEPFAR will seek to address the major findings of the assessment. With support from the Health Policy Project, PEPFAR Guyana will conduct an inventory of C&S services provided by each of the MOH facilities and non-governmental organizations (NGOs) and the numbers of people each serves, and assess the cost of services by partner. This will allow understanding and transparency of variations in service provision, per patient cost of services, and will inform the development of a minimum package of

C&S services. Currently, the national care and support program relies on NGOs to meet clients' support needs, particularly for MARPs, and has not yet created the structures to provide support for NGOs working in care and support.

The U.S. Government is promoting a national dialogue on the role and sustainability of NGOs in the national HIV/AIDS response with the Government of Guyana, NGOs, donors, international organizations, and other stakeholders and will support the development of a system that formally recognizes the role of NGOs and other community-based organizations with supportive policy and operational guidelines, as a complement to facility-based services. PEPFAR will also support the MOH in establishing a formalized bi-directional linkage system with a national tracking system that allows for standardized monitoring of referrals and tracking of clients.

The U.S. Government will develop a systematic approach to providing community-level psychosocial and mental health support services to effectively address issues including stigma, depression and substance abuse. Efforts will continue to ensure that both males and females have equal access to services.

To improve the uptake of pediatric services, PEPFAR will support the integration of pediatric care of HIV-exposed infants (HEIs) into the maternal and child health services, and the establishment of a monitoring and evaluation system for case tracking of HIV-positive pregnant women and their HEIs to improve the uptake of cotrimoxazole (CTX) in exposed infants and early infant diagnosis (EID).

The PEPFAR Team will also continue to provide support for the integration of collaborative TB/HIV activities, such as provider-initiated counseling (PITC) services for all TB patients, their partners, and children of TB/HIV co-infected patients, linking TB/HIV co-infected patients to HIV care services for early initiation of ART and improved TB outcomes and expanding the Directly Observed Therapy, Short-Course (DOTS) initiative (DOT-HAART). The University of Maryland/Institute of Human virology will also continue to train health care workers in managing TB/HIV co-infection.

In the scale-up of the Three Ones of TB/HIV, PEPFAR will provide support in TB infection control with the development and implementation of a national TB infection control plan. Additionally, support will be provided to implement infection control measures to prevent TB transmission in several out-patient settings in each administrative region of the country.

Improving retention in care, adherence to treatment regimens, uptake and access to services among key populations, and individual PLHIV goal setting to prevent onward transmission of the virus will remain priorities.

PREVENTION

Following the Guyana Prevention Assessment in February 2010, the U.S. Team worked to align activities and implement technical team's recommendations, particularly in the prioritization of activities for MARPs. In addition, planning and implementation of strategies to transition mature prevention activities to the government, Global Fund and other stakeholders in accordance with the PEPFAR Guyana Transition Plan: 2013-2017 will intensify during this year.

PEPFAR transitioned the Injection Safety (IS) project to the MOH at the end of October 2012. The MOH now has a cadre of IS trainers, segregated disposal and incineration of hazardous waste, IS certification of facilities, and IS integrated into pre-service training. In addition, the MOH is procuring all IS protective gear and commodities.

The condom marketing program was successfully transitioned to the private sector. Six sub-distributors in Regions 1, 2, 5, 6, 7 and 10, and, one main distributor in Region 4 continue to supply condoms to non-traditional retailers. Consequently, those most at risk for infection have greater access to condoms when and where they need them.

The Secretariat of the Guyana Business Coalition on HIV/AIDS (GBCHA), previously funded by PEPFAR to implement HIV workplace prevention activities, is continuing with support by the private sector after PEPFAR funding ended in 2012.

PEPFAR Guyana's prevention approach during COP 2013 will focus on evidence-based interventions and combination prevention strategies. The PEPFAR team will continue to strengthen the focus on key populations, especially MSM and CSWs, which remain the most vulnerable, marginalized groups in need of services. The U.S. team will better target and increase prevention programs to reduce new infections and further decrease the cost of care of persons living with HIV/AIDS, with the aim of transitioning activities to country leadership, implementation and financing.

In COP 2013, PEPFAR will continue to support HIV prevention activities within the Guyana Defence Force military members and their families in the areas of sexual prevention, VCT--with increased emphasis on STIs--gender-based violence, stigma and discrimination. Peace Corps will continue to focus on capacity building in advocacy leadership among NGOs and individuals from within vulnerable populations. In addition, Peace Corps will develop and implement a core set of cost-effective, context appropriate and evidence-based strategies for HIV prevention, focusing on the behavioral and structural strategies to address knowledge, attitudes, risk perception, and sexual behavior of MARPs and other vulnerable populations (OVP). This will be achieved through: adapting evidence-based/high impact

prevention interventions; integrating behavior change strategies into every volunteer activity while promoting HIV/AIDS awareness and evidence-based behavior change interventions with OVP; collaboration with other USG agencies on targeted MARPS interventions; and, life skills development with OVP.

PEPFAR will also continue to provide a minimum package of services to MSM, CSWs and their clients through a network of community-based organizations. These services include: peer education and outreach, risk reduction counseling, condom and lubricant promotion and distribution, VCT, and referrals for STI screening and treatment. In addition to these services, the comprehensive package of services for both MSM and CSW will include referrals for mental health, substance abuse treatment and social services, and Positive Health Dignity and Prevention (PHDP) interventions. In addition, activities targeting FCSWs will include linkages to economic strengthening programs, parenting skills training, referral for family planning services, and referral for PMTCT services. The lack of an unsupportive legislation for MSM continues to be a major challenge, since male homosexual acts are illegal. Efforts will continue to focus on enabling populations at elevated risk of infection to access and use HIV prevention-related services without discrimination. Gender-based violence (GBV) will continue to be a major focus of all prevention activities.

PEPFAR will also continue to support the PMTCT program, but will focus on transitioning aspects of the program to the government and other partners. Support for counseling and testing of pregnant women for HIV will be concentrated in Region 4, which has the highest disease prevalence nationally. Case tracking of HIV-infected pregnant women and their HEIs will continue to receive support in order to ensure an increased uptake of prophylactic ART for HIV-infected pregnant women to reduce mother to child transmission, improved EID, and uptake of CTX prophylaxis for HEIs. PEPFAR will further support the integration of reproductive health into care and treatment programs, which will ensure that HIV infected women of childbearing age have access to family planning services.

In addition PEPFAR funds will be used to support the transition of the National Blood Transfusion Service (NBTS) in areas that are critical to the safety, quality, and availability of blood products. Primary objectives for COP 2013 include blood collection and will encompass revision of policies and procedures to have quality systems in place while at the same time implementing best practices and evidence based strategies. Additionally training and mentoring of key staff in quality management and further training for collaborators and volunteers will be done during the year. Fifty percent of blood donor staff will be transitioned to the MOH, and the financing of procurement of reagents and commodities for testing for transfusion transmissible infections will also be transitioned to the government or other donors.

GOVERNANCE & SYSTEMS

As PEPFAR Guyana shifts from direct service delivery to a technical assistance model, shared responsibility and investing in public health systems becomes a critical component in Guyana's roadmap to an AIDS Free Generation. PEPFAR will continue to actively engage the government and other stakeholders to ensure that the transition of direct services and country ownership remains a priority and that the necessary action is taken to achieve transition benchmarks. The PEPFAR Team will also identify assistance required to support transition, develop a monitoring and evaluation framework for transition, and determine the nature of PEPFAR support as the transition advances. PEPFAR will also continue its role in supporting donor coordination through the recently revamped Health Donor Coordination Group and continue actively engaging all stakeholders; donors, civil society, faith based, PLHIV, key populations, and the private sector in the HIV response. In addition, PEPFAR will continue to participate in the drafting, review, and implementation of HIVision2020.

Retention of skilled workers is one of the greatest challenges in Guyana, and addressing it will be critical for transition, integration, and sustainability of HIV within the broader health response. PEPFAR recognizes the magnitude of this challenge and will work together with the government and other donors to identify comprehensive approaches to improve retention and capacity building.

PEPFAR will also strongly focus on building the capacity of local institutions to deliver various training needs and has already supported the revision of the University of Guyana's Infectious Diseases Curriculum. To further advance local capacity in leadership and management of the HIV response, PEPFAR is establishing a Master of Public Health (MPH) program at the University of Guyana, and will also support the development of a detailed sustainability plan for transitioning the program to the University Health Sciences Faculty, as well as a career structure for retaining MPH graduates for the public health leadership roles in Guyana.

U.S. support will also continue to fund capacity building in continuing medical education, classroom and on the job training, etc., and support the MOH in identifying its service training needs for health care providers and in developing a national training plan for health professionals.

Over the years PEPFAR has also supported laboratory strengthening through capacity building, quality systems management, procurement of reagents, and equipment procurement and maintenance. Such support ensured that all clients who are infected and affected with HIV/AIDS received quality laboratory services. PEPFAR will continue to support the implementation of the National Laboratory Strategic Plan, focusing on sustaining quality systems, implementation of the laboratory information system, and building on molecular techniques, to include chlamydia, gonorrhea, TB, and bio-security, equipment and facilities maintenance.

PEPFAR will also continue to support the area of continuous quality improvement at HIV care and treatment sites, and maternal and child health sites through the Health Qual Program.

Building and improving the existing supply chain management system in Guyana is a critical component of the HIV response and one of the most challenging, due to critical staff shortages. PEPFAR will continue to support this initiative through the development of a second edition of the Standard Treatment Guidelines (STG) to promote rational drug use which will cover 135 diseases and conditions. PEPFAR will also support the updating of the National Formulary and the integration of the STG into the curriculum for health care providers.

In addition PEPFAR will continue to support the MOH's Materials Management Unit (MMU) to strengthen in-house capacity and systems, in order to improve the management, planning, procurement and distribution of all pharmaceuticals in Guyana; and will conduct a cost/benefit analysis of transportation functions and develop a transport and distribution plan for the MMU. With the completion of the new warehouse, PEPFAR will support the expansion of the testing capacity of the mini-lab to maintain quality and ensure that drugs are screened regularly. Quantification and forecasting will also continue to provided, while building the capacity of the MOH to undertake program level and national level quantification activities for all ARVs, HIV-related commodities, TB, Malaria and all essential drugs and supplies for the MOH. PEPFAR will continue to work toward an integrated procurement planning process to include both donors and the MOH and will continue to support the supply chain management system while building the MOH's capacity to take over these essential responsibilities. A strategic planning workshop to discuss the continued funding for ARVs is scheduled for March 2013, with Guyana, the United States, Global Fund, and other stakeholders.

To achieve successful transition and maintain routine monitoring and evaluation of the HIV response, investing in strategic information must be a priority. PEPFAR over the years has supported critical pieces of research and evaluations that have informed the status of the epidemic and shaped many of the interventions. Many of the activities proposed in COP 2012 will be implemented in COP 2013. PEPFAR will support the third Antenatal Care Survey to determine the current prevalence of HIV among the general population and will continue to invest in strengthening routine surveillance systems and capacity building for surveillance, through training and mentorship etc. PEPFAR will also provide consultation on the national surveillance strategic plan and the related implementation plan, including assessing the capacity building/training needs to support sustainable and MOH-led implementation.

Recognizing the effect of HIV on key populations and the need to increase access and uptake of services by these populations, PEPFAR will support through technical assistance implementation of a third round

of the BBSS among key populations (CSWs, MSM, miners and loggers), establishing the current prevalence among these groups and assessing their risks, access to services, and size estimations.

Transitioning of strategic information responsibilities to the MOH requires not only strong data collection systems, but strong organizational systems in place to monitor, regulate and evaluate information process. PEPFAR will support the MOH in a series of organizational strengthening activities to determine the Ministry's vision for strategic information, and its role and responsibilities, as well as identify the physical and human resources needed to support such a role and its capacity building needs. Data quality and data use continues to be an area of concern, and PEPFAR will support capacity building for data quality assessments and establishing platforms for data sharing. As PEPFAR advances its transition from direct services, the PEPFAR M&E Framework will also change and the team will develop strategies and indicators to best monitor their non-direct services and transition.

GHI, PROGRAM INTEGRATION, CENTRAL INITIATIVES, AND OTHER CONSIDERATIONS

Over the past year, the interagency team has made a concentrated effort to improve coordination and communication with Global Fund. There are regular monthly calls between the PEPFAR Coordinator and Portfolio Fund Manager in Geneva; the CDC Director continues to serve on the CCM; and with Front Office support, the interagency secured a U.S./PEPFAR seat on the CCM. The PEPFAR Coordinator and USAID Health Officer will serve as member and alternate beginning in March 2013.

Formal coordination with stakeholders, including other donors, was identified last year as a barrier to PEPFARS's support for the national response. The team has initiated a series of actions to improve joint donor coordination that will be continued in 2013. The team re-introduced the donor coordination group in 2012, which has led to increased information sharing and discussions on how to jointly engage with the government on underlying structural issues, e.g., HRH and release/approval process of/for donor-funded studies. The purpose of this group is to provide a platform for supporting efficiency of resources and avoidance of duplication, share program updates, exchange views on opportunities and obstacles to effective use of donor resources in Guyana, and identify joint capacity building opportunities. PEPFAR also engages in regular meetings with UNAIDS and is planning joint dissemination meetings on the PEPFAR Blueprint and the UNAIDS Investment Framework. The Country Team has identified opportunities to partner with the government to build its capacity for financial and technical ownership of its response and prioritization of its interventions and programs. These include a series of joint review meetings of the PEPFAR transition plan, which has resulted in identification of focused working groups on areas including HR and procurement. While these groups obviously will address key PEPFAR transition issues, they are meant to create a broader foundation for addressing impediments across the national HIV program.

The PEPFAR Gender Challenge Fund project in Guyana addresses two of the five Gender Strategic Areas: Prevention and Response to Gender-based Violence; and Engaging Men and Boys to Address Norms and Behaviors. Through this project, eight community-based organizations commenced activities in October 2012. The NGOs address prevention and response to GBV through training and group and mass media awareness programs. Specific activities include: radio and television interactive programs; a radio serial drama; in and out of school, workplace and community awareness sessions; focus group discussions; and essay writing, debating and poetry competitions. These programs aim to enhance the capacity of women and girls to prevent and respond to GBV. The target group includes women and girls who are in and out of school, parents, women in workplaces, and general community members and leaders. GBV prevention and response activities typically focus on: the impact of traditional norms and values on violence against women and girls; strengthening community-based social and educational programs to prevent and reduce GBV; raising awareness on GBV legislation, and available legal recourses in addressing GBV; discussions on the correlation between GBV and HIV; and raising awareness and promoting improved access to health and law enforcement GBV services.

In addition to the focus on women and girls, two of the eight NGOs are implementing GBV activities to modify traditional definitions of values of power, control and roles based on gender specifically targeting men and boys. Shared domestic responsibilities are being encouraged by training men and boys to prepare meals and encouraging greater involvement in child rearing and other domestic chores. One NGO is maximizing the involvement of boys in sports to engage them in discussions on GBV to promote better understanding of gender roles and personal responsibility of men in reducing violence. Men and boys also benefit from conflict resolution training to enhance methods of engaging in healthy relationships and managing complex situations. Drawn from the health, education, religious, private, and civil society sectors, the newly trained facilitators are expected to sustain activities within the varying sectors, beyond the life of the current GBV Project.

Through the GBV project, PEPFAR is also supporting the MOH to provide training on the new sexual and domestic violence protocol for health care providers at Georgetown Public Hospital Corporation and other health care facilities in regions 2, 3, 4, 6 and 10. Support to the MOH will also include public education and media campaigns and awareness sessions addressing norms and behaviors and GBV.

In addition, the Embassy nominated two organizations in response to the S/GWI-PEPFAR request for applications for community-based projects to prevent and respond to GBV issues with a clear link to HIV prevention, treatment, or care. Both were selected for funding and are currently finalizing responses to queries and preparing for implementation in 2013.

The U.S. Mission remains dedicated to supporting a long-term, sustainable, Guyana-led national response to the HIV epidemic. The past year has been one of transition, not only for the portfolio but for the Country Team as well. The interagency team continues to strengthen its ability to implement a comprehensive transition strategy that reflects ongoing changes and ensures that transition occurs responsibly and successfully. In the coming weeks, the team will complete the update of the five-year transition plan and will continue to respond to local and external factors that influence transition. The team will continue to monitor and help document the transition process not only for Guyana but for other countries addressing similar challenges.

Population and HIV Statistics

Population and HIV Statistics				Additional Sources		
	Value	Year	Source	Value	Year	Source
Adults 15+ living with HIV	5,900	2011	AIDS Info, UNAIDS, 2013			
Adults 15-49 HIV Prevalence Rate	01	2011	AIDS Info, UNAIDS, 2013			
Children 0-14 living with HIV	00	2011	AIDS Info, UNAIDS, 2013			
Deaths due to HIV/AIDS	500	2011	AIDS Info, UNAIDS, 2013			
Estimated new HIV infections among adults	200	2011	AIDS Info, UNAIDS, 2013			
Estimated new HIV infections among adults and children	00	2011	AIDS Info, UNAIDS, 2013			
Estimated number of pregnant women in the last 12 months	14,000	2010	UNICEF State of the World's Children 2012. Used "Annual number of births as a proxy for number of pregnant women.			
Estimated number of	150	2011	WHO			

pregnant women living with HIV needing ART for PMTCT						
Number of people living with HIV/AIDS	6,200	2011	AIDS Info, UNAIDS, 2013			
Orphans 0-17 due to HIV/AIDS	3,100	2011	AIDS Info, UNAIDS, 2013			
The estimated number of adults and children with advanced HIV infection (in need of ART)	4,182	2011	WHO			
Women 15+ living with HIV	2,600	2011	AIDS Info, UNAIDS, 2013			

Partnership Framework (PF)/Strategy - Goals and Objectives

(No data provided.)

Engagement with Global Fund, Multilateral Organizations, and Host Government Agencies

How is the USG providing support for Global Fund grant proposal development?

Two members of the PEPFAR Interagency Team are on the HIV proposal writing group. In this role, they work with the interagency team and the Global Fund PR to improve partnership and collaboration with civil society organizations, coordination of donor resources, development of performance indicators and technical guidance in evidence-based strategies and interventions in response to the HIV epidemic.

Are any existing HIV grants approaching the end of their agreement (Phase 1, Phase 2, NSA, CoS, or RCC) in the coming 12 months?

Yes

If yes, please indicate which round and how this may impact USG programming. Please also

describe any actions the USG, with country counterparts, is taking to inform renewal programming or to enable continuation of successful programming financed through this grant(s).

Phase 1 ends March 31, 2013, but the PR/CCM has received a six-month extension. The Phase 2 renewal grant was originally submitted to Global Fund in July 2012 but was not approved. The CCM was invited to resubmit by March 15, 2013. The PEPFAR interagency team has been working with the current PR to identify priority program activities and interventions to transition from PEPFAR support to GF or domestic support over the next five years with special emphasis on prevention for MARPs and ongoing support for non-governmental organizations.

Redacted

To date, have you identified any areas of substantial duplication or disparity between PEPFAR and Global Fund financed programs? Have you been able to achieve other efficiencies by increasing coordination between stakeholders?

Yes

If yes, how have these areas been addressed? If not, what are the barriers that you face?

Redacted

Public-Private Partnership(s)

Created	Partnership	Related Mechanism	Private-Sector Partner(s)	PEPFAR USD Planned Funds	Private-Sector USD Planned Funds	PPP Description
2013 COP	ILO/USDOL/PEPFAR/Guyana Sugar Corporation	14399:DOL	Guyana Sugar Corporation	6,000	6,000	The partnership between the Guyana Sugar Corporation, Guyana Revenue Authority, Republic Bank

						Guyana, Guyana Rice Development Board and the ILO/USDOL/PEPFAR Project has the following objectives: to build the capacity of these partners to sustain their HIV/AIDS workplace programs, to monitor the implementation of the workplace programs and to report on the progress of the workplace programs. Private partners contribute by covering the cost of accommodation, travel and per diem for staff members attending training sessions and by providing venues and equipment for workshops.

						Activities for FY 2013 will include training of trainers. The in cash and in kind contributions for FY 2013 are TBD as the work planning process for 2013 is still in progress.

Surveillance and Survey Activities

Surveillance or Survey	Name	Type of Activity	Target Population	Stage	Expected Due Date
Survey	Antinatal Care Survey	Sentinel Surveillance (e.g. ANC Surveys)	Pregnant Women	Planning	10/01/2013
Survey	Assessment of MARP Programming	PLACE	Female Commercial Sex Workers, Men who have Sex with Men	Other	12/01/2013
Surveillance	Data collection form and electronic system for HIV case surveillance (HIV and advanced HIV)	AIDS/HIV Case Surveillance	General Population	Implementation	08/01/2013
Surveillance	Data collection form and electronic system for tuberculosis case surveillance	TB/HIV Co-Surveillance	General Population	Other	08/01/2012
Survey	Guyana Defence Force HIV Seroprevalence and	Surveillance and Surveys	Uniformed Service	Other	11/01/2011

	Behavioral Epidemiology Risk Survey (SABERS)	in Military Populations	Members		
Survey	Health care workers attitudes towards PLHIV survey	Qualitative Research	Other	Data Review	12/01/2012
Survey	MARPs Size Estimation	Population size estimates	Female Commercial Sex Workers, Men who have Sex with Men	Planning	12/01/2013
Survey	Round III Biological and Behavioral Surveillance Survey among local MARPs	Behavioral Surveillance among MARPS	Female Commercial Sex Workers, Migrant Workers, Men who have Sex with Men	Planning	12/01/2013

Budget Summary Reports

Summary of Planned Funding by Agency and Funding Source

Agency	Funding Source			Total
	GAP	GHP-State	GHP-USAID	
DOD		188,500		**188,500**
DOL		0		**0**
HHS/CDC	865,739	3,453,606		**4,319,345**
HHS/HRSA		75,000		**75,000**
PC		128,120		**128,120**
State		51,217		**51,217**
State/WHA		12,800		**12,800**
USAID		4,691,022		**4,691,022**
Total	**865,739**	**8,600,265**	**0**	**9,466,004**

Summary of Planned Funding by Budget Code and Agency

Budget Code	Agency								Total
	State	State/WHA	DOD	HHS/CDC	HHS/HRSA	PC	USAID	AllOther	
CIRC			1,000				12,233		**13,233**
HBHC			7,000	212,289			598,117		**817,406**
HKID							288,886		**288,886**
HLAB			20,000	260,304					**280,304**
HMBL				157,419			0		**157,419**
HMIN			7,500				12,233		**19,733**
HTXD							459,493		**459,493**
HTXS				576,284			30,582		**606,866**
HVAB			0						**0**
HVCT			3,000	79,706			528,656		**611,362**
HVMS	33,717		50,000	1,318,229		101,085	258,045		**1,761,076**
HVOP		0	10,000	69,919		23,135	757,738	0	**860,792**

HVSI	17,500	12,800	73,000	308,027		3,900	8,000		**423,227**
HVTB			2,000	188,870					**190,870**
IDUP							12,233		**12,233**
MTCT				169,231			24,465		**193,696**
OHSS			15,000	838,589	75,000		1,651,411		**2,580,000**
PDCS				47,146			24,465		**71,611**
PDTX				93,332			24,465		**117,797**
	51,217	**12,800**	**188,500**	**4,319,345**	**75,000**	**128,120**	**4,691,022**	**0**	**9,466,004**

National Level Indicators

National Level Indicators and Targets

Redacted

Policy Tracking Table

Policy Area: Most at Risk Populations (MARP)						
Policy: Reform of unsupportive legislation						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date	End FY12		2011	2013		
Narrative	USG will advocate for a policy on reducing stigma and discrimination, particularly related to most-at-risk populations, to increase access to HIV and other health services. Or, a more viable alternative may be to work to add special consideration for most-at-risk populations in the existing HIV policy/law, including	The lack of an unsupportive legislation for MSM and CSWs remain a major challenge. The criminalization of same-sex activities serves to increase the susceptibility of MSM to stigma and discrimination. Attitudes such as stigma-induced, HIV-related discrimination, social hostility and violence	A non-discriminatory policy statement was created in the form of a plaque and placed at the National Care and Treatment Centre and other treatment sites.	USG will continue to support legislative, regulatory and policy changes to reduce stigma and discrimination, especially focused on enabling populations at elevated risk of infection to access and use HIV prevention-related services without discrimination.		

	provision for reducing stigma and discriminati on. USG will engage all stakeholder s in this effort, including PLHIV and civil society groups.	discourage MSM from seeking testing or treatment and sharing their status with their sexual partners.				
Completion Date	2010	2010	2011			
Narrative	HIV prevalence in Guyana has been declining over the years but prevalence among MSM remains high (19.4%). There are laws which criminalize male to male sexual practices and the	Unsupportiv e Legislation for MSM	UNAIDS, USAID and various CSOs met with the former Minister of Health to advocate for the repeal of the sodomy law, the issue was then raised in Parliament by the then Minister but was met	USG will continue to work with the current Minister of Health and will support PANCAP's efforts to conduct country level dialogue geared towards advancing the human rights agenda, as well as the	This is a major challenge to the overall national prevention program and USG will continue it advocacy for the laws to be repealed.	

	prison sentence for men-who-have-sex-with-men ranges from two years to life. Faced with legal and social sanctions such as stigma and discrimination, MSM exclude themselves from sexual health and welfare services. This situation can have potentially harmful impacts on the trajectory of the HIV epidemic in Guyana.		with strong opposition from the religious community. USG, however, developed a stigma and discrimination policy statement to reduce the barriers to MSM accessing health services with input from MARPs communities and health care workers, which was endorsed by the former Minister of Health in 2011.	adoption of the Model Anti-Discrimination Legislation, in whole or in part by Member States. A Regional Human Rights Summit is scheduled for December 10-11, 2012, aimed at developing a regional strategy for moving forward that will be incorporated into the new Caribbean Regional Strategic Framework.		

Policy Area: Orphans and Other Vulnerable Children
Policy: National OVC Policy

Stages:	Stage 1	Stage 2	Stage 3	Stage 4	Stage 5	Stage 6
Estimated Completion Date	TBD	TBD	2007		TBD	TBD
Narrative	USG will advocate for final adoption of the OVC policy, including working with civil society stakeholders. If adopted soon, the USG will assist relevant ministries in assessing steps needed to begin implementing the policy, followed by providing technical assistance in implementing specific areas of the policy.	No clear mandate or system and processes for addressing issues related to OVC given that the needs are multidisciplinary. There is need to have a policy to guide care and support for health and other sectors to support OVC	A policy framework to address the needs of children was developed around 2007. UNICEF led this activity with support from USAID.	Although the policy was reviewed and several meetings held with the former Ministers of Health and Minister of Human Services and Social Security, the policy was not tabled in Parliament and could not be implemented. In January 2012, USG support to UNICEF ended; hence this issue will no longer be on the USG agenda since there		

				is an apparent lack of political will.		
Completion Date	2006	2007	2008-2010			
Narrative	In 2006, the GOG conducted a rapid assessment to determine levels of vulnerability of children. The assessment was conducted in all regions using group discussions with children and caregivers and interviews with key personnel from various organizations. Findings revealed	National OVC Policy for Guyana	A multi sectoral OVC task force under the guidance and leadership of the National AIDS Program was established. The national task force served as a coordinating body and an advisory body to the policy drafters, providing key inputs and oversight during the drafting and review	Even though the policy was reviewed and several meetings with the former Minister of Health and the former Minister of Human Services and Social Security were conducted, the policy was not tabled in Parliament and could not be implemented.	Implementation did not take place because the Policy was not tabled in Parliament. However the policy was used as a guide in developing the minimum standards for institutions which is globally acknowledged as a best practice. Implementation did not take place because the Policy was not tabled in Parliament. However	

	that children who lose their parents become immediately vulnerable. Based on the findings, it was agreed by partners to develop a policy framework that will address the needs of orphans and vulnerable children in Guyana.		process.		the policy was used as a guide in developing the minimum standards for institutions which is globally acknowledged as a best practice.	

Policy Area: Strengthening a multi-sectoral response and linkages with other health and development programs						
Policy: National HIV/AIDS Workplace Policy						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date	Completed, February 2004	Completed, February 2005	Completed, February 2006	Completed, February 2006	September 2013	
Narrative					USG through ILO will support	

					the development, implementation and monitoring of a costed implementation plan for the National HIV/AIDS Workplace Policy.	
Completion Date						
Narrative						

Technical Areas

Technical Area Summary

Technical Area: Care

Budget Code	Budget Code Planned Amount	On Hold Amount
HBHC	817,406	0
HKID	288,886	0
HVTB	190,870	0
PDCS	71,611	0
Total Technical Area Planned Funding:	**1,368,773**	**0**

Summary:

Overview

PEPFAR programming aligns with the treatment and support section of Guyana's National Strategic Plan for HIV/AIDS 2007-2011 whose objective is to "ensure access to care and treatment for all persons living with HIV/AIDS," including providing a supportive environment and quality home-based care (HBC) services. Programs were implemented at the community and national levels and focused on the care of persons living with HIV (PLHIV) and support for orphans and vulnerable children (OVC). Community level work through NGOs provided a package of services including educational/vocational skills training, psychosocial support, nutritional counseling, legal assistance, and general health care. PEPFAR-supported activities succeeded in reaching a significant proportion of the estimated 5,900 HIV-positive individuals in Guyana. In FY11, there were 4,804 PLHIV receiving care in 19 clinical sites. In addition, 7,689 clients (3,404 males and 4,285 females), including 1,853 OVC, were also receiving the full, home-based and palliative care package through nine PEPFAR-supported NGOs and other USG partners. Approximately 500 HBC providers were trained. Cervical cancer services were provided to 7,981 women, 900 of whom are HIV positive, at 10 of the 16 treatment sites.

In FY12 and beyond, the PEPFAR programmatic vision is to transition from scaling-up services to improving the quality of services, building capacity, shifting from direct service delivery to a limited technical assistance model, and promoting sustainability. Program priorities include: addressing stigma and disclosure to enhance uptake of care and support services, particularly for MARP and OVP groups; supporting a comprehensive package of care services delivered in facility and home-based settings through a family-centered approach; strengthening linkages to prevention of mother-to-child transmission (PMTCT), the cervical cancer program, and provider-initiated testing in health care facilities; strengthening bi-directional referrals from the facility into community-based programs and vice versa (emphasis will be placed on following up with clients to ensure they are accessing the referrals and receiving needed services); monitoring the quality and delivery of care services; strengthening case navigation to trace clients who have defaulted from the program; establishing and/or enhancing partnerships with existing public sector social services; strengthening referrals to reproductive health/family planning services;strengthening the capacity of families and communities to provide care;; and strengthening data quality.

In FY11, the USG continued to serve as the primary Ministry of Health (MOH) partner in the provision of adult and pediatric HIV care and treatment services, through the development of guidelines and protocols, and continuous quality improvement. Through the PEPFAR-supported National Public Health Reference Laboratory (NPHRL), the

capacity of the MOH was strengthened to conduct DNA polymerase chain reaction (PCR) for early infant diagnosis (EID) of HIV. In addition, the PEPFAR-supported mobile unit in remote areas led to improved case-finding. At the end of 2010, there were 62 children in care nationally. FY12/13 priorities will include improving EID through the case tracking system implemented by the MOH, so that treatment of infected infants can be initiated early. USG will continue to work with the MOH to improve weak data systems and the training of health care providers to provide high quality care and support to the pediatric population.

Tuberculosis (TB) continues to be a priority for the GOG as it impacts HIV mortality in Guyana. Roughly 25-30% of all newly-diagnosed TB cases are co-infected with HIV. The USG will support the National TB Control Program, which provides care and treatment for all TB cases in the country. Activities will include: support to review the TB screening guideline, enhance patient monitoring using the Integrated Management of Adolescent and Adult Illnesses (IMAI) model; train volunteers to provide intensified case finding (ICF); decentralize izoniazid preventive therapy (IPT) to major public and private HIV sites; increase TB screening of HIV infected patients; intensify case finding; enhance laboratory diagnostic support; improve access to first and second line TB medications and the implementation of a continuing quality improvement plan; ensure health care facilities adhere to the standards for the prevention and control of nosocomial infection; and improve TB/HIV surveillance.

In support of OVC, USG-supported NGOs provided a package of services, including educational/vocational skills training, psychosocial support, adherence support, age-appropriate prevention education, nutritional counseling, legal aid, general healthcare, and other services to approximately 1,565 OVC, 84 of whom are HIV positive. A child protection policy was developed in collaboration with UNICEF and the Ministry of Human Services for all child care providers. PEPFAR will continue the family- centered approach which enables the program to identify and link OVC to specialized services, ensures children are immunized, encourages family members to be tested, provides support for acceptance and disclosure of HIV status, offers family planning counseling, nutritional and hygiene counseling for the family, as well as bereavement care. Other opportunities include strengthening the referral system, enhancing the capacity of USG-supported NGOs to deliver services to address the "core" needs of OVC, through interventions at the child, caregiver and family levels.

The private sector continues to be a critical partner, given the threat that HIV poses to the stability of the economy. Through the Guyana Business Coalition (GBC) on HIV/AIDS, PEPFAR will create a platform for collective action in care and support, by bringing together the private sector and encouraging their commitment to support an identified menu of program needs. Complementing these efforts are international technical assistance, partnering with UN agencies, increasing access to government grants and small business loans, and continuing support for the development of an enabling environment free of stigma and discrimination.

The GOG provides free access to care and treatment services through public and community facilities for both adults and children. There is no discrimination based on gender, however stigma and discrimination act as barriers to service uptake for MSM and other MARPs. In FY 12/13, emphasis will be placed on the creation of an enabling environment for MSM to increase access and utilization of services. PEPFAR will also work with its partners to develop forms for collecting and reporting on the number of HIV-positive clients who are MARPs, as well as procedures for how to collect this information in a non-discriminatory and non-stigmatizing manner.

USG will continue to focus on family-centered approaches to ensure that all members of the family unit infected and/or affected by HIV/AIDS receive the full package of services based on need. Efforts will be made to involve men as partners particularly in the PMTCT program and to address OVC needs. In terms of health systems strengthening, PEPFAR will work with the GOG and local partners to strengthen Guyana's public health system to take on a broader range of health problems and larger shares of costs to mitigate HIV/AIDS. The loss of health professionals due to emigration requires the development of local institutional and structural capacity for educating and retaining the health workforce.
The USG will continue to support capacity building of health care workers, civil society members and other categories of staff. In addition, USG will support the institutional capacity building of the University of Guyana Health Science Faculty through curriculum development, training and mentoring of faculty members, development

of distance learning opportunities, renovation of laboratory facilities and limited procurement of equipment and supplies. This includes the implementation of an infectious disease residency program, a supply chain management program and a Master of Public Health in Epidemiology program. Technical assistance (TA) will be provided in the areas of TB identification and DST methods. A comprehensive HRH strategy that addresses production, retention and effective utilization of staff was developed in 2010 by PAHO but has not been disseminated to the public. USG will collaborate with PAHO to advocate for making the document operational. USG will also advocate for the integration and coordination of HIV/AIDS programs with broader global health and development programs to maximize thri impact and help sustain basic health infrastructure.
In terms of strategic information, the USG will strengthen the capacity of the MOH to collect and use data for the coordination and management of care services to PLHIV, OVC, their family members and other care providers. TA will be provided to CSOs to monitor and report good quality data to make evidence-based policy decisions.

Adult Care and Support

The goals of the USG contribution to the National Strategy support the five categories of essential palliative care services to all people infected or affected by HIV/AIDS: clinical care, psychological care, spiritual care, prevention PLHIV, and social care services. These services are provided in both facility and home-based settings.

Clinical care services are provided through the public health sector and the St. Vincent de Paul Society hospice and rehabilitative care facility, with linkages to community-based organizations. At care and treatment sites, USG partners provide comprehensive family-centered, palliative clinical services for adults and children that include routine clinical and CD4 monitoring, prevention and treatment of opportunistic infections (OIs), including providing cotrimoxazole (CTX), TB screening, pain management, nutritional assessment and support, and promotion of physical exercise, personal and household hygiene. Clinical sites are located in 20 health care facilities (15 of which provide treatment), including six regional facilities and the central treatment center of excellence.

MOH regional nurse supervisors, supported by the Global Fund to Fight AIDS, Tuberculosis, and Malaria (GF), are based in health facilities and work alongside community-based providers at treatment sites to ensure a continuum of care. HBC nurse supervisors directly link patients to NGOs where household members can receive care and support services. When a client tests positive at an NGO site, s/he is enrolled in the home and palliative program at the NGO and also referredto the treatment site for treatment and care. Monthly networking meetings are held between nurse supervisors at the MOH clinical/treatment sites and NGOs to discuss active cases in HBC.
Cervical cancer screening and treatment are integrated as part of the HIV service delivery package for HIV-positive women, and health care provider capacity was built in the public health sector to utilize this technology. The cervical cancer project will be fully transitioned to the MOH in June 2012.

Psychological care services will continue to address the non-physical suffering of the individual and his/her family members. In FY11, monthly support groups at NGO sites included approximately 723 persons living with HIV (440 females and 283 males). Activities include support for disclosing one's HIV status, treatment adherence, referral to the MOH Mental Health program, involvement of partners of PLHIV, stigma and discrimination, and addressing violence.
Spiritual care service was provided to approximately 318 PLHIV in FY11, including counseling related to fears, guilt and forgiveness, and seeking pastoral/spiritual care.

Prevention services for PLHIV address their special needs and issues and their partners through sharing experiences and identifying best practices for disclosure, partner testing, family planning, and other strategies for positive living, such as proper nutrition and hygiene (including food preparation techniques and safe storage and treatment of drinking water), sexual risk reduction and adherence counseling, alcohol abstinence or reduction in use, and safer sexual practices.

Social care services are delivered through the NGO sector and include: referrals for alcohol and substance use

treatment, gender-based violence support services, creating kitchen gardens, parenting skills, employment training, linking families to the MOH Food Bank and other safety net programs, and work place internships. Linkages with vocational training institutions have trained over 100 HIV-positive women in garment construction, catering and hospitality. HIV-positive men have been trained in skills such as carpentry and masonry. Trainees were able to utilize their new skills to generate income and access small loans. A partnership with Habitat for Humanity and Food for the Poor resulted in the construction of fifteen homes for PLHIV. PEPFAR will continue to explore new partnerships for economic empowerment of PLHIV through the private sector and GOG.

Pediatric Care and Support

PEPFAR's pediatric HIV care and support activities have produced major accomplishments. There has been improvement in the coordination in care, support, and treatment services between MCH and HIV and referral links from ANC services to HIV care, support and treatment for children and adolescents have been improved. With PEPFAR support, the MOH/National AIDS Program Secretariat (NAPS) mobile unit has led to improved case-finding in remote areas. Early infant diagnosis (EID) of HIV has been made possible with the boosting of local capacity for virological testing through DNA PCR at the National Public Health Reference Laboratory (NPHRL). Development of new clinical guidelines has led to improved pediatric diagnosis and treatment. InFY12 and FY13, PEPFAR will support scaling-up EID through the Case Tracking System implemented by the MOH so that treatment of infected infants can initiate ART promptly.

CTX is accessible at all care and treatment sites for HIV-infected children and exposed infants. CTX prophylaxis is mandatory for exposed infants from six weeks of age until they are confirmed HIV negative. Increasingly, CTX is dispensed by nurses to exposed infants where necessary. Provider Initiated Testing and Counseling (PITC) for exposed infants and their siblings, pre-adolescents and adolescents are also supported. Confirmed HIV positive cases are assessed and screened for respiratory infections, TB, and other OIs. All suspected cases of TB are referred to the TB Center. Pediatric medications including drugs for OIs are procured through the PEPFAR-supported SCMS and are widely available at care and treatment centers. Through PEPFAR funding, the USG will continue to support training of health care workers in pediatric HIV care and treatment to further strengthen capacity to provide high quality services.

The capacity at the national level to collect and analyze pediatric HIV care and support data, including costing is fairly good. However, the extent to which such data are used to support policy-making needs improvement. The USG team will continue to work with MOH to improve data quality and application.

TB/HIV Care

The principal goal of the National Tuberculosis Strategic Plan of Guyana, 2008-2010, is to maintain and expand quality TB services while addressing cross-cutting social, demographic and economic challenges with the objective of decreasing TB incidence from 111/100,000 population in FY10. USG support will contribute towards several objectives in accordance with the Strategic Plan and the National TB Manual: (1) Expand and improve Direct Observed Therapy Short-course (DOTS) strategy to increase case detection from 56% to 75% and the treatment success rate to 85% for sputum smear positive cases; (2) strengthen management of the National TB Program; (3) establish and strengthen integration of TB and HIV service delivery; (4) intensify the surveillance and management of TB/HIV and MDR-TB; (5) strengthen infection prevention and control activities; (6) have a functional laboratory network that enhances TB case finding; 7) increase screening for and treating of 90% of HIV infected persons for LBT; and (8) decentralize IPT to HIV sites and provide ART in TB sites.

The USG will support scaling up ICF in PLHIV at all levels of the health care system. A review of the TB screening guideline will be done to ensure it reflects the WHO ICF recommendations. PEPFAR will support implementation of the recommendations and will strengthen laboratory services for accurate and timely diagnosis and treatment of TB. The MOH plans to improve the identification of TB and MDR-TB through the use of the Cepheid Xpert MDR/RIF testing. Feasibility studies will be conducted to determine the best possible site(s) for its implementation.

DOTS workers (TB outreach workers) have been trained in ICF and volunteers will be trained to provide this service to their communities. Health care workers will be trained in the clinical screening of TB in HIV patients. Guidelines on efficient and effective referrals for further TB investigations and the correct placement and reading of TST will be highlighted. Provision of IPT will be decentralized to public and private HIV sites to reduce the structural barriers. The USG team and the MOH will develop strategies to integrate TB screening and IPT into HIV care and treatment. The results of a retrospective evaluation, supported by the USG, on TB and HIV treatment and diagnosis at selected health facilities will help inform future strategies to improve implementation or revision of the current National TB and HIV guidelines.

Infection control measures to prevent the TB transmission have begun at both HIV and TB settings. The USG partners will continue to support the MOH in the development of the National Infection Control Plan and the establishment of a National Infection Control Committee that will coordinate with other infection control programs and the occupational health and safety department to scale up IC activities. The USG will assist the MOH in the development and implementation of a TB infection control plan for outpatient and inpatient facilities, and will build the capacity of the Department of Standards and Technical Services to develop an infection control training curriculum and conduct trainings of health care workers and to monitor compliance with the National Infection Control Plan.

The USG will help assess implementation and barriers with respect to current National TB Control Guidelines which recommend early initiation of ARV for all TB patients who test positive for HIV, regardless of their CD4 count. Quarterly collaborative meetings will support integration of TB and HIV services in accordance with government priorities. The USG will collaborate with PAHO to continue working with the National TB Program to improve TB/HIV surveillance and M&E and to improve the use of electronic registers. USG technical assistance in strategic information will strengthen the surveillance system regarding the prevalence of HIV and TB co-infection. Advancing the use of electronic registers and consolidating the paper-based registers will assist in monitoring and evaluating.

Orphans and Vulnerable Children

The PEPFAR OVC program responds to Guyana's National Strategic Plan for HIV/AIDS 2007-2011 which includes an objective to "Reduce the socio-economic impact of HIV/AIDS on children and increase protection for children."

In FY11, OVC programs focused on interventions at the community and national levels. In communities, NGOs provided a package of services including educational/vocational skills training, psychosocial support, adherence support, age- appropriate prevention education, nutritional counseling, legal aid, general healthcare, and other services to approximately 1,565 OVC, 84 of whom are HIV positive. In FY12, the program will enhance its collaboration with UNICEF, the private sector, and government agencies to deliver quality services to 1,380 OVC with a focus on: providing appropriate quality care and support services to OVC and their care-givers/family members; strengthening the capacity of the family unit to care for children in need; increasing economic opportunities for adolescent OVC and their families; improving case finding through linkages with PMTCT, counseling and testing, care and treatment sites; and targeted interventions for OVC who are also MSM.

Through PEPFAR's support, UNICEF worked with a number of governmental and non-governmental partners such as the Guyana HIV/AIDS Reduction project GHARP II to develop and implement a multi-sectoral approach to OVC activities. This collaboration resulted in establishing the country's first child protection agency, enacting relevant legislation, and developing a child protection policy for organizations/agencies working with children to safeguard the well-being of children and families accessing OVC services.

In FY11, a foster care program was implemented, serving 141 children and exceeding the project target of 125. Probation officers and representatives from civil society organizations were trained in counseling and psychosocial support. Continuous efforts will be made to reintegrate children into their families through UNICEF. The "TELL"

campaign addresses child abuse and reached over 5,000 children and 2,000 teachers and parents. UNICEF will not be funded by PEPFAR in FY12 but will utilize other funding sources to continue strengthening the capacity of the Ministry of Labour Human Services and Social Security (MOLHSSS), training social workers and child care professionals, supporting the Child Protection Agency, and reintegrating children from residential institutions to their families or other community care options.

The PEPFAR OVC program focuses on four objectives. The first is to provide appropriate quality care and support services to OVC and their care-givers/family members. Support to seven NGO/ FBO partners will continue in FY12 to deliver services to address the "core" needs of OVC through interventions aimed at the child, caregiver and family. These include: ensuring children's access to education with an emphasis on promoting equal opportunities for girl children; vocational training; provision of medical care and targeted nutritional support; basic food support (including community gardens); psychosocial support; protection and legal assistance, and economic strengthening opportunities. The program collaborates with the private sector to support the needs of children in the six key areas (food/nutrition, shelter and care, protection and legal assistance, health care, psychosocial support, and educational/vocational training). This public-private partnership resulted in both cash and in-kind support to the OVC program in FY11. Economic empowerment of adolescent OVC will be carried out through innovative models for public-private alliances.

Recognizing that there is a need to sustain OVC efforts beyond the life of the project, the USG, through its NGO network, will collaborate with UNICEF to increase OVC access to community services and resources by targeting "community care points" established through UNICEF, as well as professionals/skilled individuals to support vulnerable families. Youth participation in national or local level planning and service delivery will be promoted and facilitated. Through community mapping exercises, areas of potential linkages with other HIV/AIDS and development programs will be identified.

The quality of OVC services will be improved through linkages with NAPS, the private sector, MOLHSSS, UNICEF, Global Fund and other donor agencies. This coordinated effort will ensure that the quality, including cost effectiveness of services, is appropriate, and that limited resources are spread across the many children and families requiring temporary or long-term assistance. The MOLHSSS, the MOH, and civil society organizations through the Global Fund and World Bank projects, will continue to provide OVC and their families with food, school uniforms and supplies, psychosocial support and public assistance. PEPFAR quality assurance/quality improvement (QA/QI) measures will focus on on-site supervision and develop effective mechanisms for case management. Capacity building, care coordination and client management will also be addressed. To address some of the challenges with double counting, organizations will be assigned to specific facilities and communities.

The second objective is to strengthen the capacity of the family unit (parents/caregivers) to care for children in need. Parenting skills workshops and increased male involvement will strengthen parent/guardian interaction with OVC and enhance their participation in service delivery. Parents will be referred to the MOLHSSS for economic and other social assistance needed to support OVC. The program will collaborate with the private sector to facilitate greater access to income-generating activities and linkages to micro-financing opportunities for caregivers. Linkages will also be made with Food for the Poor and the Ministry of Agriculture to acquire seeds and farming implements for the development of kitchen gardens.

The third objective of the PEPFAR OVC program is to strengthen linkages with adult care and other appropriate health and social care services. Ongoing effort is needed to strengthen programs to support all the OVC identified. The program will concentrate on recruiting children, through linking closely with high probability sources for case finding, including such partners as government social service offices, PMTCT sites, treatment sites, PLHIV support groups, and palliative care providers. PEPFAR will collaborate with MOH, NAPS and other partners to strengthen Standard Operational Procedures for referrals from the respective sites/agencies. The estimated beneficiary target for FY12 is 1,380 OVC.

The fourth objective of the PEPFAR approach is to support targeted interventions for OVC who are also MSM.

USAID-supported NGOs will be strengthened to identify and provide specific and appropriate support for gay, lesbian, bisexual (GLB) youth to ensure that this group can remain in school and access available services without stigma or discrimination. Service providers will be sensitized regarding stigma and discrimination and the impact on program uptake.

Cross Cutting Areas
Public Private Partnership (PPP)

PPPs are a growing tool in combating the spread of HIV. Six years ago, PEPFAR/Guyana launched its partnership with the private sector, which developed into the Guyana Business Coalition, comprising 43 companies that are actively engaged in helping the Government to reach its goals of preventing and reducing HIV in Guyana. The GBC serves as a central coordinating body, promoting HIV prevention messages through in-house workplace training and sensitization, developing and implementing workplace policies, reducing stigma and discrimination, ensuring access to HIV services among its employees and providing in-kind and financial support for HIV/AIDS activities.

In FY12/13 the USG will continue to leverage financial and in-kind support for HIV programs that support community HIV initiatives, but with a much stronger focus on developing long-term public/private partnerships between coalition companies, NGOs, and government agencies. Support for the activities of the GBC will be transitioned to corporate support in March 2012. The USG will, however, maintain its partnership with the private sector.

Gender

The GOG provides certain health care services in the public sector at no charge and their delivery is guided by the Guyana Package of Publicly Guaranteed Health Services (PPGHS). Regardless of gender, everyone has access to treatment and other care and support services and resources. The 2011 APR reveal that more females (4,285) than males (3,404) received the full home-based care package of services. Among other activities, USG will continue the family-centered approach in order to identify more males and link them to services. Although members of the most-at-risk population receive the same package of services as any other HIV+ client, yet stigma, resulting in discrimination, often prevents MSM from seeking and accessing essential health services. In FY12/13, the strategy includes developing innovative methods to build the competence of all health personnel to provide services in a non-discriminating, non-stigmatizing, confidential and friendly manner, in order to allow increased access to care and treatment services to MSM.

Care programs include special support and recognition of the special burden women face as the primary care-givers. The PEPFAR Guyana program will strengthen linkages to social services and programs in the public and private sectors that increase women's access to income and include vocational training and access to credit. USG will continue to explore new partnerships for economic empowerment of PLHIV through the public service and the private sector. Both boys and girls will continue to be targeted equally by OVC programs but vocational and life-skills will be tailored to the specific challenges that girls and boys face. OVC programs address the need to support girls in continuing their education, and reducing their vulnerability to sexual and other kinds of exploitation.

Through USG support, cervical cancer screening and treatment are fully integrated within the MOH as part of the HIV service delivery package for HIV positive women. PEPFAR/Guyana care and treatment partners utilize a family centered approach to care and treatment services which ensures equitable access for women with linkages to family planning and PMTCT.

PEPFAR will continue to implement programs targeting men and boys. Parenting skills trainings are conducted for both male and female caregivers to strengthen their coping and supportive skills. As there has been minimal participation by men, encouraging male participation will be a priority in FY12/13 to strengthen/obtain their participation in care-giving and household functions.

The USG will also build on its current activities with boys and men to reduce violence in the house-hold through the Gender Challenge Fund. Activities will be carried out in health settings, faith-based organizations, schools, workplaces and places in the communities where men congregate, to change attitudes of men and boys towards sex and violence, and also to empower women to take charge of their reproductive health and decision-making. Prevention efforts will seek to empower women and counter the attitudes, beliefs and valuesamong boys and men that condone partner violence as "normal", as well as address alcohol use which is a risk factor for violence, through community outreach activities, parent-teachers associations and work-place programs. Alternative ways in dealing with conflict and managing anger will also be key in addressing violence against women. Health care providers will be trained to recognize gender-based violence and make the appropriate referrals.

Through the home-based care program, PEPFAR will continue to target older women caregivers. Over the past year, 40 caregivers benefited from vocational skills training in garment construction, catering and hospitality. Referrals were also made to the National Food Bank and Voucher Program. In FY12/13, emphasis will be placed on increasing the enrollment of this target group in vocational skills training activities, as well as strengthening linkages with social services and programs to increase women's access to income and vocational training.

MARPs

Currently care and support services for MARPS are provided through CSOs, who are monitored by the MARPs coordinators and enrolled in the MARPs support groups, which meet bi-monthly. Each agency services a specific geographic area and is linked with treatment facilities within the same region. There are bi-directional linkages at these facilities to social and other needed support and treatment services.

The minimum package of services offered to both MSM and CSW includes peer education and outreach; risk reduction counseling; condom and lubricant promotion and distribution; HIV testing and counseling; BCC materials; support groups; and referrals for STI screening. In addition, the comprehensive package of services also includes referrals for mental health and social services; substance abuse treatment; or provision of these services by trained social workers. In addition, for FSW, there are linkages to economic strengthening programs; parenting skills training; and referral for family planning and PMTCT services.

While basic socio-demographic information, such as age and sex, is collected in HIV care and treatment program data, there is a need to improve monitoring service utilization and uptake among MARPs/priority groups. Though some of these data may be collected in individual patient charts, it is not summarized and monitored at a program level. With increasing use of an electronic system, the USG will help enhance the system to monitor MARPS.

In order to increase access and service utilization for MARPs, PEPFAR has conducted a number of sensitization workshops with staff at the NGOs and care and treatment sites to reduce stigma and discrimination. The USG will continue to advocate for supportive policies by working with MARPs, other target populations, and health facility staff to enhance access to health and other services at public sector facilities providing care and treatment services to these populations. Support will also be provided to gay youth to remain in school and have equal access to services.

HRH

Guyana has no national HRH plan. While a significant number of health care professional are trained annually, there is significant loss due to external migration. The majority of training is conducted in collaboration with the MOH through donor support. CHWs work in Health Centers and Health Posts in rural communities and are financed by the GOG. In FY12 and beyond, the USG will support professional development activities for CHWs. Training in HIV Basics including opportunistic infections and supportive care services for PLWHis planned. The USG will also support training in DOT-HAART for CHWs in order to increase adherence to ARVs and anti-TB therapy in TB/HIV co-infection.

USG supported partners hire and compensate qualified social workers who were trained at the University of Guyana to provide support for OVC and their families. Those who possess a Diploma must have three years practical experience and those with a bachelor's degree one year experience. There are no existing policies governing Social Workers but they provide counseling in support groups, conduct home visits, and address social issues through referrals and may accompany clients to ensure that services are provided.Supervision is provided by a USG partner.

There will be continuing efforts to reorganize the workforce by shifting tasks where appropriate to less specialized health care workers. This would increase work coverage by effectively utilizing existing human resources while expanding training and retention programs. The USG will support increasing human and institutional capacity in developing HIV policies to support task shifting. The MEDEX programs will be strengthened by integrating aspects of HIV into its curriculum.

Through PEPFAR support, a national in-service training and mentorship program for practicing clinicians will be developed with international experts providing technical consultation. This will improve clinicians' skills and knowledge in the care and management of patients with HIV and associated opportunistic infections. Support continues to be provided in the dissemination and implementation of new guidelines.

Laboratory

The National Public Health Reference Laboratory (NPHRL) performs TB culture, identification and drug susceptibility testing (DST). In FY12/13, technical assistance will be provided by the American Society for Microbiology (ASM) to NPHRL in the areas of TB identification and DST methods. Activities will include retraining laboratorians in solid and liquid culture and in DST for 1st and 2nd line drugs. In addition, ASM will support the implementation of opportunistic infection testing using simple microscopy and rapid assay-based methods. The Chemistry/Serology Department of NPHRL also intends to provide serological diagnosis of other pathogens such as Chlamydia, Toxoplasmosis, Cytomegalovirus (CMV), and Herpes Simplex Virus (HSV) until molecular methods are implemented.

Public sector laboratory services in Guyana are tiered and provided through a laboratory network which includes hospital laboratories, health centres and health posts at central, regional, district level and community level. The Package of Publicly Guaranteed Health Services in Guyana defines the levels of care within the health services including the Essential Package of Laboratory Services available at each level of care. All diagnostic and clinical monitoring functions for PEPFAR programs are currently performed at NPHRL.

Clinical laboratory services within the public system are provided through NPHRL and the Georgetown Public Hospital Corporation (GPHC) Medical Laboratory (ML). The NPHRL provides high complexity laboratory services and advanced diagnostics for specific diseases of public health significance such as HIV, TB, and H1N1. It also provides clinical testing and referral services for all public sector laboratories in the areas of hematology, serology/immunology, biochemistry, and molecular biology.

The main focus of the regional hospital is to provide secondary health care to the population. Laboratory servicesareavailable on a twenty-four hour basisand include testing inbiochemistry, hematology, basic serology, basic microbiology, and urinalysis.

District hospitals offer varying degrees of testing in their laboratory departments. Sevendistrict hospitals provide the basic services in biochemistry, hematology, serology, microbiology (e.g. TB and malaria microscopy), and urinalysis. Anadditional seven district hospitals have some of the infrastructural requirements to house laboratory facilities,however, there is need for structural alterations to make them more suitable for fulfilling theselaboratory functions.

Health Centers and Health Posts provide varying levels of point-of-care testing, e.g. HIV testing using rapid test kits and blood glucose using a glucometer. Most HIV-related laboratory services provided by NPHRL departments are supported by External Quality Assessment (EQA) programs. The Hematology Department participates in a UK National EQA program for CD4 enumeration. The Molecular Biology Department participates in an EQA program provided by CDC for Early Infant Diagnosis and Viral Load monitoring. This department is also enrolled in a WHO EQA program for rRT-PCR for H1N1. The chemistry/serology department has only recently become operational for testing other than for HIV and Syphilis and is seeking EQA support. Regional hospital laboratories participate in Digital PT EQA program provided by Healthmetrx Canada which includes chemistry, hematology, urinalysis, and basic microbiology, Twenty-sixVCT sites are also enrolled through this program for HIV rapid testing. In addition, the NPHRL now has the capacity to provide an HIV rapid testing EQA program for all VCT sites in Guyana using Dried Tube Spot panels.

Strategic Information

The goal of the HIV monitoring and evaluation system (MES) is to collect and use relevant, comprehensive and timelydatafor the coordination and management of care services to PLHIV, OVCs, and their family caregivers. The USG has worked with the MOH to develop a standardized system to facilitate the collection of such information and is reviewing the MESto ensure that data collected reflects the family-centered approach with stronger linkages with the treatment program for better care management models.

In addition, PEPFAR is supporting a transition from the current paper-base system to scale up use of the electronic systemsavailable at USAID-funded CSOs. The USG will provide TA to CSOs to strengthen links for monitoring clients enrolled in community-based programs whoare also on ART.A major focus in FY12 is to increase the availability and use of data to support the care coordination process. Ongoing support will be provided to build local capacity to continue to monitor and report good quality data to make evidence-based policy decisions.

Capacity Building

USG collaboration with the MOH has led to the development of a national policy for cervical cancer prevention based on the single-visit approach (SVA) with visual inspection with acetic acid (VIA) and cryotherapy, and the development and implementation of a national Cervical Cancer Prevention and Treatment CECAP initiative.

This initiative included a largecommunity mobilization and education campaign, along with pre-service and in-service training of physicians, MEDEX, senior nurses and midwives to detect and treat precancerous lesions of the cervix, specifically among HIV+ women. This project, which will end in September 2012, is now fully integrated into the HIV service delivery package.

The MOH has assumed responsibility for training and program management/coordination. Training in this new technology is integrated into the in-service curriculum for health care providers and plans are to add this material into pre-service training as well. To ensure quality service, the Medical Extension Workers (MEDEX) conduct supportive supervision visits. At the community level, training is provided to PEPFAR-supported NGOs (often in conjunction with staff from NAPS), in areas such as palliative care, stigma and discrimination, prevention with positives, parenting and psychosocial skills, and substance abuse to enhance their service delivery. Site visits are conducted by the USAID contractor, the Guyana HIV/AIDS Reduction Project, to observe application of skills and provide coaching and mentoring.

Technical Area: Governance and Systems

Budget Code	Budget Code Planned Amount	On Hold Amount
HLAB	280,304	0

HVSI	423,227	0
OHSS	2,580,000	0
Total Technical Area Planned Funding:	**3,283,531**	**0**

Summary:

Background and Overview

Over the past ten years, the U.S. Government PEPFAR program has assisted the Government of Guyana to develop a set of strategies which have enabled the health sector to provide free universal access to many HIV/AIDS services, which have had measureable impact on the reduction of HIV/AIDS prevalence to 1.2% (UNAIDS, 2009). However, as the U.S. Government begins to hand over various responsibilities to the Government, a major challenge to sustainability is the limited capacity of local organizations. As a result, the USG and GOG have to work in close collaboration on a variety of issues to ensure that both institutional and human resources capacity is strengthened, and to continue to prioritize, manage and implement effective HIV interventions and policies. Orchestrating this overarching transition in the next several years will require leadership at the highest levels of the USG and GOG in addition to the utilization of high quality data, especially for securing more financing including host country budgets and other donor resources.

In FY12, the USG will collaborate with the Ministry of Health (MOH) to transition aspects of the HIV/AIDS program, which has been catalyzed through PEPFAR support and assistance, to the GOG and other stakeholders including the Global Fund. This transition process will be guided by a USG five-year vision statement which will continue to be developed during FY12, in consultation with the MOH and other partners. Assessments will be made of each program area for transition and detailed timelines and budgets will be developed to enable the transfer to occur systematically. The overall aim is to work with the GOG through a limited technical collaboration model. Such a model fosters country ownership, which is critical to ensuring the sustainability of the national HIV/AIDS response and infrastructure. The PEPFAR program will shift its focus to building partner capacity to respond to HIV/AIDS effectively and efficiently, thereby ensuring that the vision of intensified country partnership and ownership is reflected in USG programs. PEPFAR strategies will be evidence-based to prioritize the most important and effective HIV/AIDS mitigation interventions and strategies while simultaneously increasing local country capacity to develop and implement financially and technically sustainable programs.

Leadership & Governance

The USG will continue to provide technical assistance to review and strengthen both the institutional and human resources capacities of the national HIV/AIDS coordinating and technical committees improving their ability to address governance and policy reform as part of program implementation. These will significantly enhance the process for addressing issues in HIV/AIDS programming nationally. At the individual and facility level the USG will continue to support the use of the Leadership Development Program (LDP) to build local capacity and skills in strategic thinking and planning and develop shared leadership and problem solving techniques among HIV/AIDS health care providers. Within the Ministry of Health, LDP training was conducted with staff from the National AIDS Program Secretariat (NAPS), health centers, and hospitals. Workshops were also conducted with USAID-funded NGOs and private hospitals providing care and treatment for HIV. Additional leadership, training and mentoring skills have been developed in a group of graduates of the LDP, referred to as the Core Group, who are trained to deliver or assist with delivery of the LDP workshops, as well as to provide mentoring and support. Efforts will be made to integrate these activities into existing health managers training within the Ministry of Health. The USG will work with graduates in the Regions and with Core Group members to plan and implement activities to promote sustainability. Curriculum will be pilot tested and integrated into the overall nurses training program. The same approach is being considered for the medical school.

The USG, through GHARP II, has implemented the Management and Organizational Sustainability Tool (MOST) with both public and private sector partners. MOST is a process whereby teams from organizations assess their capacity in aspects of management and operations, including monitoring and evaluating. The teams work among themselves to identify and prioritize issues, and then determine an appropriate Action Plan for addressing these problems. USAID assists MOH entities and NGOs to finalize and implement their plans. Supervision is provided to assess progress towards implementation of the Action Plans. Appropriate tools will be identified to conduct similar activities with smaller NGOs that also face management and organizational challenges.

The Guyana PEPFAR program has been successful in transitioning service delivery from international partners to local NGOs and the MOH, thereby reducing significantly costs to provide care and treatments services. This achievement, though, is partial insofar as those local organizations are struggling with long term viability, particularly as PEPFAR and other donor funding continues to decline. The USG is strengthening local NGO capacity through technical assistance and training in financial management, administrative/operational management, governance, and monitoring and evaluation. The assistance is designed to adopt sound business and project implementation practices. Serious sustainability issues remain regarding NGO service delivery, primarily because as service providers they compete with the public sector to provide free services to address unmet needs. This type of competition undermines any cost recovery strategy which may be linked to long term sustainability of services and needs to be addressed through policy dialogue.

Another focus of the NGO technical assistance program will be on collecting and utilizing information to guide and evaluate evidence-based approaches to support more effective and cost-efficient operations. Another area of focus should be in enhancing NGO appreciation of how they may become more self-sufficient in carrying out their missions. USAID/Guyana is concluding their Democracy and Governance program, part of which focused on NGO sustainability. The activity produced a methodology which reviewed NGO revenues and expenditures. Many of the USAID-funded NGOs now have the capacity to understand the relationship between income and expenditures and develop well-aligned strategies. All organizations pioneering the sustainability roadmap are required to develop a business plan to balance income and expenditures. Support to the USAID-funded NGOs and CDC-funded FBOs will continue in FY12. Assistance will be provided to develop sustainability plans, strengthen skills in proposal writing, use data in decision making and planning for services, and promote advocacy for policy issues such as fees for services and unfair competition The NGO Coordinating Committee (NCC) is an important group representing the health sector in Guyana. Their focus will shift to self-advocacy as it relates to sustainability and policy reform that will enable NGOs to continue performing their important service delivery functions. The NGO and FBO constituencies are also represented on the GF CCM. These representatives will be encouraged to become more actively engaged in representing their needs and addressing these in future funding proposals.

NGOs will also be supported to explore other sustainable financing strategies such as fees for services. Through public and private sector partnership, there may be opportunities for promoting MARPS programming. Guyana is currently undergoing a surge in direct foreign investment in mining and oil exploration by large corporations such as EXXON, REPSOL, CXG and Guyana Goldfields. The mining companies are playing an increasingly larger role in public issues that affect their labor forces. In addition to the direct benefits, large foreign investors usually have significant Corporate Social Responsibility programs some of which can be channeled towards the fight against HIV/AIDS and support for NGO service delivery.

Capacity Building

Perhaps the single greatest challenge to building local capacity is emigration of skilled Guyanese. The U.S. Consulate estimates that 90 percent of University of Guyana graduates immigrate to the Caribbean and beyond. This constant turnover of human resources necessitates ongoing training and capacity building. In the past, training has been heavily reliant on international NGO's and has been focused on increasing knowledge and skills of individual workers. To better address this ongoing need, the USG will support institutional capacity building at the University of Guyana, through curriculum development, training and mentoring of faculty, development of distance learning opportunities, limited renovation of laboratories and classrooms and select procurement of

equipment and supplies. This includes the implementation of an infectious disease residency program and a supply chain management program. In-service training and professional development opportunities will continued to be supported by the USG, however priority will be given to enhancing skills in areas where there is evidence of poor staff performance. As part of the long term strategy to address health sector worker retention, the USG, through PAHO, funded a Human Resource for Health Strategy. Unfortunately, the Ministry of Health is yet to release the report, nor implemented any of the strategies. However, the USG Team will actively advocate for the implementation of key recommendations.

The USG, through the GHARP II project, continues to increase human and institutional capacity in HIV policy development. MARPS and other beneficiaries have been actively engaged in the program planning process. With respect to stigma and discrimination, members of the MARPs (MSM and CSW) are involved in developing policy documents and implementation plans, and are involved in sensitization workshops with health care facility staff, leading to more accepting attitudes towards MARPs. Through the PEPFAR-supported International Labor Organization (ILO), the GOG developed a national workplace HIV and AIDS policy in March 2009. In addition, the USG supported policies which led to the enactment of legislation to create a child protection agency.

Strategic Information

A major weakness in Guyana is the inability of public sector institutions to produce, analyze and disseminate timely information required to plan and implement effective health programs. Current practices support information gathering for reporting as opposed to robust analysis and use for guiding public health action. Concomitantly, data identifying challenges are met with skepticism and may not be used by public sector partners. The USG funded Guyana Demographic and Health Survey, the first to be implemented in the Caribbean, was completed in 2009. To date, however, the report has not been officially released to stakeholders for prioritizing health and other programs. The MOH/NAPS has the overall responsibility at the national level for data collection, management and analysis of the HIV/AIDS program. While this mandate is clear, the processes and systems to ensure effective management and coordination of health information system are fragmented. Challenges such as frequent staff changes and poor policies related to access and use of data makes it extremely difficult to have confidence in data quality. The process of defining strategic information needs is not well coordinated and routine surveillance requires further strengthening. Within the public and civil society sectors, limited data analysis and research capabilities also present obstacles to realizing a strong, functional HIV M&E system and overall health information system.

The USG Team will provide technical assistance to review the national strategic information plan taking into consideration resource availability and critical data needs for effective management of the local HIV/AIDS response. A key priority will be identifying what additional information is needed to improve the effectiveness and impact of current programming. The USG will provide funding and technical assistance for the implementation of behavioral surveys, including population size estimation, among MSM, CSWs, and miners. These findings will guide the refinement of the USG prevention strategy which shifted to a targeted MARP focus in FY11, and will allow for reprioritizing of resources to address programming gaps. To further strengthen the research and evaluation agenda, technical assistance will also be provided to support secondary data analyses to address additional data needs beyond reporting by stakeholders including program managers and MARPS population.

Strengthening the HIV surveillance system including antenatal HIV surveillance, as well as routine surveillance and improving regional outbreak investigation capabilities, are USG priorities. The USG will support the MOH in developing a multi-year national surveillance strategy and updating the Guyana HIV epidemiological profile. The USG will support implementation of recommendations from the PAHO and UNAIDS Modes of Transmission Study (MOTS) assessment. Support will focus on ensuring that routine surveillance for MARPs is improved. Support to NAPS for the supervision of the PMS and monitoring for early detection of drug resistance among patients on ART will continue. The USG will provide support for a round of ANC surveys in keeping with the recommendation of the prevention of mother-to-child transmission (PMTCT) data quality assessment conducted in FY10. This data will also be used with routine program data for calibrating prevalence estimates.

USG capacity building support to the government and civil society will continue to further enhance local capability to monitor and evaluate the HIV/AIDS response and strengthen data use capabilities beyond reporting. Efforts will also be made to enhance technical skills through implementation of M&E capacity building plans for HIV program managers and MOH M&E staff, and the implementation of data analysis and use training. Within civil society, the USG will support M&E capacity building within PEPFAR-funded NGOs and continue with the roll out of an electronic community-based information system which enhances organizations' ability to use information and report in a timely manner. In light of staffing challenges, innovative strategies will be developed to address capacity building for strengthen HIV program monitoring, evaluation and reporting within these organizations.

To better coordinate the U.S. agencies, under the direction of the PEPFAR Coordinator, the overall PEPFAR reporting responsibility will shift to a PEPFAR SI Specialist at the Embassy in FY12. A USG SI TWG will also be revitalized with participation of all agencies and greater involvement of the SI Liaison at the headquarters level for essential support and technical assistance. The USG team will continue to ensure that critical data is available and used to guide the USG portfolio review process. The USG will work in collaboration with the MOH to support the development of the National HIV M&E Plan and targets for 2012-2020. This will ensure full integration of the PEPFAR indicators.

The MOH has worked with the USG and other stakeholders to draft a concept paper for the reorganization of the Health Management Information Systems (HMIS) to include an integrated health sector SI unit. To develop a more supportive environment for SI at all levels within the MOH, the USG will support capacity building to help staff better understand their M&E related responsibilities within HIV/AIDS programs. Specific emphasis will be placed on continuing to develop national and regional level M&E staff in areas such as data quality assurance, data analysis, data dissemination and use, strategic planning, supportive supervision, etc. Support will be provided to the MOH to enhance data quality through building data quality strategies and carrying out regular assessments. The USG will continue to provide TA to the NAPS M&E unit to improve HIV/AIDS M&E and health information systems, as well as for the establishment of its Strategic Information Unit/M&E and Planning Unit.

Service Delivery

USG efforts have been aimed at creating sustainable service delivery models and systems for quality HIV prevention, care, and treatment in Guyana. The service delivery mechanism links clinical treatment and care services with community-level civil society organization (CSO) care and support programs. The primary goal of the Guyana continuum of response (CoR) approach is to provide clients and their families with essential prevention, care and support, and treatment services, to reduce HIV transmission and disease progression and to maximize health outcomes. The CoR approach identifies populations at risk of acquiring HIV infection and following them throughout their lifetime, providing prevention and care and treatment services, as applicable. These strategies are defined locally based on community needs and epidemiologic data.. At the community level, education, counseling and testing will be provided and linked to care and treatment if infected with HIV. Similarly, MSM, people living with infectious diseases (PLWID), CSW, and other at-risk groups identified at the community level will be followed and assessed through the health system. These groups will be targeted for preventive services such as use of condoms, provider-initiated counseling and testing (PICT), as well as care and treatment as necessary.

The USG will work with NGO partners and the public and private sector health facilities to improve varying aspects of the HIV/AIDS service delivery system, including: improving the quality of counseling for HIV testing and counseling, prevention of mother-to-child transmission of HIV, antiretroviral treatment, improving retention and care for ART patients, increasing the use and effectiveness of treatment services, reducing medical transmission of HIV, strengthening the quality of laboratories, and basic care and support to people living with or affected by HIV/AIDS. The USG will work to increase early enrollment among pregnant women, especially those identified as HIV positive. New prevention strategies will also be implemented to effectively target MARPS, prevent new HIV infections among children and adults, increase the use and effectiveness of treatment services and reduce medical transmission of HIV.

Other initiatives will include the development and implementation of facility- and community-based client management models to improve the quality of life for HIV-infected patients and their families, as well as supporting the development of a national information system to collect data and improve capacity for monitoring and evaluating HIV care. The USG will continue to utilize a health systems approach and proven quality improvement methods to achieve rapid improvements in HIV/AIDS service delivery, uptake, and retention. National technical work groups (TWG) or committees for all of the HIV/AIDS service delivery areas convene regularly to review and address issues related to program implementation. The USG will continue to work through these existing structures to be able to address critical service delivery issues. As part of the overall health systems strengthening (HSS) approach, PEPFAR agencies and partners, will provide technical assistance to build the capacity of HIV TWGs at the national level to effectively achieve improved service delivery.

Human Resources for Health

Overall, there is a shortage of health care professionals in Guyana and a weak Human Resources Information System (HRIS). The health sector is challenged by external migration, poor wages and compensation, limited supervision and some poor working conditions. Additionally, staff performance reviews done at the regional level do link to the central level.
Given the importance of retaining health workers in order to sustain the delivery of HIV/AIDS and other critical services within the sector, there is a major GOG strategy focused on training new health care professionals. However, the GOG's inability to obtain central level data on date of hire, date of transfer, and training of current staff makes managing human resources for health (HRH) quite difficult. The GOG will need to operationalize its HRIS to improve health worker data collection and processing so that data can be used for decision-making. PEPFAR/Guyana continues to place an emphasis on HRH work. PEPFAR has supported numerous pre-service and in-service training programs for various categories of primary health care workers. Persons were trained in blood and injection safety, HIV, malaria, TB/HIV co-management, cervical cancer screening and treatment, provision of PMTCT services, leadership development management and supervision, provision of HIV counseling and testing, prevention of mother-to-child transmission, warehouse management systems, logistics management information systems, standard treatment guidelines, care and support services.

Through the USG, an MOH Human Resource Development Unit was established in 2007 to provide advice and direction on health human resource planning and development. Research was also conducted to better understand nurse migration patterns, including emigration, internal migration and immigration. These findings are expected to guide the development of sound policies related to local nursing training and efforts to keep trained nurses in country. In addition, an assessment of the training capacity of the nursing school and a revision of the professional nursing, nursing assistant and midwifery curricula were conducted. The findings of the assessment and revision of the curricula aim to improve training and the skills of nurses employed by the MOH.

It is also challenging to retain staff since better salaries, pension schemes and other benefits are available in developed countries and in the Caribbean and are good incentives to migrate. The salary levels of the private sector, generally higher than in the public sector, further complicate staffing issues. Unfortunately, the Ministry of Health does not have the financial capacity to compete with salary levels in other countries or the private sector, and as such, have considered other kinds of incentives such as allocation of land for housing to recruit and retain nursing staff. This initiative has commenced at one of the major hospitals and is expected to be rolled out to the remaining hospitals. In addition, persons who acquire tertiary education receive salary increases.

Another challenge is the approval, selection and hiring process for Guyana's public service employees, which is slow and complex. The process involves the Ministry or the Regional Democratic Council making the request, followed by the necessary approvals from the Public Service Ministry, the Public Service Commission and the Ministry of Finance. This activity may take six months to a year to complete. During the long delay the employee may only receive a student stipend though he/she is on the job. Apart from the complications in the system, the other challenge seems to be in the timing of the requests. Through the USG's support to PAHO in FY12, efforts will be made to work with the Health Sciences Education and the Human Resources Departments, as well as the Regional

Health Authorities to address this issue as part of the national Human Resources Plan, with the intention of retaining staff, of which 95% are women.

To facilitate planning for the future, the USG helped complete a national diagnosis of human resources which quantifies, by region, the current and future health staff needs, according to occupational competence. The USG also supported a gap analysis to establish staffing needs of the health system and a human resources plan was developed to ensure that health workers are available in sufficient numbers to deliver services outlined in the Package of Publicly Guaranteed Health Services.

In FY 2012, PAHO will support the Ministry of Health's Human Resources Development Unit to implement the Human Resources Plan and other activities that contribute to further developing the health workforce such as: training staff in use of the HRIS; developing a database for the general nursing council; developing a pre-service training database; and, developing staffing standards for selected health facilities to assist with training of health staff and the appropriate placement of heath care providers. Student nurses, MEDEX (medical extension workers/residents), nursing tutors, and other health workers will be supported to meet the demands of the health system, through activities which include integrating HIV topics into the pre-service and in-service MEDEX curricula, and implementing the clinical instructor project to build teaching capacity in nursing schools.; This activity will support the continuing dissemination of the Research Agenda which was developed in 2010 by the MOH and the University of Guyana, in collaboration with PAHO with funding from USAID. Health Research is a commitment for PAHO's Regional Goals for Human Resources for Health 2007-2015. Overall, this activity seeks to develop the MOH's human resources (nurses and MEDEX) and put into practice the recommendations from external evaluations carried out by PAHO/USAID in 2010.

The GHARP program will help the MOH to conduct an operations research study to assess appropriate staffing for PMTCT sites, determine roles and responsibilities and standardize job descriptions for nurses and midwives working in PMTCT; assist the MCH Unit prioritize where PMTCT services should be available, and identify programs or facilities where PMTCT can be integrated; and, include PMTCT as part of the MCH supervisory visits. Emphasis will be placed on supporting the development of innovative and flexible means to deliver health education and training to facilitate accelerated entry into the workforce, particularly for categories of health staff that are needed most. Strategies and activities will include: new technologies to deliver training online; decentralized organization of training; training of trainers in instructional methodologies; and accelerated training programs.

CDC will support the institutional capacity building of the University of Guyana medical school to strengthen pre-service education through professional development and training of faculty, and expansion of the post-graduate medical program with the implementation of a three-year Internal Medicine/Infectious Disease residency program. Additionally there will be development of a national in-service training and mentorship program with technical consultation from international experts to ensure practicing clinicians have the opportunity to improve their clinical skills and knowledge in the care and management of patients with HIV, TB and other opportunistic infections.

Laboratory Strengthening

In FY12, laboratory strengthening plans build on FY11 activities and will continue to rely on partners including CDC, MOH, the Association of Public Health Laboratories (APHL), and the American Society for Microbiology (ASM), to provide technical assistance and training on new laboratory diagnostic and screening technologies, quality assurance management, and accreditation of regional laboratories. Additionally, the USG supports strengthening laboratory services and infrastructure by providing technical, policy, human resources, equipment support for the National Public Health Reference Laboratory (NPHRL). The NPHRL performs all diagnostic and clinical monitoring functions for PEPFAR programs. The NPHRL also currently performs tests for TB and other OIs, Early Infant Diagnosis (EID) by DNA PCR, HIV and syphilis testing for ANC/PMTCT, and CD4 testing for all public sector care and treatment sites and two faith-based institutions.

In FY12/13, PEPFAR support to the MOH laboratory system will continue to align with the objectives of the

National Strategic Plans (NSP) for Medical Laboratories 2008-2012 and for 2012-2015. A priority is to support laboratory services required for the delivery of HIV care and treatment programs at the national and regional levels and to ensure that public sector laboratories are certified in compliance with the Health Facilities Licensing Act. Another key priority is to continue with the certification of public sector laboratories. By the end of FY12, it is anticipated that all regional hospital laboratories will be certified by the Guyana National Bureau of Standards (GNBS). In FY 12/13 MOH laboratories will continue to participate in international and local External Quality Assurance (EQA) programs. The USG will also support quality assurance managers at NPHRL to travel to regional/district laboratories and HTC sites to provide oversight, training and assessment of compliance with QA programs.

PEPFAR funds will be used to support procurement of reagents and consumables to conduct laboratory tests for the national HIV program, including control and proficiency testing. Continued technical assistance will be provided to improve quality management systems and ensure that new procedures are properly implemented. Training opportunities, attendance at conferences, and assignments to laboratory leadership positions are incentives for staff to remain within the public sector system. In FY12, USG will also support continuous improvements in human resources (e.g., training) to provide for staff capacity development and retention at NPHRL and regional hospital laboratories. This will ensure that an adequately trained laboratory workforce is available to provide quality laboratory services for HIV and other diseases of public health importance.

Health Efficiency and Financing

Guyana is at a crossroads as PEPFAR funding begins to decline and demand for HIV/AIDS services continues to increase. The USG remains the largest bilateral contributor to Guyana's HIV/AIDS response, accounting for approximately 65 percent of the total country budget. This funding supports not only direct service delivery, but technical assistance, capacity building, and institutional strengthening activities. The generous support of the U.S. Government's PEPFAR program in Guyana has enabled the country to make great strides in combating HIV/AIDS, however sustaining those accomplishments will be among the country's biggest challenges. The next several years will require that the PEPFAR Team dedicate time and resources to a dialogue on how to finance the program as it shifts from the USG to the GOG. While this is a great challenge, Guyana has an abundance of natural resources, a relatively small population, and, a significantly improved tax policy and collection system. In 2011 the country's economy grew at a rate of 5% and graduated to World Bank "Low Middle Income Country" status. However, there is a need to address how the government can begin to take on the funding responsibilities for the HIV/AIDS program whilst simultaneously improving efficiencies in the system that will support long term sustainability.

Policy discussions to be addressed in the next two years include procurement reform and performance-based financing. Support for the MMU, and reforms such as procurement policy will ensure that essential medical supplies are readily available at competitive prices. Addressing inefficiencies in public sector procurement systems has a significant impact on long term sustainability. Other important areas to explore include the introduction of user fees to generate revenues for services provided through public sector facilities such as the MMU. In addition, a process for prioritizing, developing, and managing reforms with stakeholder participation must also be defined. The utilization of financial and programmatic data to guide and improve efficiencies in the system is also important. Support to the MOH planning unit to conduct economic studies and develop recommendations for performance based financing needs to be examined. With a growing economy and increased capacity to collect taxes, the GOG is in unique position to realistically examine more sustainable health sector financing options.

While these policy actions will be gradual, there is a need to build capacity within the Ministry of Health (MOH) Planning Unit, and the new Health Policy Coordinating Committee chaired by the Minister of Health with participation of the Minister of Finance and other relevant parties, to collect data, develop analyses, and identify future revenue sources to support such policies in the medium and long term. These mechanisms will be responsible for managing the reform policy agenda and deliberating on the studies and reports to frame the policy dialogue which are required for the GOG to take full ownership of the fight against HIV/AIDS.

Over the past few years, the USG has conducted key assessments, including ART costing, HIV/AIDS Program Sustainability Analysis Tool (HAPSAT) and Health Sector assessments which have outlined a number of gaps and recommendations. Many of the findings focused on increasing the host country capacity to develop and implement sustainable and cost-effective national HIV/AIDS programs. Ongoing technical assistance and support will be provided to assist the GOG to assess the feasibility of the assessment results and to develop and implement strategies in support of the key recommendations.

While the goal is to build national government capacity and systems to assume complete financial, technical, and administrative ownership of the HIV/AIDS response, the USG will work to ensure that a model for the provision of a minimum package of services is developed and supported by the GOG.

Supply Chain Logistics

In 2008, the USG led the development of the first Strategic Plan for the current Supply Chain project in partnership with key MOH departments such as the Materials Management Unit (MMU), Food and Drug Department (FDD), NAPS and the Tuberculosis, Malaria and Management Information Systems Units. A review of the Strategic Plan was conducted in February 2011, and a number of activities were included to address the weaknesses identified in the first strategy. The MOH has taken ownership of the document and has integrated the recommendations from the strategic planning exercise into their work plan.

The USG also contributed to the development of the Global Fund Pharmaceutical Health Products Management country profile. This document identifies the strengths and weaknesses of the current national supply chain, and proposes an action plan to fill the gaps identified. At the last Joint Donors Meeting held in February 2011, the USG proposed drafting a Supply Chain Master Plan which would result in a robust supply chain and guarantee commodity security. More recently, the USG has engaged the MOH to obtain the Ministry's vision for the development of a national health supply chain master plan and is proposing to conduct this activity as part of its COP12 activities.

The USG has also provided training to MMU staff on topics such as quantification and forecasting, supply chain management, and warehouse operations. Capacity building activities also include mentoring, coaching and general supportive supervision. The trained staff now has the skills to manage their respective areas of responsibility, thereby furthering the emphasis placed by the USG on transitioning roles and responsibilities to the MOH. For example, an MOH staff person was seconded to the ARV warehouse to develop the MMU capacity to manage ARVs and HIV-related products to eventually assume responsibility for managing these products. In addition, persons were trained on quantifying needs for HIV/AIDS-related medicines (Quantimed) as members of a super-user group which will have responsibility for quantification and supply planning for the MOH programs.

The USG has consistently engaged donors such as UNFPA and PAHO to collaborate in supply chain areas of common interest to maximize the use of resources. The USG also facilitated donor coordination through the establishment of the Joint Donors Meeting which initially concentrated on procurement issues but has evolved to include all supply chain activities. However, the most outstanding effort in this regard is the multi-donor funding for a new MMU warehouse, involving, PEPFAR, Global Fund, World Bank and Inter-American Development Bank.

In an effort to improve the availability and use of information within the supply chain system for decision-making, the USG supports improved data capture and reporting at the central level through implementation of a management system for the warehouse. In addition, the national MOH Logistics Management Information System (LMIS) plan was developed and is being implemented in collaboration with UNFPA. This plan included activities to standardize record keeping, data capture, reporting and analysis in order to inform decision making at all levels.

Gender

For Guyana PEPFAR program in FY12, gender is a key priority area, and is mainstreamed in all activities. The

USG will encourage a gender balance in training programs, advocate for the hiring of more males as health care providers, implement activities to reduce gender-based violence, and promote integration of gender in all HIV/AIDS programs.

Guyana has not conducted any gender assessments and does not have any plans to do so. There is not a formal gender strategy. Although there are no full-time gender specialists on the USG Guyana team, all members of the team seek to integrate gender into their respective program areas. There are also focal points from CDC and USAID who provide guidance to USG implementing partners and interface with the PEPFAR Gender technical working group experts.

Gender issues are integrated into USG programming in a number of ways. For example, a PEPFAR-supported study of nurse migration was conducted in 2009 by PAHO. Study findings included poor work environment, low professional recognition, poor equipment and supplies, and high workloads, resulting in work-related stress. These difficult working conditions disproportionately affect women, as women comprise the majority of health care providers in Guyana, despite a transparent hiring process open to both males and females.
PEPFAR has supported numerous in-service training programs for various categories of primary health care workers. In FY11, over 1,500 health care providers, 98% of whom are women, were trained in AIDS disease management. The USG will continue to advocate for the inclusion of men in its training programs.

PEPFAR Guyana continues to incorporate gender-based violence (GBV) awareness and prevention into prevention programs and address male norms in Guyana that might lead to high-risk behavior, detrimental attitudes and behavior towards women and girls, and gender-based violence. The USG also collaborates with a local NGO for linking and referring victims of violence to services, including Post Exposure Prophylaxis (PEP) for HIV in clinical settings.

In FY10, the Guyana PEPFAR team received funds through the Gender Challenge Fund to implement a project to counter GBV. The USG will build on its current activities with boys and men to address this issue in FY12. Activities will be carried out in health settings, faith-based organizations, schools, workplaces and places in the communities where men congregate, to change attitudes of men and boys towards sex and violence, and also to empower women to take charge of their reproductive health and decision-making. Prevention efforts will seek to empower women and counter the attitudes, beliefs and values among boys and men that condone partner violence as "normal," as well as address alcohol use which is a risk factor for violence, through community outreach activities, parent-teachers associations and work-place programs. Alternative ways to address conflict and managing anger will also be key in addressing violence against women. Health care providers will be trained to recognize gender-based violence, treat, if necessary, and make the appropriate referrals.

With the focus on sustainability and country ownership, technical assistance will be provided to the Maternal and Child Health Department to integrate PMTCT into MCH and HIV/AIDS into primary care. Approaches involving men as partners, activities to reduce gender inequities in care and treatment, detection of gender-based violence as well as stigma and discrimination, will be incorporated in all levels of the health care system. Emphasis will also be placed on activities to reduce stigma and discrimination towards MSM.
The USG has supported the development of policies focused on eliminating workplace gender violence and discrimination by Ministry of Labor, resulting in the National HIV and AIDS Workplace Policy developed in 2009. This document provides the policy framework for the HIV workplace response in Guyana and includes "gender equality" as one of the policy principles. Monitoring and enforcement of the policy is done by the Labor Occupational Safety and Health (LOSH) Department. In FY12, the USDOL through the ILO will provide capacity building to the LOSH Officers to ensure greater "AIDS Competence" including paying more attention to the reduction of gender violence and discrimination.

The USG considers the Ministry of Human Services and Social Security (MOHSSS) and the Men's Affairs Bureau (MAB) as key partners in its efforts to counter GBV. The MOHSSS is the lead agency addressing gender-based violence in Guyana and established a Domestic Violence Policy Unit in 2010. This unit promotes law reforms,

provides support services for victims of violence through a crisis center and shelter, and supports training for police. In March 2011, MOHSSS launched the MAB to address the tensions between men and women and reduce and ultimately eliminate GBV. Through the Gender Challenge Fund, the USG will support these agencies and strengthen coordination between the MOH and the MOHSSS. Strategies will be developed at a workshop for all stakeholders scheduled for mid-March 2012. A major focus of the program will be the integration of gender at all levels of the health care system by infusing this topic in all in-service training programs.

Technical Area: Management and Operations

Budget Code	Budget Code Planned Amount	On Hold Amount
HVMS	1,761,076	0
Total Technical Area Planned Funding:	**1,761,076**	**0**

Summary:
(No data provided.)

Technical Area: Prevention

Budget Code	Budget Code Planned Amount	On Hold Amount
CIRC	13,233	0
HMBL	157,419	0
HMIN	19,733	0
HVAB	0	0
HVCT	611,362	0
HVOP	860,792	0
IDUP	12,233	
MTCT	193,696	0
Total Technical Area Planned Funding:	**1,868,468**	**0**

Summary:
Overview of HIV/AIDS Epidemic in Guyana

The activities in prevention fall under Guyana's National HIV/AIDS Strategy (2007-2011) and complement the 2010 Guyana National HIV Prevention Principles, Standards and Guidelines of the Ministry of Health (MOH), the HIV/AIDS Behavior Change Communication Strategy for Guyana 2006-2010, the National Strategic Plan for Blood Safety 2006-2010, the National HIV and AIDS Workplace Policy and other related strategies and policies. This TAN for Prevention is intended to align PEPFAR prevention activities with Guyana's national priorities and strives to ensure that US Government (USG) contributions to the national HIV response reflect the needs of the host country.

Analysis of the available epidemiological evidence suggests that the HIV prevalence in Guyana has decreased among the general population over the last six years. At the end of 2009, UNAIDS estimated the adult HIV

prevalence at 1.2% (range 0.5%-1.9%) with approximately 5,900 persons living with HIV. Since 2002, the proportion of deaths attributed to AIDS has progressively decreased from 9.5% to 4.8% at the end of 2008. The number of AIDS-related deaths has also declined for the same period from 475 to 239 (MOH Statistics Unit). Information for 2009 is preliminary and unavailable for 2010. At the inception of the epidemic, more males were being diagnosed with HIV and AIDS compared to females. This scenario changed in 2003 with the male to female ratio shifting from 1.1 in 2002 to 0.9 in 2003. That trend was maintained until 2009, when, for the first time in six years, more males tested HIV positive, with a male to female ratio of 1.1 (National AIDS Program Secretariat Annual Report, 2010).

According to the NAPS 2010 report, the majority of the HIV cases occur in the 20-49 age group, accounting for 81% (842/1,039) of all cases, a slight increase over the percentage reported in 2009 (80.5%). There were notable increases among the age 15-19, 20-24, and 30-34 age groups in 2010. With regard to the regional distribution of HIV cases against the population of the regions, Region 4 (Georgetown) remains the region that is disproportionately affected by the epidemic, with 41.3% of the population but 71.5% of the cases in 2010.

The local HIV/AIDS epidemic is just above the minimum threshold of a generalized epidemic; however, it is known that several sub-populations have much higher prevalence rates. These most-at-risk populations (MARPs) include men who have sex with men (19.4%) and commercial sex workers (CSW, 16.6 %). Biological and behavioral surveys also identified high prevalence rates among other vulnerable populations (OVPs). These include: miners (4.0%), security guards (2.7%), and prisoners (5.24%). The HIV positivity rate in donated blood did not change significantly between 2009 and 2010, but there has been a significant decline since mid-2000, which possibly is related to an increase in voluntary, non-remunerated donors. In 2011, the MOH reported, among women attend ANC and labor and delivery services at prevention of mother-to-child-transmission (PMTCT) sites in the last twelve months, (81.4%) were tested for HIV and knew their results. However, there are significant needs for data quality and surveillance system improvement. In 2010 Data Quality Assessment (DQA) for ANC and PMTCT register showed that there were no standardized ANC register and low level of completeness and legibility of register information that are critical for strategic planning. A pilot study conducted at three treatment facilities indicated that current case surveillance system captured fewer number of HIV/AIDS cases. The matching rate of case abstracted and cases reported was 13%.

There are a number of other populations also considered at higher risk, however prevalence data for these populations is not currently available. These include out-of-school youth, in-school youth, migrant populations, mini bus drivers and conductors, police and military. The MOH will seek support from the Global Fund (GF) to address this data gap. Risk-taking behavior among female sex workers (FSWs) and men who have sex with men (MSM) may also affect levels of heterosexual transmission, since many MSM (65.4%) also indicate having female sexual partners and 62.7% of FSWs have regular steady partners.

Guyana employs thousands of men in hundreds of mines in remote interior regions. A survey conducted among gold and diamond miners revealed that less than half (47%) were married or were living together in a heterosexual relationship. Fifty percent were migrant workers. Eighty-nine percent reported sexual activity in the last year. Fifty percent reported having had sex with only one partner, and 15% had had sex with commercial sex partners.

Collectively, the best available data identifies sex workers and their clients, MSM, and other vulnerable populations such as miners, as most at risk for HIV. Together with persons living with HIV, and TB and sexually transmitted infection (STI) patients, these persons must continue to be the main focus for targeted interventions.

Accomplishments since Last COP

Over the past year, sexual prevention has concentrated on working more effectively with MARPs and OVPs to improve access and availability to HIV prevention products and services. The program reached over 12,000 individuals from high-risk populations, including MSM and CSW with HIV prevention services; trained over 100 health workers on preventing stigma, discrimination and gender-based violence (GBV); provided job readiness

training to FSWs; trained MSM, sex workers and military personnel as peer educators; developed and trained USG-supported NGOs on the Positive Health, Dignity and Prevention (PHDP) training manuals; developed and adopted tools for monitoring, evaluation and quality assurance of MARP program components; worked with the health sector on the development of a stigma and discrimination policy document for patients accessing services; reviewed and established draft prevention guidelines for USG-supported NGOs, and developed job aides for care providers. Through strategic collaboration with the Gold and Diamond Miners Association and the Guyana Forestry Commission, over 2,500 miners and loggers were reached with services.

The retail network of branded condoms expanded to 1,070 non-traditional outlets, including nightclubs, brothels and bars, which are open in the evenings when most traditional outlets are closed. Three local private sector companies have absorbed 51% of the 1,070 non-traditional retail outlets previously targeted with USG support. All of the outlets will be transitioned fully to private sector support by March 2012.

In youth prevention activities, two Health and Family Life Education (HFLE) workshops were held to follow-up on the HFLE training of trainers' workshop. These workshops are part of the capacity building support to transition youth prevention activities to the GOG in FY12. In addition, life skills interventions through NGO partners, regional and local health care facilities in both coastal and interior locations were provided to adolescent youth, young men and women.

With regards to HIV Testing and Counseling (HTC), the USG supported routine HTC in various settings, including ANC and traditional VCT sites. Support was provided for the procurement of Rapid Test Kits and other HIV testing consumables. Heightened patient education, community mobilization and sensitization on HIV increased the demand for HTC services among priority groups and within underserved areas, with 44,989 persons tested, including 10,977 pregnant women. The USG supported the implementation of the national week of testing and couples testing activities aimed at promoting universal access and the development of a tool (VCTQUAL) to monitor VCT implementation. Revisions were made to the case navigation protocol to get HIV-positive people into treatment and care as well as the care and treatment curriculum to include updates from the recently revised PMTCT and home-based care (HBC) national guidelines.

Successes in PMTCT included the roll out of the revised national PMTCT guidelines to contain infant feeding, eligibility for HAART and early infant diagnosis. Health care providers within the Maternal Child Health (MCH) department were trained on its use. Over 13,000 pregnant women accessed PMTCT services, and approximately 84% were tested for HIV and received their results. Just over 70% of the women identified as HIV positive received ART. During the period under review, specific emphasis was placed on strengthening follow up supportive care for HIV positive pregnant women. Significant strides were also made in formalizing the PHDP program within community-based settings.

As of September 2011, health care providers at 32 ANCs were trained on dry blood spot (DBS) testing. Program data from January to June 2011 indicated that 44 (61%) HIV exposed infants were tested by PCR by two months of age. Besides HIV testing, HIV exposed infants should receive cotrimoxazole (CTX) prophylaxis by 6 weeks of age until diagnosed as HIV negative. Program information from January to June 2011 suggested 61 (85%) HIV exposed infants received the drug by six weeks after birth. In order to reduce MTCT through breastfeeding, USG funded the breast milk substitute provided by MOH. In FY 2012procurement of this commodity will be transitioned to the MOH. Priority will be given to improve the receipt of DBS tests and CTX prophylaxis for HIV-Exposed infants.

An estimated 14,716 employees (10,999 males and 3,717 females) were reached with HIV/AIDS programs within the workplace. Almost 2,000 male workers participated in gender sensitization training for HIV/AIDS. GBV continues to be a major issue nationally and will be further addressed with the implementation of the Gender Challenge Fund (GCF) in FY12.

Key Priorities and Major Goals for Next Two Years

Following the Guyana Prevention Assessment in February 2010, the USG interagency team worked to align activities and implement the technical team's recommendations, particularly in the prioritization of activities for MARPs and OVP. Additionally, planning and implementation of strategies to transition mature prevention activities to the MOH, GF, and other stakeholders is underway and will intensify during the year. In FY12/13, the USG prevention approach will focus on evidence-based approaches and combination prevention strategies. The USG Team will increase prevention programs to reduce new infection and further decrease the cost of care and management of persons living with HIV/AIDS. Activities include expanding programs that aim to reduce HIV prevalence within MARPs and OVP, who are disproportionately affected with high prevalence levels, strengthening PMTCT activities, continuing to support the safe blood program, increasing access to VCT for high risk-groups, collecting and reviewing qualitative data on high risk populations and improving prevention activities for PLHIV.

Most-at-risk-populations

With epidemiological and behavioral data suggesting concentrated epidemics among MARPs and OVP relative to the general population, prevention efforts targeting these groups will occupy an increasingly critical focus for PEPFAR in Guyana over the next two years.

The USG prevention program will build on current platforms for successfully reaching key MARPs, incorporate innovative approaches to increase access and remove barriers to services, and replicate and expand proven prevention models for MARPs. In keeping with PEPFAR guidance, the minimum package of services will continue to be offered to both MSM and FSWs by USG-supported NGOs. These services are accessible when public sector sites are closed and include: peer education and outreach to locations considered "hot spots", risk reduction counseling, condom and lubricant promotion and distribution, HTC, STI screening and treatment, referrals to HIV care and treatment, including PMTCT, referrals to mental health and substance abuse treatment services, and linkages to other health, social, economic and legal services.

Though prevention efforts are tailored to reach MARPs and OVP, challenges exist. These include difficulty in assessing coverage since the size of the MARPs population is unknown; poor linkages with STI services; minimal monitoring of service referrals; poor evaluation of service delivery quality; ad hoc systems for reaching and sustaining access to remote areas; and, a limited supply of lubricants and female condoms. Policy issues such as stigma and discrimination and unsupportive legislation for MARPs also remain a major challenge. Attitudes such as stigma-induced, HIV-related discrimination and social hostility discourage MSM from seeking testing or treatment, accurately reporting how they may have contracted HIV, and sharing their status with sexual partners. Moreover, these factors distort the limited data available on MSM and HIV and can accelerate HIV transmission within the community and contribute to generalizing the epidemic.

Emphasis will be placed on: reducing stigma and discrimination, completing the MARPs size estimation survey, developing stronger linkages with the national STI program to ensure future transition, including strengthening linkages between STI facilities and CSO programs, developing a quality assessment/quality improvement system to monitor critical elements of the program, especially related to referrals to HIV treatment, care and support services, STI diagnosis and treatment services and enhancing and building on activities to address stigma and discrimination previously conducted at health facilities and in the wider community. Programs will also ensure participation of target MARP and other vulnerable groups in the development, implementation, and monitoring of prevention programs. The USG will work to develop and implement a standardized prevention curriculum for MARP groups. Assistance will also be provided to develop a system to measure and improve service delivery.

There are encouraging steps at the national level to develop an enabling environment for HIV prevention with MARPs. In particular, the MOH has developed a stigma and discrimination policy for health care facilities with USG support. This work could be expanded to establish a more supportive and enabling environment for MARPs in society. Building upon this initiative, there are opportunities for the MOH and other ministries, as well as civil society stakeholders, to work together on complex issues such as stigma and laws/policies that affect MARPs, such

as laws criminalizing homosexuality, along with the development of a national MARPs strategy. The USG will continue to provide technical assistance (TA) to civil society partners and the MOH to improve the effectiveness of efforts to contain and reverse the spread of HIV among MARPs and ensure adequate delivery of services. Strategies and activities will be tailored and delivered as a package to address the needs of MARPs, with interventions designed in a manner that addresses and fits the groups' special needs, risks, and behaviors.

The USG advocates for supportive policies by working both with MARPs and staff within health care facilities where MARPs access care and treatment. This provides an opportunity for MSM and CSWs to voice their experience and concerns and led to the drafting of a policy statement against stigma and discrimination for treatment sites. The USG will continue to advocate for the removal of structural barriers to HIV prevention, such as clinical contexts where MARPs feel unwelcome, and assist the MOH in the development and implementation of a national MARPs strategy, as well as a review of the law that criminalizes homosexuality. The USG will support legislative, regulatory and policy changes to reduce stigma and discrimination, especially focused on enabling populations at elevated risk of infection to access and use HIV prevention-related services without discrimination or loss of confidentiality.

Structural interventions that address factors such as gender inequality, poverty, socio-cultural norms, stigma and discrimination will also be intensified to address the reduction of vulnerability factors that impair the ability of individuals and communities to avoid HIV infection. The USG will continue to enhance the capacity of service providers to address MARP clients. Prevention programs will be encouraged to systematically mainstream gender, including integration in health sector policies and programs.

As part of inter linkages across the HIV/AIDS program, the USG will work with private and public sector partners to leverage support for training opportunities for MARPs and provide income-generating activity (IGA) support to vulnerable women. Programs will also work to establish formal linkages with the Ministry of Human Services and other public sector agencies to integrate HIV/AIDS services within social safety-net programs.

HIV Testing and Counseling

Counseling and testing (C&T) activities during FY2012/13 will increase access to HCT services for most-at risk populations, particularly MSM, CSWs and their clients, other vulnerable populations (miners, loggers and the military), and men. HTC for the general population will be led by the MOH. The main priorities of the USG HTC program will be to sustain expansion of services, particularly to the hinterland areas and chronic disease clinics, through training of counselor/testers to improve the quality of pre- and post-test counseling; assessing provider-initiated testing and counseling (PITC) within clinical facilities, strengthening the referral and case navigation systems and streamlining the mobile unit outreach. MSM and CSW peer educators within USG-supported NGOs will mobilize their peers to access C&T services at either NGO or MOH sites. Persons testing positive at NGO sites are enrolled in the care and support program and referred or accompanied to the clinical site, and vice versa. However, the number of HIV-positive clients identified remains higher than those entering the care and treatment program. USG will strengthen the case navigation system to ensure that persons identified as HIV+ are guided into the care and treatment program. The referral and follow-up system within and between public and NGO service points will be strengthened to ensure that all HIV-positive clients are enrolled early within care and treatment programs.

Community organizations will provide mobile services to hinterland areas in Regions 7 and 8 where the largest mining and timber industry sites are located and will link those in need of care to the regional health care facility for follow up. A mobile testing schedule for remote/priority areas will be developed through linkages with the private sector, such as the Guyana Geology and Mines and the Guyana Forestry Commission or other health services.

The MOH will maintain provider-initiated HTC at sites delivering diagnosis and treatment of tuberculosis (TB) and STIs. The USG will assess the extent to which provider-initiated testing and counseling is being implemented,

barriers to implementation, and determine what additional training and capacity building is needed in these clinics.

The USG will also continue education activities with health care providers and MOH auxiliary staff to combat stigma and discrimination, particularly towards MARPs, as well as advocate for the revision of legislation to address access to services among MARPs.

Partner counseling will continue to be promoted in FY 2012 in an effort to increase the number of males who access C&T, reduce transmission between sero-discordant couples, and encourage faithfulness in concordant negative couples.

The USG FY12/13 strategy includes strengthening the capacity of health care providers to deliver high quality and comprehensive counseling and testing services. Support for training of counselor/testers will continue in order to improve the quality of pre- and post-test counseling as part of HTC service delivery. USG will work with MOH/NAPS to review national eligibility and competencies for counselors and testers, enhance supportive supervision systems and processes for monitoring persons trained, and advocate for changing the HIV testing algorithms.

USG efforts to improve quality assurance of testing services at sites will include implementation of the recently developed VCT quality tool, revision of data collection tools and systems for monitoring MARPs tested at the community level, development and piloting of QA/QI systems at NGO sites and expansion to high volume public facilities.

The USG will support the MOH to lead the quality assurance programs to track rapid testing proficiency and training needs. Consistent with our focus on targeted testing for most-at-risk populations, the USG will no longer support mass testing in FY12/13.

Commodities management, procurement, and storage of test kits and related supplies will be implemented by the Supply Chain Management System (SCMS) project and overseen by the MOH Materials Management Unit (MMU). The USG expects to transition this area to the MOH in 2013.

Through these activities, the HTC program will try to address its major challenges, including the use of the exiting parallel testing algorithm, limited scope of counselor/tester counseling skills that inhibit them from providing comprehensive counseling to clients, limited testing among "high risk" and priority groups, including MSM, CSW, miners, loggers, and partners of PLHIV; poor referrals and follow-up among HIV-positive clients; poor coverage and coordination to remote and geographically-isolated locations; low uptake among men; and the absence of a quality assessment/quality improvement (QA/QI) system.

Condoms

The USG condom strategy will focus on increasing targeted demand and access to condoms among MARPs and other vulnerable populations at non-traditional retail outlets (nightclubs, brothels, and bars) at convenient operating hours. To ensure a sustainable country-led condom program, TA will be provided to improve supply and logistics within both the public and private sector for the distribution of condoms (free and branded). USG partners will work with national stakeholders to develop a national policy and distribution strategy for condoms.

Condoms are currently available at public, private sector facilities and through civil society organizations (CSOs). Condom distribution within the public sector occurs within sexual and reproductive health programs and HIV prevention programs. Within CSO programs, condoms are distributed to high-risk groups and the general population as part of a comprehensive array of product and services for HIV prevention outreach programs. Distribution by the public sector totaled 4,443,228 pieces in 2010 and represented 91% of all condoms distributed for the year. Despite significant success in making condoms available, the DHS 2009 reported low levels of condom use, with only 48 percent of women and 65 percent of men reported using a condom at their last sex act. Female

condoms are also available at the MOH through support from UNFPA.

PMTCT

Key priorities for the PMTCT program include: improving the linkage between PMTCT and HIV care and treatment sites; expanding the scope of practice of the nurse-midwives so that ARVs and cotrimoxazole (CTX) can be prescribed at the ANC; improving the tracking of mother-infant pairs; improving the quality of the data; improving the receipt of Dry Blood Spot (DBS) test and CTX prophylaxis for HIV-exposed infants by two months of age; couples testing and counseling; improving partner disclosure; and, strengthening integration with family planning.

Guyana has achieved high coverage and acceptance of HIV testing among the ANC population over the years, and services were extended to the labor and delivery wards to ensure timely administration of ARV to reduce mother-to-child transmission. PEPFAR data suggest, however, that linkages between testing and treatment need improvement. Most ANC sites that offer PMTCT services do not provide HIV treatment. Poor linkages between the ANC and care and treatment facilities contribute to the low proportion of treatment and lost opportunities to reduce MTCT. In FY12, the program will develop a case management system to strengthen the referral and tracking of positive women and their HIV-exposed infants. As part of this system, staff serving HIV-positive pregnant women will be in close communication with the care provider at HIV care and treatment facilities to ensure linkage to services. An open cohort of pregnant women identified/known to be HIV positive will be initiated when they enter antenatal care and followed through pregnancy, delivery and post-natal period until the infant reaches 18 months of age.

PEPFAR-supported NGOs will work within their communities to encourage early antenatal enrollment. They will also work with high volume sites to navigate HIV-positive women identified through ANC into care and support at NGO sites. In addition, they will follow up with mothers post-delivery to ensure that mother and exposed infant are taking their medication, keeping monthly clinic appointments and that the infant is enrolled in ongoing care and treatment programs, as appropriate. Partner testing will also be emphasized. Data with regards to services provided to HIV-positive women and their exposed infants will be obtained through the case-based reporting system to allow better monitoring of the program at various levels.

The PMTCT program has been incorporated into the existing structure of the MCH. While most services and activities were integrated with antenatal, delivery and post-natal care, the administration, training, staffing and reporting have not yet been aligned with MCH systems. In order to ensure full integration and to hasten the future transition of all PMTCT program areas to the MOH, support will be provided to integrate administration, training, reporting and staffing with general MCH practice. In FY12, USG will coordinate with MCH to implement a PMTCT element as part of the national program's supervisory visits to enhance MOH administrative support. Data quality assurance will be included in the current supervision structure through the MCH Department with the revision of the MCH supervisory tool.

Currently PMTCT training is provided as a stand-alone course for new practitioners and as refresher training for current health providers. This training will be integrated with the regional Safe Motherhood training.

Monitoring of data quality and verification has not been a routine practice in PMTCT, and discrepancies are not uncommon. In collaboration with MCH, the USG will develop a plan to include data quality assurance in routine monitoring of program performance in order to improve program data as well as provide training and supportive supervision. This program will be transitioned to the MOH in 2013.

A major challenge of the program is staff retention. To support the paucity of human resources, the USG is currently funding staff positions at PMTCT sites. Over the next two years, the USG will work with the GOG to transition this staff to the MOH. In addition, a human resource strategy will be developed to propose long-term solutions to retaining skilled health care workers. Support will also be provided to assess the appropriate staffing for PMTCT sites. Focus will be placed on task-shifting. Currently, a general PMTCT module has been included in the nursing

training and as part of family planning counseling. Additional components will be integrated to enable nurses to perform PITC and also to expand the scope of practice of the nurse-midwives so that ARVs and CTX can be prescribed at the ANC. ANCs are staffed by midwives who do not have authority to prescribe ARVs. A priority will be encouraging couples testing through PITC and disclosure.

Voluntary Medical Male Circumcision

The male circumcision program is currently being implemented on a small scale by the Department of Defense and is not a major focus of the USG as the current scientific literature does not point to use of this prevention method for non-generalized epidemics.

Positive Health Dignity and Prevention

Prevention with PLHIV is part of The Guyana National HIV Prevention-Principles, Standards and Guidelines 2010-2020, which states "HIV prevention encompasses positive health and dignity". In FY11, Positive Health, Dignity and Prevention (PHDP), formerly the Prevention with Positives Program, was developed and integrated within NGO and public sector care and support programs. The aim is to reduce the number of new infections; increase the number of people who know their HIV status; and increase the number of PLHIV who receive appropriate prevention, care, and treatment services to improve their quality of life.

The care and support NGOs provide a full range of services for PLHIV: risk reduction counseling, condom promotion and distribution, partner testing, adherence counseling, referrals for family planning/safer pregnancy counseling and for STI testing and treatment; alcohol use assessment and counseling on reduction or abstinence; peer support activities and development and support of client-driven goals. The PHDP program also provides physical psychosocial and social support services. Additional services include one-on-one and group counseling, provided by social workers. Discordant couples are offered risk reduction counseling via care sites and other support services. Referrals for clinical services, including to family planning services and on-going counseling, are made based on need. PLHIV are also referred for home-based care as the need arises. Challenges to PHDP include weak linkages to public sector services as part of a comprehensive package of care such as STI and cervical cancer screening and treatment. A priority this year will thus be to strengthen the bi-directional linkages and referrals. PHDP activities will also be strengthened through TA to build the capacity of NGO staff at the community level and the MOH health care staff to provide PHDP services at care and treatment sites through training, sensitization and exposure to PHDP job aides, and the creation of behavior change communication (BCC) tools, such as posters and infomercials targeting both PLHIV and service providers.

General Population

Guyana's PEPFAR program employs a combination prevention approach through behavioral, structural and biomedical interventions specific to Guyana's context. In line with the epidemiologic profile of HIV/AIDS in Guyana, the USG prevention program has gradually shifted to provide a balanced portfolio that focuses on MARPs and OVP. At the end of FY11, the in-school youth program was transitioned to the Ministry of Education (MOE) Health and Family Life Education Program with support from the MOH/Adolescent Health and Wellness Unit. The USG's partnership agreement with the MOE will continue to focus on curriculum strengthening, replicating effective behavior change programs, incorporating evaluation methodologies, and assisting in implementation of the national in-school youth program through volunteer placements at the ministry, departmental and school levels.

Engagement of the private sector will continue through workplace prevention programs. The workplace program will continue to advocate for integrating HIV/AIDS into all health promotion activities at the tri-partite (the Ministry of Labor, private sector, and trades unions), and business place levels. Activities will also include the development, review and revision of the HIV/AIDS workplace policy and workplace programs at fifteen workplaces. An assessment of the programs conducted in August 2011 indicated the need for additional support in the revision and further strengthening of programs to ensure sustainability. A competence-based training for Labour,

Occupational and Safety (LOSH) Officers from the Ministry of Labour will also be conducted.

Health Systems Strengthening/Human Resources for Health (HSS/HRH)

Greater emphasis will be placed on projections of the health workforce availability for HIV/AIDS and the government's ability to absorb the costs of PEPFAR-supported health care workers. In addition, current staff migration will be addressed through the establishment of an MPH program to be piloted in 2013 as an incentive for upward mobility in the health sector. As part of the transition process of activities to the GOG, integration and coordination of HIV/AIDS programs into broader health care services, coupled with joint supply chain management of HIV and non-HIV commodities, will be strategically examined to offer a comprehensive, cost effective and holistic approach to transferring activities. TA to the PEPFAR-supported NGOs will continue to be provided for the development of sustainability plans, skills in proposal writing, as well as a roadmap (including research on funders).

Medical Transmission (Blood Safety)

Blood collection and storage is currently performed at six public sites and six private hospitals in Guyana. The six private hospitals access their blood directly from the National Blood Transfusion Service (NBTS). All of the blood collected by public sites is tested at the NBTS laboratory in the capital or at the National Public Health Reference Laboratory (NPHRL). Based on WHO estimates, Guyana requires approximately 15,000 units of blood per year. In 2006, voluntary, non-remunerated donors contributed approximately 32% of 5,192 units collected. The remaining units were collected from family/replacement; blood supplies with a preponderance of non-paid, voluntary donors are associated with significantly lower rates of transfusion-transmitted infections (TTI). The focus of the program is to achieve 100% voluntary, non-remunerated blood donations. With PEPFAR's support there has been a steady increase in total blood collected during the 2004-2010 period, from a total of 2,400 blood units collected /20%voluntary blood donation in 2004 to 7,700 blood units collected /80%voluntary blood donation in 2010. There has also been an increase in the number of voluntary, non-remunerated blood donations with a concurrent decrease in the number of family/replacement blood donations. The USG will continue to support donor recruitment, blood collection, testing of donated units for TTIAs component preparation and storage and distribution, but will work diligently with the MOH to develop a transition plan that will be implemented over the next two years.

Injection Safety: The Guyana Safe Injection Project promotes and increases prevention actions against infections and the use of control practices in health care settings. This includes the prevention of biomedical transmission of HIV and other blood borne pathogens, such as Hepatitis B and Hepatitis C, due to unsafe injections. Activities focus on decreasing the risks encountered in health care settings by promoting universal precautions and appropriate health care waste management. Systems ensure safety of health care workers, laboratory professionals, phlebotomists, patients and the community from the point of care to final disposal of infectious and sharps (needle) waste. Bio-safety, universal precautions and medical waste management practices are being integrated into existing medical care facilities, including HIV/AIDS care and treatment, prevention, counseling and testing and laboratory programs.

The project is focused on ensuring that systems, skills and people are in place to enable a transfer of ownership of injection safety knowledge, practices, and systems to national institutions. Thus, the Safe Injection project works collaboratively with the MOH and other partners on all components of the project. MOH has taken responsibility for all training activities while the project staff performs a coaching and mentoring role. Ongoing discussions are held with the Minister of Health so that the procurement of safety equipment can be included in the national budget. A wide cross-section of persons will be trained to maintain the incinerators constructed through collaboration with the Humanitarian Assistance Project (HAP). The focus is to ensure that injection safety-related activities are integrated into ongoing MOH and health care facility service delivery. This project ends in September 2012.

Gender

All prevention programs geared toward men and boys incorporate and address male norms in Guyana that might lead to high-risk behavior, detrimental attitudes and behavior towards women and girls, and GBV. Through the gender-based violence matching grant from OGAC, activities will be carried out in health settings, faith-based organizations, schools, workplaces and places in communities where men congregate, to change the attitudes of men and boys towards sex and violence, and empower women to take charge of their reproductive health and decision-making.

USG will continue to work with the Guyana Defense Force, emphasizing male norms and associated high-risk behavior in addition to GBV. Through the ILO program, GBV prevention activities will comprise a major component of the workplace program. As part of the overall implementation, assessments will be conducted to evaluate the effectiveness of these programs.

Addressing harmful practices, gender inequality and GBV will also be strengthened within existing prevention approaches for MARPS. Condoms will be strategically placed at the non-traditional retail outlets (nightclubs, brothels, and bars) for male high-risk groups, including MSM, miners and loggers, and male and female sex workers and their clients. Activities during FY 2012/13 will also increase access to C&T services for MARPs, particularly MSM, sex workers and their clients, other vulnerable populations (miners, loggers and the military), and males to boost prevention efforts and to identify those who need treatment. Couples counseling will also continue to be emphasized in an effort to increase the number of males who access C&T, reduce transmission between sero¬-discordant couples, and encourage faithfulness in concordant negative couples.

Strategic Information

With a focus on MARP programming, there is a greater need for better data collection mechanisms and evidence-based interventions for MARPs. Collecting disaggregated data (by age, sex and other characteristics) on risky behaviors, delivery, and use of services among most-at-risk groups is crucial for informed program planning and policy decision-making. This data will improve the ability to prioritize budgeting and programming of services for MARPs. Currently, HIV prevention data is collected using a series of national program monitoring and reporting systems, which includes but is not necessarily limited to STI surveillance, CSO prevention outreach, and PMTCT and HTC programs. A major challenge with the system is the level of duplication among programs and the challenge of consolidating information across programs. To effectively address ongoing and emerging data needs, TA will be provided to local partners and stakeholders to review and revise existing routine HIV prevention program monitoring and surveillance systems. As mentioned in the SI section of the Governance and Systems TAN, support will also be provided to address data gaps related to size estimates and key risk and behavioral trends through the implementation of behavioral surveillance surveys.

USG will work with partners to develop simple systems and processes for assessing effectiveness, coverage and intensity of HIV activities for MARPs, including outreach sessions, HTC, STI screening and other service referrals. This will also involve process evaluation that will engage stakeholders, service providers and beneficiaries. Emphasis will also be placed on developing user-friendly informational products such as standardized program update presentation templates, HIV prevention newsletters and other reports to provide information and encourage dialogue on programmatic issues. The use of these tools will be integrated within the MOH HIV prevention Technical Working Group (TWG), which currently provides a means for providing feedback on HIV programming efforts. To further support the use of the data generated by the programs, HIV prevention program managers will be trained on data use for managing prevention programs as part of the capacity building efforts for program managers.

To ensure that high quality data is reported by partners, the USG will work with all stakeholders to standardize the curriculum for MARPs outreach and will work with partners to ensure that high quality data is collected and reported by all providers interacting with MARPs. Given the high mobility of MARPs, the USG will work with partners to develop comprehensive strategies to minimize double counting. Geographic zoning and targeting of hot spots, done successfully in FY11, will be continued in FY12 and beyond.

Capacity Building

As Guyana moves to a technical assistance model over the next two years, capacity building will play a larger role to ensure that key activities are transferred to GOG and local partners as systematically as possible. USG will continue to work with the MOH and local partners to build workforce capacity for the provision of quality health services. Currently, at the system level training for health care providers is conducted in leadership and development; the revised PMTCT guidelines; HTC counseling skills; stigma and discrimination reduction. At the community level, training is provided to the PEPFAR-supported NGOs (often in conjunction with staff from the National AIDS Program Secretariat), in areas such as stigma and discrimination reduction, HIV education and behavior change messages for MARPs, community mobilization, risk reduction counseling skills, GBV, alcohol use assessment and counseling on reduction or abstinence, in order to enhance their service delivery. Technical assistance is also provided to strengthen their administrative and financial management systems, and program monitoring and evaluation. With respect to individuals training is conducted in condom negotiation skills, dealing with self-stigma, job-readiness for female sex workers (FSWs), recognizing and addressing GBV.

In FY12/13, USG will continue to work with health care providers and auxiliary staff to reduce stigma and discrimination towards MARPS, particularly MSM; improve the quality of pre- and post-test counseling; develop a national policy and distribution for condoms in order to improve supply and logistics for the distribution of condoms; and improve data quality for PMTCT. The MOH will be encouraged to take responsibility for all training activities while the USG implementing partner (IPs) perform a coaching and mentoring role. USG support to community-based organizations will include all the above training; however, emphasis will be placed on training more MSM and CSW as peer educators. Given the shift to a limited technical assistance model, a focus will be placed on developing NGO capacity to implement training of new staff. Site visits will be conducted by the USG IP to observe application of skills and provide coaching and mentoring. All activities at the individual level mentioned above will continue in FY12/13.

The USG will also advocate for the establishment of a National Health Sector Transition Committee to assess policies, staff development initiatives, quality assurance and improvement and activities for sustaining essential HIV/AIDS programming that will guide the transition process, as USG resources become more concentrated on TA activities. This committee will be comprised of representatives from the GOG, private sector and matured civil society and faith-based organizations.

General Population

Youth will not be the main focus of the program in 2012 due to greater ownership by the MOE; however, Peace Corps will play a major role in strengthening the national in school and out-of-school program by replicating effective prevention programs and incorporating evaluation methodologies into prevention programs. The MOE is piloting a focused HIV/AIDS program in 20 schools with the support of Peace Corps Volunteers, which will evaluate current approaches and be used as the basis for formulating a national program for in-school youth population. The workplace program, implemented through the PEPFAR-supported ILO will continue over the next two years when it will be transitioned to the Ministry of Labor.

Technical Area: Treatment

Budget Code	Budget Code Planned Amount	On Hold Amount
HTXD	459,493	0
HTXS	606,866	0
PDTX	117,797	0

Total Technical Area Planned Funding:	**1,184,156**	**0**

Summary:

Adult Treatment

PEPFAR support has produced important accomplishments for improving access to HIV treatment in Guyana. HIV care and treatment services are delivered by the Ministry of Health (MOH) and faith-based organizations through a network of 15 treatment facilities, fixed sites that are located in the higher prevalence regions and staffed physicians in HIV treatment. Extension of the treatment program to remote geographical regions was enhanced by the mobile unit. The treatment service received a boost when the FXB, through PEPFAR support, trained and mentored a number of MEDEX (medical assistants) in the management of HIV. MEDEX are stationed in the hinterland regions and supportive supervision is provided by the HIV trained physician staffing the mobile unit. The national program was able to provide free-of-charge ARVs to all eligible patients. To help sustain these accomplishments, adult HIV/AIDS treatment has been increasingly transitioned from international NGOs to the MOH. Support for continued treatment is provided to the local faith-based organization PUSH at the St. Joseph's Mercy Hospital and Davis Memorial Hospital.

The National AIDS Programme Secretariat (NAPS) reports that 3,059 HIV-infected patients were enrolled in treatment services at the end of 2010. Slightly greater than 90% of those enrolled were adults, and approximately 55% were females. There has been a steady, annual increase in the numbers enrolled in ART although the rate of increase has declined since 2008. Approximately 10% of all ART patients are currently on 2nd line regiments. According to the National AIDS Program Secretariat/MOH Annual Report, at the end of 2010 4,213 persons (56% women, 44% men) were enrolled in the national HIV/AIDS care and treatment program with 27.4% (1154/4213) in care and 72.6% (3059/4213) receiving anti-retroviral treatment (ART). Of all persons in pre-ART care, 96% (1092/1154) were adults (60% women, 40% men). Of 3,059 persons receiving ART, 2882 (94.2%) were adults of which 55.2% (1690/3059) were females. For the past five years, there has been a progressive increase in the number of patients on ART: 1611 in 2006; 1965 in 2007; 2473 in 2008; 2832 in 2009; 3,059 in 2010, representing 21.9%, 25.8%, 14.5% and 8% increases respectively over the previous year. The number of clients placed on 2nd line ART also increased progressively over the past five years: 58 in 2006; 69 in 2007; 169 in 2008; 262 in 2009; 296 in 2010, representing annual increases of 3.6%, 3.5%, 6.8%, 9.3% and 9.7% respectively. In FY 2011, 3,181 adults received antiretroviral treatment (ART), with the majority of them being females. Through the prevention of mother-to-child HIV transmission (PMTCT) program, 144 HIV-positive pregnant women received ART to prevent infection of their infants.

A national cohort report revealed that the 12-month survivability of 580 persons initiating ART in 2009 was 80.7% (468/580). Overall survival rates are good but there are high fatality rates in those patients co-infected with TB/HIV. The USG will provide support for better integration of TB/HIV with more support for the three "I"s (Isoniazid Preventive Therapy, Infection Control and Intensified case finding).

There are many challenges with regards to providing access to quality HIV treatment services in Guyana. For example, many persons seek HIV care and treatment during the latter stages of the disease and are less likely to have favorable outcomes than if treatment was initiated earlier. This late presentation with high morbidity rates results in higher treatment cost when compared to persons presenting earlier for care and treatment. Another challenge is the retention of staff at treatment sites. Approximately 50% of the physicians trained and mentored by the implementing partner FXB are no longer in the HIV Care & Treatment service. Currently there is limited capacity for ongoing training and mentoring of MOH physicians.

Another challenge is that there is little or no supervision of physicians who provide HIV care and treatment services in the regions. In the higher prevalence areas, many clients have difficulty attending clinic appointments on a timely basis because of the distances that they have to travel and the cost of transportation. Treatment adherence is a

longstanding challenge and has to be constantly addressed through different ways.

PEPFAR supports a variety of activities to address these challenges. For example, PEPFAR funds support the University of Maryland School of Medicine/Institute of Human Virology to provide pre-service and in-service training in Infectious Diseases and post-graduate programs in Internal Medicine and Infectious Diseases at the University of Guyana for local physicians. Through this arrangement, training and mentoring of physicians will be strengthened. In addition, PEPFAR programming will enhance MOH capacity for clinical supervision and help explore options for further decentralization of treatment services in some geographic areas to improve client access.

With PEPFAR support, adult HIV treatment guidelines for Guyana were produced through an intense and rigorous revision process by key stakeholders. The "National Guidelines for Management of HIV-Infected and HIV-Exposed Adults and Children 2010-2011 Revision" were developed to reflect the recommendations in the 2010 WHO HIV treatment guidelines and were partially implemented through the national treatment program in July 2011. The first line regimen remains two Nucleoside Reverse Transcriptase Inhibitors (NRTI) and one Non-Nucleoside Reverse Transcriptase Inhibitor (NNRTI). The most frequently used and preferred first line regimen for HIV-naïve individuals is Tenofovir (TDF) + Emtricitabine (FTC) + Efavirenz (EFV). The new guidelines recognize the advantages of starting ART earlier (CD4 <350cells/mm3) and recommend that ART can be initiated at levels of CD4 >350cells/mm3. The new guidelines have thus improved access to ART for HIV-infected persons, allowing any sero-positive adult to be placed on ART, regardless of his/her WHO clinical stage. The guidelines recommend the same first line treatment regimen for PMTCT among HIV-positive pregnant women. This is a marked difference from the previous guidelines which recommended a regimen containing two NRTI's and a Protease Inhibitor (PI), Lopinavir/Ritonavir (LPV/r) for pregnant women. This PI is now reserved for the second line treatment regimen in Guyana. Another difference in the new guidelines is the availability of RNA viral load (VL) testing for laboratory monitoring in HIV infection. VL testing is performed six months after ART initiation and subsequently at six months intervals for adults and at the time of ART initiation and every subsequent six-month interval in children. Scale-up of VL testing, performed at the National Public Health Reference Laboratory, has been successful but poor transportation services are impeding the full implementation of the guidelines in most areas outside of Region 4. CD4 testing is already decentralized to three regional laboratories. The MOH is in the process of acquiring PIMA equipment to perform CD4 counts at points of care in rural facilities. Finally, while Visual Inspection with Acetic Acid (VIA) for cervical cancer screening in HIV infected women was not included in the previous guideline, the procedure is now recommended at baseline and annually thereafter if the initial test was negative.

The USG is transitioning treatment services to the MOH and will continue to support institutional strengthening and capacity building for implementation of the new treatment guidelines in a manner that is feasible and promotes equitable access. In FY 2010, the majority of treatment services were provided through cooperative agreements with two international NGOs, FXB and AIDSRelief. The MOH has now been able to absorb the majority of clinical staff at the 13 public HIV care and treatment sites previously supported by FXB. AIDSRelief will have completed the transition of administrative and programmatic responsibility for treatment services at two faith-based facilities (St. Joseph Mercy and Davis Memorial) to a local FBO grantee (PUSH) by March 1, 2012. Continued technical, programmatic and administrative support will be necessary to ensure sustainability and access to high quality treatment services by these local partners.

The responsibility for the forecasting and procurement of reagents and commodities for the National Public Health Reference Laboratory were transitioned from Supply Chain Management System (SCMS) to the MOH in FY 2011. MOH staff has already been trained and mentored in Supply Chain Management to support availability of HIV commodities at service delivery points. The USG will work with the MOH to implement measures to improve program efficiency and decrease cost while ensuring quality care is delivered in a sustainable fashion.

Responsibility for the procurement of commodities for the National Blood and Transfusion Services will be transitioned from SCMS to the MOH by the end of FY 2012. PEPFAR support for treatment services will continue at the local faith-based hospital facilities and the National Care and Treatment Center. In addition, supportive supervision of the MEDEX in the Hinterland Regions of Guyana, through the mobile van will continue with

COP12/13 support. The USG will also continue to support institutional strengthening and capacity building, including the support of the ongoing monitoring and evaluation of the implementation of the new treatment guidelines and supply chain management in a manner that is feasible with equity of access. The USG will work with the MOH to implement measures to improve program efficiency and decrease cost while ensuring quality care is delivered in a sustainable fashion. In addition, the USG will work with both local treatment partners to identify alternative funding sources to ensure that universal access to HIV treatment is not compromised as PEPFAR support declines.

To improve linkages between TB and HIV programs, efforts began during FY11 and will intensify during FY12 to integrate TB services at ART sites. The ART sites that are not currently offering TB services refer patients in need of these services to a chest clinic. This system however, does not work well as many patients do not access TB services and many of those who access the service often do not return to get their results. Increasingly ART sites are offering Tuberculin Skin Test (TST) to patients but this is done annually as per current guidelines with very little clinical evaluation for TB on routine visits. Increased emphasis will be placed on increasing Isoniazid Preventive Therapy (IPT) through adoption of clear guidelines for screening at every visit using the WHO recommended algorithm in addition to improving TST return readings and decentralization of IPT. Recently, a retrospective evaluation of HIV and TB screening at HIV care and treatment sites and chest clinics was done by the USG. Analysis of results will help inform next steps. The importance of infection control to protect TB-uninfected persons, including staff and clients from becoming infected, is recognized, but measures to protect them need improvement. In FY12, more emphasis will be placed on infection control in TB/HIV treatment sites.

While PMTCT and MCH services are often co-located in the same facility, there is very little integration of these programs. The USG will support Health System Strengthening (HSS) to improve this integration and build on the success of PMTCT programs through which 82.9% of pregnant women know their HIV status and have opportunities to receive care and treatment if necessary.

The quality of Guyana's HIV treatment programs is enhanced and monitored through several interventions. Extensive training and mentoring of physicians was done by FXB and AIDSRelief. While six MEDEX were trained and mentored to deliver treatment services in the hinterland regions, they are not fully participating in HIV care and treatment as was intended. These "physician extenders" are supervised by the doctor who operates the mobile unit. Although the national program does conduct periodic program reviews, there is little or no supervision of physicians in the communities. The HEALTH-QUAL program is a key initiative to monitor quality of services in the HIV Care and Treatment program with guidance from the HEALTH-QUAL Technical Working Group and the AIDS Institute of New York State Department of Health. Through this system, health services data are systematically audited to measure the extent to which set indicators are met. The Patient Monitoring System (PMS) s another mechanism through which quality is monitored. This is a paper-based system through which monthly summaries and cohort reports undergo regular data validation and verification.

Determining treatment failure for persons on first-line ART can be challenging because of the many issues that may be involved. At the main treatment center National Care and Treatment Center (NCTC) the first line failure is determined after discussion on a case-by-case basis by the multidisciplinary team. At other MOH treatment sites on-site clinicians make decision about failure on ART. They may contact the physicians at the NCTC for advice as some do but there is no structured policy. The increasing percentage of patients on second-line ART in Guyana is significant because choices of ARVs are very limited and very expensive. In addition, Guyana does not have any 3rd line ARVs for those who may eventually fail the second-line regimens.

Typically, pharmacovigilance is practiced in a limited manner in Guyana, mainly from a clinical perspective, in which caregivers use guidelines to report adverse drug reactions in patients placed on ART. Through this methodology, adverse events are noted and corrective action may be taken at the point-of-care level, but reports are not always formally, thus limiting its effectiveness, Evidence-based methodologies for evaluating drug toxicities, i.e., laboratory monitoring, are non-existent. This is an important quality of care activity and presents an opportunity for steps to be taken to establish such monitoring during FY 2012 through support of PEPFAR and others donors.

Criteria for ART initiation, ARV regimes and changes in lab protocols are all areas that are strategically used to achieve a high level of programmatic efficiency. The new treatment guidelines provide for initiation of ART at an earlier stage than previously allowed. Even though this action will increase access by clients to treatment and cause increased drug consumption, it potentially leads to a decrease in morbidity and mortality, a better quality of life for clients and a return to productive lives. The rationalizing of ARV use through high quality treatment regimens in fixed-dose combinations will improve efficiency and effectiveness. One area that needs work, however, is the retention of patients at specific clinics and the discouragement of attending multiple clinics. This will be further improved by utilizing a standard package of ART as outlined in the treatment guidelines. Furthermore, activities that streamline procurement efficiency through changes to national drug formularies, the registration and use of generic formulations or improved drug forecasting and logistics protocols take place through the SCMS program. Moving forward, other possible approaches for increasing programmatic efficiency in Guyana include decentralization of treatment services with commensurate capacity building and increase in the use of generic formulations of ARVs.

Pediatric Treatment

In Guyana, pediatric treatment makes up a small percentage of HIV treatment provided, though all USG-supported sites offer services for children. Accordingly, out of a total of 3,059 persons actively receiving antiretroviral therapy in 2010, 177 or 5.8% were children in the 0-15 age group. These children were evenly distributed according to gender, 88 females and 89 males. The treatment outcomes indicated that for children on treatment the survival rate, the percentage of those who were alive one year after starting treatment was 78.6% (11/14) for females and 90% (9/10) for males (NAPS Annual Report, 2010).

In 2012, the pediatric treatment goal is to have 180 children on active treatment as this target was not achieved in FY 2011. Generally, the MOH sets targets for the 0-15 age group. To achieve these targets, key priorities and goals for pediatric HIV treatment for the next two years are: scaling up pediatric care and treatment services through HSS, strengthening the national program and health care system to expand pediatric services, supporting collaborative work between MCH, PMTCT, and pediatric services to ensure integration, and strengthening in-country expertise in pediatric care and treatment.

Pediatric scale-up plans mainly involve expansion and decentralization of pediatric treatment services, and ensuring that a trained workforce is available at all levels. The USG is supporting government's health systems strengthening approach to improve pediatric service through training staff in various areas, supporting diagnostic and treatment facilities, and decentralizing pediatric services. Specific elements for USG support include improvement of Dry Blood Spots testing for HIV by DNA PCR, improvement of CTX use in exposed infants, improvement of testing of siblings of HIV exposed or infected infants, and improvement of the knowledge of case managers.

Pediatric first and second line ART is provided through USG support. However, the recommendation in the new treatment guideline is not uniformly implemented for the first line treatment. The recommended first line pediatric treatment is (Abacavir+lamivudine)+ Nevirapine or Efavirenz.

The impact of Pediatric Care and Treatment programs in Guyana will be assessed principally through the regular review of country data along with MOH and partners. The patient monitoring system, consisting of ART registers at treatment sites, will be used as an important tool to evaluate the impact of the programs. Expansion of pediatric HIV services requires the capacity for program monitoring and evaluation, and the USG will work with and support the MOH to build and increase capacity to conduct M&E functions over the next two years. The USG will also continue to support the PMS that is currently being used for pediatric HIV surveillance. In order to better document the outcomes of children enrolled in care and treatment, collection of data on treatment retention rates, morbidity and mortality rates, and treatment failure rates will take place through use of the surveillance system. A case tracking and management system implemented by the MOH will ensure that Early Infant Diagnosis (EID) is maximized,

allowing newly diagnosed HIV infected infants to immediately be initiated on ART. Despite all the data generated by these systems, use of the data for programmatic improvement is inadequate. The USG will work to improve the MOH's capacity in the use of this data for decision-making.

Quality treatment services for adolescents have to be provided in an environment that is sensitive to their needs. Counseling on all aspects of HIV and encouraging adolescents to join support groups where issues affecting them are addressed will improve quality treatment services.

Pediatric drugs are funded by the USG. Through SCMS, the USG purchases laboratory supplies for NBTS, first and second line pediatric drugs, and provides technical assistance for planning for pediatric ARVs. Both the USG and GF ensure that drugs of a high quality are procured from reputable sources. Additionally, the MOH develops an Essential Drugs List every two years with inputs from all stakeholders. Procurement of pediatric ARVs is determined by the National Guidelines for Management of HIV-Infected and HIV-Exposed Adults and Children, based on WHO 2010 guidelines. MOH staff are being trained in procurement and are preparing for the eventual transition as the support of external agencies that support purchase of pediatric drugs is decreasing progressively and will eventually conclude.

Cross-Cutting Priorities

Supply Chain

The international procurement and supply chain stakeholders in Guyana are the USG, GF, Pan American Health Organization (PAHO), the United Nations Population Fund (UNFPA), and the Clinton Health Access Initiative (CHAI). The USG, through the SCMS project, procures both first and second line pediatric ARVs, second line adult ARVs, and test kits, and provides technical assistance in product selection, quantification, forecasting and supply planning, warehousing and storage, logistics management information systems, transport and distribution, strategic planning, quality assurance and performance management. The USG also allocates contingency funds for emergency procurements that may become necessary if there are delays in other procurements, such as through the GF. The GF procures first line adult ARVs, ARVs for PMTCT, PEP, OI/STI medications and home-based care kits through the MOH. PAHO funds concessionary procurement of malaria medicines and vaccines and supports technical assistance in the selection and specifications of new laboratory tests. UNFPA procures contraceptives and supports the implementation of the national logistics management information system (LMIS). CHAI has previously provided funding for pediatric ARVs from 2007-2009 and is currently providing technical assistance and support for EID. Additionally, the World Bank, GF and Inter American Development Bank (IADB), in collaboration with the US, have provided multi-donor funding for the construction of the state-of-the-art Materials Management Unit (MMU) warehouse and technical support for -the design and supervision of this warehouse.

ARVs and laboratory commodity product forecasts are conducted annually with quarterly updates of the supply plans. Technical assistance is provided by the USG for national level forecasts as well as the training of relevant MOH staff. The forecasts are based on morbidity and consumption data. In the case of ARVs, these data are collected electronically from ART sites, and aggregated by SCMS. The Quantimed User Group, established and supported by the USG, validates the data and conducts the quantification. Additionally, PEPFAR partners support the MMU for the national forecasts of essential drugs and supplies for the MOH's annual planning, forecasting and budgeting.

The risk of stock outs in Guyana is mitigated through the routine monitoring of stocks at both site and central levels. These stock levels inform the quarterly review of supply plans, which in turn inform procurement decisions. In the case of the PEPFAR program, procurements can be initiated quickly in order to prevent stock outs. All orders are planned to arrive when in-country stock levels reach the minimum/safety level of four months of stock. In the case of first line adult ARVs, SCMS conducts monthly counts to track the stock status and this information is shared with all relevant stakeholders. Additionally, SCMS manages the supply plan and provides timely reminders to the MOH and GF regarding the procurement dates and timing. In situations of imminent stock outs, the USG supports the

National AIDS Program in the redistribution and rationing of existing stock to avoid disruption of treatment or services. The USG also has contingency funds that can be used to procure emergency supplies if, during the course of monitoring the national supply plan status, it is discovered that other mechanisms, for example GF, are unlikely to deliver ARVs in a timely manner to meet the national need.

The USG has supported the MOH in a National Supply Chain Logistics Management system design workshop during which all stakeholders developed a national LMIS plan. The plan involves strengthening the current paper-based system and implementation of CHANNEL at selected sites. The USG is providing technical assistance and leadership to the LMIS core team for all pharmaceutical commodities across all health facilities in the country. The LMIS has already been implemented in five of the ten regions and is now being rolled out to the remaining regions. In addition, a Logistics Management Information Unit is to be constituted within the MMU/MOH to ensure accurate and timely reporting of facility level LMIS data to the central level for analysis, planning and decision-making. Several initiatives that need to be completed include the establishment and implementation of a laboratory information system, pre-service training, in-service training programs, and an integrated supervision program.

The main human resource challenges with supply chain issues are high turnover of staff, shortage of skilled staff, and retention of skilled and trained staff. Poor working conditions (salaries and benefits in particular) severely affect the ability of the health system to motivate and retain staff. Lack of coordination is also an issue due to different donors funding various positions in the system, often with diverse, short-term and unsustainable contracts. Efforts should be concentrated on pre-service training in order to reach as large a number of persons as possible. Supply chain management should be incorporated into the curriculum of all relevant health professional schools, and facilitated by quality instructors. Donor coordination and a consensus human resource capacity building strategy led by the Public Service Commission and the MOH could contribute to retaining and motivating staff.

In order to promote sustainability and country ownership, all USG activities are done in full partnership with the MOH. Leadership is provided by the MOH counterparts with support from SCMS technical staff. The MMU warehouse operations are jointly managed by SCMS technical staff and the MOH. There are ongoing discussions for transferring skills and examining lessons learned for making improvements. The USG has facilitated three national strategic planning exercises and reviews with the key partners fully involved. USG work plans are derived from national strategic planning exercises and are developed with key partners who incorporate supply chain activities into their work. Upon initialization of the new MMU, all operations will be transferred to MOH and the USG will provide technical assistance for the establishment and stabilization of the new MMU operations.

To assess drug quality for non-ARV pharmaceuticals procured in country, the USG has developed the capacity of the MMU/MOH in Level I inspection techniques and a simple first line quality testing with the establishment of the Mini Lab at the MMU warehouse. This allows for initial qualitative and quantitative screening of about 40 non-ARV pharmaceuticals upon receipt at the MMU. If any discrepancy is found, the product is referred to the Food and Drugs Department (FDD) for more intensive qualitative testing. Almost 85-90% of the medicines to the public sector are received and distributed through MMU. FDD also conducts independent routine sampling of these pharmaceuticals post-market.

ARV Drugs: Pediatric

As a result of coordinated USG/MOH procurement, approximately 165 children received HIV treatment over the past year. This occurred through an integrated system for all ARVs at the national level. SCMS is currently the only principal USG-supported partner working on pediatric ARV drug forecasting, procurement and distribution. A national forecast for ARVs and rapid test kits (RTKs), based on the Standard Treatment Guidelines, algorithms, and national targets, is conducted annually and reviewed quarterly, then validated by the National AIDS Program and HIV technical working group. Coordinated procurement planning has also been developed. The results of the quantifications and the proposed procurement arrangements are presented and agreed to by the National Procurement Oversight committee, chaired by the MOH. Annual technical reports on ARVs and RTKs are also

shared with all stakeholders. These include the scope of quantification, data input, and key assumptions based on the set targets by the program, ARV stock-on-hand, shipments received and supply plans by different donors. The NAPS Program Manager has been trained in Quanti-Med in order to lead and assume responsibility for the national quantification technical reporting from USG in the coming year. Current forecasting and procurement systems have proved successful, as there have been no stock outs in pediatric ARVs in the past two years. The only challenge faced in the area of pediatric ARV drug procurement is the higher cost of air-freighting pediatric ARV preparations which, as liquid solutions, are relatively heavy compared to adult ARVs.

Laboratory

For laboratories in Guyana, the National Strategic Plan (NSP) for Medical Laboratories 2008-2011, followed by the 2011–2015 NSP, outlines requirements for quality and competence across the laboratory network, which comprises of hospital laboratories, health centers and health posts at central, regional, district, and community levels. The National Public Health Reference Laboratory (NPHRL) was locally certified by the Guyana National Bureau of Standards on 2010 and completed all infrastructural, bio-safety, and bio-security upgrades in March 2011 consistent with requirements of ISO15189 standard. Plans are in place to have NPHRL accredited before the end of 2012 with a pre-accreditation audit with support from the Association of Public Health Laboratories, planned for early 2012.

Over the years, USG has supported the MOH in capacity building of the health workers to be able to respond in an adequate and timely manner to the public health care needs of Guyana within a resource constrained environment. The Package of Publicly Guaranteed Health Services in Guyana (2008-2012) defines the levels of care (1-5) within Guyana's health services, including the Essential Package of Laboratory Services available at each level of care. Within this context, PEPFAR is supporting the MOH in developing specific reform plans, such as the National Strategic Plan for Medical Laboratories 2011-2015.

The MMU manages supplies, equipment and reagents using logistical data. The USG funds the procurement of laboratory reagents for essential laboratory services in support of HIV care and treatment, including CD4 reagents for the entire national care and treatment program, ELISA, Western Blot and Syphilis reagents for the PMTCT program, and Hematology (CBC) reagents for the National Care and Treatment Centre. The procurement of these reagents was transitioned from SCMS to MOH in FY11. During the past fiscal year, no stock outs or disruption of laboratory services resulting from supplies management was reported. In FY12 there will be increased emphasis on capacity building at regional and district health facility laboratories to enhance their ability to accurately forecast and manage stock levels. Data gathered in FY11 at all health facilities will enable equipment harmonization and enhanced management of the supply chain for laboratory reagents.

Gender

In FY11, the Guyana treatment program was slightly skewed toward female clients with 53.3% of current clients being female; however, recruitment of new clients has achieved a gender balance with new clients from each gender group accounting for approximately 50% of the client load. USG care and treatment partners utilize a family-centered approach to care and treatment services that ensures equitable access for women with linkages to family planning and PMTCT. Further strategies and activities will be designed to build the competence of all health personnel and supporting staff to provide services in a non-discriminating, non-stigmatizing, confidential and friendly manner. Tools will also be developed at the facility and NGO sites to track access to services by both genders as well as MARPs. Outside of care and treatment facilities, USG will continue to incorporate gender-based violence awareness into all its programs for all populations in an effort to reduce violence and coercion. The USG will also strengthen linkages and referrals for victims of violence, including awareness and access to post exposure prophylaxis (PEP) in clinical settings.

Strategic Information

Delivery of adequate and optimal HIV treatment is contingent on the integrity of HIV Patient Information Systems and their ability to produce quality data on patient status and treatment. This, coupled with a workforce that possesses strong surveillance, data monitoring and evaluation skills needed to improve the strategic response to the treatment, will allow for the refinement of the country's approach to treatment. However, an existing cascade of systemic data collection and data quality issues across all levels of the HIV program (i.e. HIV Testing, Counseling & Care) impact the SI approaches used in the development of a strategic response.

To date, one of the major challenges faced in SI has been maintaining maximum integrity of patient treatment data collected. The weakened information base has resulted from inconsistencies in HIV case reporting. A factor influencing collection of quality data is the utilization of an anachronistic HIV/AIDS Case Surveillance Form developed in the late 1980s after the first few cases of HIV were identified in Guyana. This form has not been updated since then, and has used an outdated case definition of HIV/AIDS unaligned with the current World Health Organization (WHO) definition, recommended practices, clinical diagnoses and staging criteria. The form is an inadequate tool for tracking and enrolling HIV patients into care, monitoring treatment regimens, and monitoring HIV clients as they enter into advanced HIV clinical stages. These issues have led the USG to provide continued technical assistance and guidance, and funding to the MOH's Surveillance Unit. With PEPFAR support, the MOH will develop an HIV Case Surveillance System that captures patients at all testing stages, and follows them through all levels of care and treatment. This will assure timely enrollment into care, adequate delivery of prescribed treatments, optimal adherence to treatment at all stages of HIV disease, and tracking of patients across all treatment facilities visited.

The primary SI goal for treatment moving forward in FY12 is to increase the availability of quality data and evidence from surveillance, program evaluation, and population-based surveys to inform treatment programs. The USG will also increase the ability and capacity of local partners to analyze, present, and disseminate user-friendly information to strengthen decision-making. Efforts are in progress to expand the implementation of the PMS, a paper-based monitoring tool adopted from WHO in 2007, and digitize it to a centralized electronic system which all health facilities can access and manage remotely. The USG intends to provide technical assistance and guidance to convert the PMS into a universal electronic data management system for Care and Treatment Facilities, link the Case Surveillance System and Case Tracking System at PMTCT to the PMS, and train data entry clerks and PMS Managers for optimal use of the system. When optimized, PMS will result in the accurate monitoring of progress towards National ART program goal of "universal access to ARV-based treatment" and "reduce the economic burden of HIV/AIDS on the country."

Additionally, as part of the PEPFAR initiative to build local capacity to utilize quality data to make evidence-based policy decisions, the USG plans to work with the two private faith-based hospitals in Georgetown to carry out a public health evaluation on late-initiation of ARVs and presentation for HIV treatment to better understand the magnitude of the problem and develop strategies to address the needs. Lastly, the USG will continue to provide guidance and technical assistance to the MOH to complete the launch of the IQChart tool initially validated and piloted in 2011. The tools will merge various data sources for a consolidation of monthly reporting, which will make it easier to track ARV use across all care and treatment facilities in Guyana.

Capacity Building

The key priority capacity building objectives are: to provide appropriate training to key categories of health workers (physicians and MEDEX) to respond to the HIV epidemic; to build capacity in monitoring and evaluation; to build capacity in performing visual inspection with acetic acid (VIA), laboratory testing for CD4, and viral load; and to build capacity to do HIV counseling and testing. These priorities are all important to improve the quality of treatment services that clients receive when they seek care. Individual capacity building needs are currently being addressed through training of appropriate staff to perform treatment functions. Outputs of capacity building activities will be the number of persons who were trained, and what they will do to perform specific treatment functions. Project outcomes will be the utility of the training provided. The USG has provided capacity building over the years in many areas and those individuals have been trained according to established standards. As the services

are transitioned over to the MOH, the MOH will be able to assume greater responsibility and take ownership of response to the epidemic. The MOH needs to provide the environment for those who were trained to function effectively without compromising quality and find ways to retain them in the treatment service.

MARPs

While within the current HIV/AIDS program information is collected and reported by basic socio demographics, such as age and sex, it is becoming increasingly important to monitor service utilization and uptake among MARPs/priority groups. While some of these data may be collected in individual patient charts, it is not summarized and monitored at a program level. With increasing use of electronic systems, this will be possible as far as the data is collected. As mentioned in the SI narrative, the USG will be working with partners to ensure that systems can be enhanced to monitor MARPs.

The minimum package of services offered to both men who have sex with men (MSM) and commercial sex workers (CSW) includes: peer education and outreach, risk reduction counseling, condom and lubricant promotion and distribution, HIV testing and counseling, BCC materials, support groups, and referrals for STI screening. In addition to these services, the comprehensive package of services for both MSM and CSW also includes referrals for mental health and social services, substance abuse treatment and Positive Health Dignity and Prevention (PHDP) or provision of these services by trained social workers. In addition, for female sex workers (FSW), there are linkages to economic strengthening programs, parenting skills training, referral for family planning services, and referral for PMTCT services.

Currently, care and support services for MARPS are provided through civil society organizations. Each agency services a specific geographic space and is linked with treatment facilities within the same geographic location. There are bi-directional linkages at these facilities to social and other needed support and treatment services.

The USG advocates for supportive policies by working with the MARPs and other target populations, and within health care facilities where MARPs access care and treatment. The USG has worked to develop a policy to enhance access to health and other services at public sector facilities providing care and treatment services to MARPs. During FY12, the USG will continue to support these initiatives in order to increase access and service utilization.

Human Resources for Health

The main challenges faced by the country and USG partners in sustaining the high level of HIV treatment services are related to human resources. There is a lack of qualified and skilled staff, attrition of trained staff is very frequent and there is a lack of adequately trained support staff. The MOH, with assistance from USG partners, has been intensifying training of workers to provide care at the various levels. Physicians have been trained and mentored in pediatric HIV care. A mobile team services the hinterland, where the lack of personnel is greatest, while supporting and supervising the MEDEX, who have been specifically trained to provide HIV treatment in the hinterland, allowing continuity of the service in the hinterland.

USG support has been instrumental in the training of other cadres of health professionals. There are, for example, plans to train community health workers in aspects of HIV care and treatment. Another such group of professionals are the multidisciplinary teams at the facility level, comprised of physicians, nurses, social workers, pharmacists and counselors, who examine and deal with treatment of patients from a wider perspective. Training for non-clinical public health workforce such as managers and administrators focuses on monitoring and evaluation of the program, counseling of patients, tracking of patients and a number of other functions that are crucial to HIV treatment programs. These non-clinical managers are also trained in areas allowing them to complement the clinical staff in providing quality service to clients. USG will continue to support training of non-clinical workforce to manage the country's HIV treatment program.

The USG will work to improve health care worker capacity to provide quality treatment services through

development of capacity at the University of Guyana and Georgetown Public Hospital. Through a Cooperative Agreement between the USG and University of Maryland School of Medicine Institute of Human Virology, medical students at the pre-service level will be trained in infectious disease management as part of their medical school program and there will be a post graduate residency program in Internal Medicine and Infectious Diseases with development of faculty at the University of Guyana. The program will support in-service training of health care workers in order to build the capacity of staff to monitor HIV-infected patients on treatment and to identify treatment failure and drug resistance and enable health facility level multidisciplinary teams to periodically review suspected cases of treatment failure.

There have also been continuous improvements in institutional and human resources to provide for staff capacity development and retention at NPHRL and regional hospital laboratories. Once capacity is strengthened, the assumption is that Guyana will be better positioned to continue fighting the epidemic with local and other donor resources.

Technical Area Summary Indicators and Targets

Future fiscal year targets are redacted.

Indicator Number	Label	2013	Justification
P1.1.D	P1.1.D Percent of pregnant women with known HIV status (includes women who were tested for HIV and received their results)	n/a	Redacted
	Number of pregnant women with known HIV status (includes women who were tested for HIV and received their results)	11,115	
P1.2.D	P1.2.D Number and percent of HIV-positive pregnant women who received antiretrovirals to reduce risk of mother-to-child-transmission during pregnancy and delivery	17 %	Redacted
	Number of HIV-positive pregnant women who received antiretrovirals (ARVs) to reduce risk of mother-to-child-transmission	43	
	Number of HIV-	257	

	positive pregnant women identified in the reporting period (including known HIV-positive at entry)		
	Life-long ART (including Option B+)	31	
	Maternal triple ARV prophylaxis (prophylaxis component of WHO Option B during pregnancy and delivery)	12	
	Maternal AZT (prophylaxis component of WHO Option A during pregnancy and deliverY)	0	
	Single-dose nevirapine (with or without tail)	0	
	Newly initiated on treatment during current pregnancy (subset of life-long ART)	4	
	Already on treatment at the beginning of the current pregnancy (subset of life-long ART)	27	
	Sum of regimen type disaggregates	43	
	Sum of New and	31	

	Current disaggregates		
P7.1.D	P7.1.D Number of People Living with HIV/AIDS (PLHIV) reached with a minimum package of 'Prevention with PLHIV (PLHIV) interventions	n/a	Redacted
	Number of People Living with HIV/AIDS reached with a minimum package of 'Prevention of People Living with HIV (PLHIV) interventions	1,500	
P8.1.D	P8.1.D Number of the targeted population reached with individual and/or small group level HIV prevention interventions that are based on evidence and/or meet the minimum standards required	n/a	Redacted
	Number of the target population reached with individual and/or small group level HIV prevention interventions that are based on evidence and/or meet the minimum standards	1,490	

	required		
P8.2.D	P8.2.D Number of the targeted population reached with individual and/or small group level HIV prevention interventions that are primarily focused on abstinence and/or being faithful, and are based on evidence and/or meet the minimum standards required	n/a	Redacted
	Number of the target population reached with individual and/or small group level HIV prevention interventions that are primarily focused on abstinence and/or being faithful, and are based on evidence and/or meet the minimum standards required	0	
P8.3.D	P8.3.D Number of MARP reached with individual and/or small group level HIV preventive interventions that are based on evidence and/or meet the	n/a	Redacted

	minimum standards required		
	Number of MARP reached with individual and/or small group level preventive interventions that are based on evidence and/or meet the minimum standards required	3,455	
	By MARP Type: CSW	710	
	By MARP Type: IDU	5	
	By MARP Type: MSM	445	
	Other Vulnerable Populations	2,295	
	Sum of MARP types	3,455	
P11.1.D	Number of individuals who received T&C services for HIV and received their test results during the past 12 months	19,427	Redacted
	By Age/Sex: <15 Male	132	
	By Age/Sex: 15+ Male	4,228	
	By Age/Sex: <15 Female	251	
	By Age/Sex: 15+ Female	14,816	
	By Sex: Female	15,067	
	By Sex: Male	4,360	
	By Age: <15	383	
	By Age: 15+	19,044	
	By Test Result:	19,019	

	Negative		
	By Test Result: Positive	408	
	Sum of age/sex disaggregates	19,427	
	Sum of sex disaggregates	19,427	
	Sum of age disaggregates	19,427	
	Sum of test result disaggregates	19,427	
P12.1.D	Number of adults and children reached by an individual, small-group, or community-level intervention or service that explicitly addresses norms about masculinity related to HIV/AIDS	5,416	Redacted
	By Age: <15	1,264	
	By Age: 15-24	2,129	
	By Age: 25+	2,023	
	By Sex: Female	2,299	
	By Sex: Male	3,117	
P12.2.D	Number of adults and children reached by an individual, small group, or community-level intervention or service that explicitly addresses gender-based	5,166	Redacted

	violence and coercion related to HIV/AIDS		
	By Age: <15	1,254	
	By Age: 15-24	2,024	
	By Age: 25+	1,888	
	By Sex: Female	2,229	
	By Sex: Male	2,937	
C1.1.D	Number of adults and children provided with a minimum of one care service	5,981	Redacted
	By Age/Sex: <18 Male	667	
	By Age/Sex: 18+ Male	2,073	
	By Age/Sex: <18 Female	797	
	By Age/Sex: 18+ Female	2,444	
	By Sex: Female	3,241	
	By Sex: Male	2,740	
	By Age: <18	1,464	
	By Age: 18+	4,517	
	Sum of age/sex disaggregates	5,981	
	Sum of sex disaggregates	5,981	
	Sum of age disaggregates	5,981	
C2.1.D	Number of HIV-positive individuals receiving a minimum of one clinical service	3,376	Redacted
	By Age/Sex: <15 Male	73	
	By Age/Sex: 15+ Male	1,505	

	By Age/Sex: <15 Female	86	
	By Age/Sex: 15+ Female	1,712	
	By Sex: Female	1,798	
	By Sex: Male	1,578	
	By Age: <15	159	
	By Age: 15+	3,217	
	Sum of age/sex disaggregates	3,376	
	Sum of sex disaggregates	3,376	
	Sum of age disaggregates	3,376	
C2.2.D	C2.2.D Percent of HIV-positive persons receiving Cotrimoxizole (CTX) prophylaxis	8 %	
	Number of HIV-positive persons receiving Cotrimoxizole (CTX) prophylaxis	258	Redacted
	Number of HIV-positive individuals receiving a minimum of one clinical service	3,376	
C2.4.D	C2.4.D TB/HIV: Percent of HIV-positive patients who were screened for TB in HIV care or treatment setting	45 %	Redacted

	Number of HIV-positive patients who were screened for TB in HIV care or treatment setting	1,525	
	Number of HIV-positive individuals receiving a minimum of one clinical service	3,376	
C2.5.D	C2.5.D TB/HIV: Percent of HIV-positive patients in HIV care or treatment (pre-ART or ART) who started TB treatment	1 %	Redacted
	Number of HIV-positive patients in HIV care who started TB treatment	40	
	Number of HIV-positive individuals receiving a minimum of one clinical service	3,376	
C4.1.D	C4.1.D Percent of infants born to HIV-positive women who received an HIV test within 12 months of birth	95 %	Redacted
	Number of infants who received an HIV test within 12 months of birth during the	243	

	reporting period		
	Number of HIV-positive pregnant women identified in the reporting period (include known HIV-positive at entry)	257	
	By timing and type of test: virological testing in the first 2 months	70	
	By timing and type of test: either virologically between 2 and 12 months or serology between 9 and 12 months	173	
C5.1.D	Number of adults and children who received food and/or nutrition services during the reporting period	2,255	Redacted
	By Age: <18	1,173	
	By Age: 18+	1,082	
	By: Pregnant Women or Lactating Women	0	
	Sum of age disaggregates	2,255	
T1.1.D	Number of adults and children with advanced HIV infection newly enrolled on ART	232	Redacted
	By Age: <1	1	
	By Age/Sex: <15 Male	3	
	By Age/Sex: 15+ Male	111	

	By Age/Sex: <15 Female	3	
	By Age/Sex: 15+ Female	115	
	By: Pregnant Women	4	
	Sum of age/sex disaggregates	232	
T1.2.D	Number of adults and children with advanced HIV infection receiving antiretroviral therapy (ART)	2,826	Redacted
	By Age: <1	0	
	By Age/Sex: <15 Male	69	
	By Age/Sex: 15+ Male	1,247	
	By Age/Sex: <15 Female	72	
	By Age/Sex: 15+ Female	1,438	
	Sum of age/sex disaggregates	2,826	
T1.3.D	T1.3.D Percent of adults and children known to be alive and on treatment 12 months after initiation of antiretroviral therapy	84 %	Redacted
	Number of adults and children who are still alive and on treatment at 12 months after initiating ART	204	
	Total number of	244	

	adults and children who initiated ART in the 12 months prior to the beginning of the reporting period, including those who have died, those who have stopped ART, and those lost to follow-up.		
	By Age: <15	9	
	By Age: 15+	195	
	Sum of age disaggregates	204	
H1.1.D	Number of testing facilities (laboratories) with capacity to perform clinical laboratory tests	2	Redacted
H1.2.D	Number of testing facilities (laboratories) that are accredited according to national or international standards	2	Redacted
H2.1.D	Number of new health care workers who graduated from a pre-service training institution or program	0	Redacted
	By Cadre: Doctors	0	
	By Cadre: Midwives	0	
	By Cadre: Nurses	0	
H2.3.D	The number of health care workers who	1,080	Redacted

	successfully completed an in-service training program		
	By Type of Training: Male Circumcision	0	
	By Type of Training: Pediatric Treatment	30	

Partners and Implementing Mechanisms

Partner List

Mech ID	Partner Name	Organization Type	Agency	Funding Source	Planned Funding
7218	Partnership for Supply Chain Management	Private Contractor	U.S. Agency for International Development	GHP-State	2,288,322
7352	University of North Carolina at Chapel Hill, Carolina Population Center	University	U.S. Agency for International Development	GHP-State	0
7369	U.S. Department of Defense (Defense)	Other USG Agency	U.S. Department of Defense	GHP-State	138,500
7375	New York AIDS Institute	Other USG Agency	U.S. Department of Health and Human Services/Health Resources and Services Administration	GHP-State	75,000
10074	Association of Public Health Laboratories	NGO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	50,000
10076	Ministry of Health, Guyana	Host Country Government Agency	U.S. Department of Health and Human Services/Centers for Disease	GHP-State	913,750

			Control and Prevention		
13175	Remote Area Medical	NGO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	48,000
13245	American Society for Microbiology	Private Contractor	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	50,000
13246	University of Maryland	University	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	486,562
13384	Davis Memorial Hospital and Clinic	FBO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	655,864
14260	U.S. Peace Corps	Other USG Agency	U.S. Peace Corps	GHP-State	27,035
14399	International Labor Organization	Multi-lateral Agency	U.S. Department of Labor	GHP-State	0
14713	TBD	TBD	Redacted	Redacted	Redacted

14778	Vanderbilt University	University	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	330,000
14779	U.S. Department of State	Other USG Agency	U.S. Department of State/Bureau of Western Hemisphere Affairs	GHP-State	12,800
16971	United Nations Children's Fund	Multi-lateral Agency	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	0
17122	John Snow Inc (JSI)	Implementing Agency	U.S. Agency for International Development	GHP-State	1,900,000

Implementing Mechanism(s)

Implementing Mechanism Details

Mechanism ID: 7218	**Mechanism Name: The Partnership for Supply Chain Management**
Funding Agency: U.S. Agency for International Development	Procurement Type: Contract
Prime Partner Name: Partnership for Supply Chain Management	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: TA	
G2G: No	Managing Agency:

Total Funding: 2,288,322	
Funding Source	**Funding Amount**
GHP-State	2,288,322

Sub Partner Name(s)

(No data provided.)

Overview Narrative

SCMS in Guyana aims to transform health care delivery by ensuring that quality medicines and health care commodities to reach the people living with and affected by HIV/AIDS. In close partnership with the MOH, in-country and international stakeholders, as well as with donors, SCMS transforms health care delivery by ensuring quality medicines and health care commodities reach PLWHA. SCMS' solutions are deployed to assist the MOH enhance their supply chain capacity. To achieve these objectives, SCMS works with the MOH and the Material Management Unit to improve its capacity and the capacity of supply chain implementing partners across the broader Guyanese Health Commodities Logistics System, thus maximizing HIV funds and resources to improve and strengthen the SCS capacity for all essential medicines and supplies for MOH programs. SCMS also aims to collaborate and seek synergies in common supply chain and HSS with Global Fund, PAHO and UNFPA in common objectives and synergies for Capacity Building Services/Supply Chain Management Assistance. These efforts will build on and expand existing platforms to foster stronger systems and sustainable results and will strengthen health systems functions to ensure quality and reach of health services and public health programs in both short and long term by working with donors and governments to incorporate sustainability into health programming. In FY12,

SCMS will strive to promote accurate data collection and dissemination for use in completing quantifications, building capacity to conduct quantifications and transferring skills. SCMS also plans to retrain leaders from within the MOH and donor programs in the application of quantification tools in order to facilitate the transition of quantification activities to the MOH.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	162,083

TBD Details

(No data provided.)

Key Issues

Increase gender equity in HIV prevention, care, treatment and support

Budget Code Information

Mechanism ID:	**7218**		
Mechanism Name:	**The Partnership for Supply Chain Management**		
Prime Partner Name:	**Partnership for Supply Chain Management**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Governance and Systems	HVSI	8,000	0

Narrative:

Improving information systems at both the central and facility level are vital components of a secure and reliable supply chain. The ability to collect accurate data and communicate that data through Management Information Systems (MIS) systems is a key part of the Ministry of Health (MOH) MIS strategy and an area where SCMS has been providing support. SCMS has provided technical assistance to improve the central level information system for supply chain management to ensure strategic information is readily available to drive decisions for key

stakeholders, e.g. MOH, Ministry of Finance, donors, and implementing partners. At the facility level SCMS supported a facility inventory management system assessment, which then informed a National Logistics Management Information System (LMIS) Design Workshop out of which a LMIS Core Team was established to implement and manage the LMIS. SCMS in collaboration with the MOH and UNFPA will complete the implementation, training of health facility personnel in all regions. The cadre of trained personnel being developed will lead to the strengthening of facility level inventory management, reporting of all essential logistics information will help planning and decision making at all levels, particularly as it relates to supply chain management and health commodities management. Implementation and supportive supervision of the LMIS will continue in 2012. Transition of LMIS functions and responsibility in some regions is also planned.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	OHSS	1,620,829	0

Narrative:

Key technical program areas contributing towards Health Systems Strengthening (HSS) constitutes product selection and use, quantification/forecasting, warehousing and distribution, technical support, assistance and supervision of the multi-donor funded international standard new Materials Management Unit (MMU) warehouse, which supports the Ministry of Health (MOH) in the overall strengthening of the health systems. (a) Product selection: SCMS will continue to support Guyana in the implementation and revision of National Standard Treatment Guidelines and to promote rational drug use through education, training, and monitoring and evaluation (M&E). SCMS will also enhance drug registration capability, national formulary and support pharmacovigilance activities. (b) Quantification : Ongoing national level forecasting, quantification and supply planning of antiretrovirals (ARVs), rapid test kits (RTKs) and lab reagents represent an opportunity for streamlining, simplifying, and improving the national health commodities logistics systems. SCMS will assist in improving the accuracy of routine national quantifications of core commodities for the TB and Malaria programs and essential medicines and consumables. These quantifications will contribute to data-driven decision making. It will also improve the accuracy of facility level requirements and orders. (c) Warehousing, Inventory Control and Storage: SCMS has been providing continuous technical support to the operations and management of the MMU. The technical assistance and oversight for the construction of the new MMU facility will continue in 2012 with an expected completion in mid-2012. Relocation and migration of both the Kingston and the Farm MMU facilities will be planned and assisted by SCMS. This will be followed by a period of technical support to ensure stabilization of operations at the new warehouse. SCMS will also provide appropriate change management process training of the MMU staff so they are able to adjust to a changed environment. (d) Quality Assurance: SCMS is committed to ensuring that quality is an integral part of the supply chain. In this regard, SCMS has supported the establishment of a mini-lab site at the current MMU warehouse, where a total of 40 drugs are screened on a regular sampling. SCMS will continue to support this activity as well as expand the testing capacity of the mini-lab site following the

migration and transition to the new warehouse. Interventions to strengthen the Food and Drug Department (FDD), in both areas of quality inspections and quality control testing are expected to continue. (e) National Supply Chain Master Plan : SCMS will support the MOH in the execution of the Global Fund (GF) Pharmaceutical and Health Products Management Plan (PHPM) country profile Action Plan and in the development of a National Supply Chain Master Plan on the foundation of the GF PHPM country profile in order to strengthen the management of the supply chain for pharmaceuticals and health commodities, and to build the capacity of the MOH to manage procurements.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HMBL	0	

Narrative:

SCMS will procure reagents and other consumables to support blood screening at MoH facilities.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	200,000	0

Narrative:

CDC is responsible for providing all rapid test kits (RTK) for Ministry of Health (MOH) programs. During FY11, CDC and SCMS continued worked closely with the MOH to establish necessary capacity such as forecasting, consumption data and ordering systems. Funds for procurement of RTK in FY 2012 will again be provided to SCMS. SCSM will continue to provide technical assistance and training in procurement systems to the MOH. SCMS and CDC will continue to work closely on forecasting and ordering to ensure that there are no stock-outs. The CDC Office will continue its responsibilities for quality assurance for rapid testing in all PEPFAR programs.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXD	459,493	0

Narrative:

In FY12, PEPFAR, through SCMS, will continue to support the procurement for adult second line ARVs and pediatric first and second line ARVs. SCMS will continue to work towards an integrated procurement planning process to include both donors and the Ministry of Health (MOH). This will be accomplished by developing a two year quantification and a one year rolling supply plan. There will be quarterly reviews of the forecast to ensure not only continued availability but also to avoid stock-out situations. Transitioning of procurement responsibilities as well as the continued funding for ARVs will be discussed with donors and the MOH with a view of developing a transition plan for project activities. The procurement of CDC supported commodities will be gradually transitioned to Materials Management Unit (MMU)/MOH. Labs commodities procurement transition has been informed to have commenced in September 2011. Procurement of the remaining CDC funded commodities for

voluntary counseling and testing (VCT) and National Blood Transfusion Service (NBTS) will be transitioned at a later stage in 2012. SCMS still will continue its support to MMU in this transition and to provide any technical support and mentoring as is needed to ensure a smooth transition and enable MMU to fully take over.

Implementing Mechanism Details

Mechanism ID: 7352	**Mechanism Name: Measure Evaluation Phase 111**
Funding Agency: U.S. Agency for International Development	Procurement Type: Contract
Prime Partner Name: University of North Carolina at Chapel Hill, Carolina Population Center	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 0	
Funding Source	**Funding Amount**
GHP-State	0

Sub Partner Name(s)

John Snow, Inc.		

Overview Narrative

MEASURE Evaluation's mission in Guyana is to strengthen the strategic information capabilities of USAID/Guyana partners within the Ministry of Health and civil society to better use data for decision making in order to respond to the HIV epidemic. MEASURE has been working to strengthen monitoring and evaluation of the national HIV/AIDS response by providing technical assistance to the National AIDS Program Secretariat, as well as other organizations within MOH, and external partners. Moving forward the priority will be on fostering institutional systems and relationships that make collection, sharing and use of strategic information efficient, seamless and sustainable. This will be achieved through two main objectives: strengthening and sustaining individual and institutional capacity to effectively monitor and evaluate HIV/AIDS programs and improving the routine monitoring and systematic data collection for decision-making in the future planning of HIV-related activities. Support to the MOH and civil society will build on the strength of past successes and existing systems to maximize outcomes. As part of the capacity building activities, fellowships were awarded to the National TB Program M&E Coordinator

and CSDS M&E Officer to attend a workshop on measuring and improving routine health information system performance. With the FY2010 COP funds, MEASURE is still able to perform its activities in country for FY 2011. A M&E Specialist will be placed to continue providing M&E technical assistance along with additional short term technical assistance as needed to the MOH and any other civil society organization in country to improve HIV/AIDS M&E and health information systems, as well as for the establishment of its Strategic Information Unit /M&E and Planning Unit.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**7352**		
Mechanism Name:	**Measure Evaluation Phase 111**		
Prime Partner Name:	**University of North Carolina at Chapel Hill, Carolina Population Center**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Governance and Systems	HVSI	0	0
Narrative:			
A full-time monitoring and evaluation (M&E) Specialist will be available in country to continue improving and strengthening partners' ability to collect, analyze and use HIV/AIDS strategic information. This specialist will also be available to provide in-country assistance for PLACE implementation (see below). Additional support from headquarters will be available to provide short-term technical assistance and participate in training events.			

Supporting the Ministry of Health (MOH) in creating a centralized M&E unit. This integrated unit is expected to make more effective and efficient use of M&E resources, providing the MOH with comprehensive, timely and accurate data that can be used for planning, monitoring and evaluating health services in the country. The process will create a new organizational structure and ensurie that it is functional and properly fulfills its mandate requires coordinated effort from the different stakeholders involved. MEASURE Evaluation will facilitate: discussions on the purpose of the mission and vision for the unit; functional responsibilities of the unit; organizational relationships of the unit within the MOH, organizational chart; staffing needs, roles and responsibilities (draft job descriptions for key staff); mapping of existing resources into staffing plans; additional HR considerations, including: supervision, staff development; building in leadership from the start; Road map for establishing the unit and finally monitoring and support for the process. Another activity will develop and pilot the use of the Toolkit for Rapid Monitoring of AIDS Referral Systems (R-MARS), a toolkit designed to monitor referral system information within a network of HIV/AIDS service providers. This pilot will determine the appropriateness and feasibility of the R-MARS instruments, utility and, possibly, the quality of the information produced. Ultimately, R-MARS is meant to improve referral system functioning through better monitoring. This activity includes an assessment of the existing referral system and its monitoring, including such activties as the review of current data collection forms, data elements and reporting forms. Finally, MEASURE Evaluation will collaborate with the MOH/National HIV/AIDS Program (NAPS) M&E staff, Program Coordinators and NGOs to implement the Priorities for Local AIDS Control Efforts (PLACE) Methodology, which is a venue-based approach to understanding sexual networks, rather than a risk-group approach. It will provide rapid assessment and monitoring of behavior and program coverage.

Implementing Mechanism Details

Mechanism ID: 7369	**Mechanism Name: Department of Defense**
Funding Agency: U.S. Department of Defense	Procurement Type: USG Core
Prime Partner Name: U.S. Department of Defense (Defense)	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 138,500	
Funding Source	**Funding Amount**
GHP-State	138,500

Sub Partner Name(s)

(No data provided.)

Overview Narrative

In FY 2012, the Department of Defense (DOD) in Guyana will be moving from support to the Guyana Defense Force (GDF) for service delivery to building public health institutions from disease surveillance and response. The GDF will maintain an independent health system with clinics at each of its bases. To ensure that the GDF members are in good health and are not vectors for diseases, development of a routine surveillance system and response capacity will link to the national health system. To provide more accurate data on the behaviors and military base locations that will present the greatest risk for transmission amongst the GDF members at bases or deployment, the National Public Health Reference Laboratory (NPHRL), the GDF laboratory and the USG have conducted a behavioral and biological survey (SABERS), the first of its kind in Guyana. SABERS will collect results for HIV and other STI, and results will be incorporated into a capacity building plan by NPHRL with help from the USG. Based on the SABERS results, targeted prevention activities will also continue to scale up not only at GDF locations but also to reach GDF family members and the civilian communities surrounding the military bases. Efforts will also be made to establish an electronic health record to institute an e-health educator at every medical clinic and health facility of the GDF. As the MOH develops their own electronic disease reporting system and medical record, the open access nature of the system can export in any form needed by the national health system, allowing the capacity for reporting, analysis over time and strengthening of an essential component of the health system. Note: The entirety of funding for this program, $347,625, will be carryover funds from FY11.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	15,000
Renovation	40,000

TBD Details

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**7369**
Mechanism Name:	**Department of Defense**
Prime Partner Name:	**U.S. Department of Defense (Defense)**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HBHC	7,000	0

Narrative:

Clinic-based basic health care and support will be provided to HIV-infected members of the Guyana Defnese Force (GDF). Access for HIV-infected ranks to the diagnosis and treatment of opportunistic and sexually transmitted diseases will be ensured. Laboratory and pharmacy support will be continued. One doctor/health care provider will attend the Military HIV/AIDS Training Course where training will be provided in the diagnosis and management of HIV complications (neurologic, oral, skin, pulmonary, opportunistic and ophthalmic emergencies) and on mental health and ethical issues in HIV patients. Support will be provided for this individual to train other GDF health care personnel to provide health care and support for HIV-infected personnel. Additionally, training will continue with the GDF nurses and medics by the Ministry of Health. A referral network into the civilian health care system will be established to provide health care and support beyond the support available in the GDF. Activity tracking and reporting mechanisms will be continued.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVTB	2,000	0

Narrative:

Provision of technical assistance to the Guyana Defense Force (GDF) medical personnel will be continued to enable diagnosis and treatment of tuberculosis (TB) in HIV-infected individuals within the GDF. Training, educational resources and standard operating procedures for TB-HIV management will be provided in collaboration with the National Chest Clinic. Training, local organization capacity development and strategic information activities will be done in conjunction with activities in the HBHC program area. Equipment and laboratory supplies to maintain this program area will be procured as part of the HLAB program area. The GDF will implement HIV counseling and testing (C&T) for all TB patients and TB screening.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HLAB	20,000	0

Narrative:

Laboratory personnel training will be continued for the Guyana Defense Force (GDF) laboratory personnel to strengthen and maintain skills and capabilities acquired. Technical assistance will be provided in developing logistics mechanisms to sustain basic laboratory capabilities. Strengthening of laboratory systems and facilities will support HIV/AIDS related activities including procurement of equipment, reagents, commodities, the provision of quality assurance and other technical assistance.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HVSI	73,000	0

Narrative:

The epidemiology of HIV/AIDS in the Guyana Defense Force (GDF) will be established through increased surveillance and analysis of strategic information from the HIV Seroprevalence and Behavioral Epidemiology Risk Survey (SABERS). The GDF will have an established health information management system that increases availability of HIV/AIDS strategic information. Collaboration with the USG country team will be established for a strategic information and monitoring and evaluation (M&E) program for HIV/AIDS prevention/treatment activities in the GDF that will be compatible with the PEPFAR M&E system. Collaboration will also lead to the development of a health information management system to: 1) Increase availability of HIV/AIDS strategic information 2) Develop and manage HIV/AIDS interventions3) Develop policies and programs and 4) Assure confidentiality and appropriate referral. Existing data will be analyzed from SABERS and additional surveys conducted to establish HIV/AIDS prevalence and incidence within the GDF. Human resource capacity will be built with the hiring of a Surveillance officer and sustainability for M&E will be improved through training and the development of a monitoring program. Information technology materials will be procured for implementation of PEPFAR initiatives with the GDF (e.g.) computers, software, projector, screen flipcharts etc.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	OHSS	15,000	0

Narrative:

One Guyana Defense Force (GDF) health care provider will attend the Military International HIV Training Program in San Diego, California where comprehensive training will provide a conceptual background and practical experience in HIV management, management of common opportunistic infections, policies and operational aspects of clinical and military management of HIV infected personnel and their families. HIV diagnostics and the laboratory diagnostics of parasitic diseases and opportunistic infections will be taught. Vital concepts and methods of epidemiology and biostatics will address the critical public health issues including surveillance, bias, confounding and study design using and evaluating medical information and use of statistics from the HIV Seroprevalence and Behavioral Epidemiology Risk Survey (SABERS) will be reviewed. Training and

experience in database development, maintenance and data entry will be provided. Key elements of health communication messages and social marketing efforts to promote HIV prevention, voluntary testing and counseling (VCT), relevant software, library and medical researching skills will be enhanced with the provision of multi-purpose health Netbooks.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	CIRC	1,000	0

Narrative:

This activity will provide male circumcision and counseling and testing for those who seek circumcision surgery in accordance with international standards and international guidance. Approximately 40-70 males in the Guyana Defense Force (GDF) will also be counseled on the need for abstinence from sexual activity during wound healing, wound care instructions and post-operative clinical assessments and care also promotion of correct and consistent use of condoms. Activities for supportive supervision and quality assurance will be performed by registrars from the Georgetown Hospital. Training programs will be established and education materials provided. Provision of equipment and commodities will be in support of male circumcision procedures.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HMIN	7,500	0

Narrative:

Medical and laboratory personnel including doctors, nurses, phlebotomists, laboratory technicians and medics will continue to be trained in the implementation of universal precautions in all the Guyana Defense Force (GDF) clinical settings. Refresher training will be held in standard, safe blood drawing, sample handling techniques, infection prevention and control, waste management, needle stick precautions/post-exposure prophylaxis and safe phlebotomy and lancet procedures. Commodity security will include sustained availability of bio-hazard bags, safety disposable containers, gloves, lancets and single-use syringes. Monitoring of safety precautions will be continued internally by the trained, certified laboratory supervisor for injection safety and waste management.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	0	0

Narrative:

This program area targets officer cadets, recruits of both male and females aged 18-25 and male ranks aged 18-30 deployed to outlying posts. Training will continue to support medical personnel and peer educators to provide AB messages. Additionally, leadership positions will be encouraged to provide prevention education to their subordinates. Activities will be extended beyond Georgetown to outlying military posts in Regions 1, 2, 3, 5, 6, 7, 9 & 10. Peer education will be supplemented through the distribution of HIV/AIDS prevention information,

education and communication (IEC) materials. Fifteen HIV/AIDS awareness sessions will be continuous with the integration at military training sessions and national HIV/AIDS prevention activities in collaboration with the National AIDS Program Secretariat (NAPS) at the Ministry of Health (MOH). Activity reporting mechanisms will be implemented by supportive supervision from Youth Challenge Guyana, standardized IEC materials and record keeping of registration will be maintained.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	3,000	0

Narrative:

Counseling and testing (C&T) by trained counselors will be available at all four counseling and testing sites at Base Camp Ayanganna, Base Camp Stephenson, Coast Guard and Base Camp Seweyo. C&T will continue to be performed in accordance with international guidelines and will include targeted ABC messages. Reduction of stigma and discrimination will be emphasized, including implementation of mechanisms to maintain the anonymity of those tested and confidentiality of their test results. Linkages into the civilian health sector for referrals of HIV positive ranks will be maintained. Plans are also underway to increase the service portfolio at C&T sites to provide other health related services such as domestic violence, psychosocial and alcohol and substance abuse counseling. Refresher training will be continued on an annual basis and in collaboration with the National AIDS Program Secretariat (NAPS) national activities. Data collection and activity reporting mechanisms will continue and maintained with monitoring by NAPS.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	10,000	0

Narrative:

Ranks of the Guyana Defense Force (GDF) will continue to train and promote preventing HIV transmission within the force including prevention messages, sexually transmitted infection (STI) management and programs to reduce other risks of persons. Currently, male and female condoms are available through the National AIDS Program Secretariat (NAPS) and distributed to all bases and locations. Safe sex messages will include partner reduction, consistent and correct condom use and correct knowledge of HIV transmission with special focus to the role of men in adopting safer sex behaviors to protect themselves and their partners/families. Sensitivity to issues surrounding stigma and discrimination will be emphasized. Population-targeted information, education and communication (IEC) materials will be continued to be reproduced and distributed. Activity tracking and reporting mechanisms will continue internally.

Implementing Mechanism Details

Mechanism ID: 7375	Mechanism Name: HIV/QUAL International

Funding Agency: U.S. Department of Health and Human Services/Health Resources and Services Administration	Procurement Type: Cooperative Agreement
Prime Partner Name: New York AIDS Institute	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 75,000	
Funding Source	**Funding Amount**
GHP-State	75,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

HEALTHQUAL is a collaborative effort between the Ministry of Health of Guyana, UNICEF, CDC and HIVQUAL International. The overarching goal of the Project is to improve the quality of care provided to all children and people living with HIV/AIDS in Guyana. The Project balances quality improvement and performance measurement while building a solid foundation of programmatic infrastructure.This approach emphasizes the development of systems and processes involving clinic staff and consumers with active support from agency leaders. These structural features are designed to be sustainable even when staff turnover is high or organizational affiliations change. HIVQUAL has been implemented in the areas of PMTCT and Care and treatment of TB and HIV. The Georgetown Public Hospital Corporation is only one inpatient facility that has begun to utilize this approach. The activities of HIVQUAL greatly support the data collection on which quality projects are crafted to improve performance in not only areas related to TB and HIV but also to other areas(well child and pregnant mothers) Coaching and mentoring of team leaders/ supervisors has been ongoing. These personnel are given the task to mentor another leader. The Plan is to expand the number of coaches and help the build the skills of the Continuous Quality Improvement (CQI) Cordinator(s) and leaders.Decision makers and stakeholders will be involved in the CQI integrated into the Health Care system. A National assessment of QI programs to identify gaps,challenges of the program will be conducted. The HIVQUAL team will work with the CQI team in country to develop a process for regular review of the indicators, as well as develop a plan for spreading QI across the health system.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	75,000

TBD Details

(No data provided.)

Key Issues

Child Survival Activities

Safe Motherhood

TB

Budget Code Information

Mechanism ID:	**7375**		
Mechanism Name:	**HIV/QUAL International**		
Prime Partner Name:	**New York AIDS Institute**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Governance and Systems	OHSS	75,000	0

Narrative:

The HIVQUAL program will assess technical capicity and resources of the MOH for full integration performance measurement, which will help in developing a sustainable program that includes a plan for data collection. reporting and analysis. They will also seek to build capicity at the national level to analyze Quality Improvement (QI) projects and interventions. development of a plan to include consumers in QI work at national, regional and at the facility levelis included for the succeccful transition of the program. The data collected are based on the areas of which in which the country measures performance for PEPFAR reports. For example the next genetation indicators selected to be reported on for prevention of mother-to-child transmission (PCTCT) provided a guide for drafting the HIVQUAL indicators. The data informs the program of it's performance which inturn guides QI projects to improve the quality of care that will be captured in the data.

Implementing Mechanism Details

Mechanism ID: 10074	**Mechanism Name: Partnership with HHS/CDC to Assist PEPFAR-built Quality Laboratory**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Association of Public Health Laboratories	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 50,000	
Funding Source	**Funding Amount**
GHP-State	50,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The Association of Public Health Laboratories (APHL) has been involved in technical assistance to the Guyana MOH and the National Public Health Reference Laboratory (NPHRL) for the development of the national public health laboratory system through a unique twinning partnership with the North Carolina State Laboratory of Public Health (NCSLPH). APHL will continue to manage this partnership and provide other technical assistance to the MOH and NPHRL, as requested and in keeping with the 5-year national laboratory strategic plan for Guyana. APHL will also explore the feasibility of installation and implementation of a laboratory information system for the reference laboratory network systems to support ART program implementation in the country. Under the twinning partnership, APHL and NCSLPH will continue to provide mentorship and technical assistance in the areas of quality management systems and biosafety. In addition, assistance will be provided in building capacity for the NPHRL to perform rapid high-complexity laboratory methods that will help to identify HIV-related illnesses faster. APHL will continue to also provide travel for key NPHRL staff to attend trainings and workshops that will aid in the performance of their job duties. The goal of this award is to further solidify the relationship between the NPHRL and NCSLPH as a long-term partnership between public health institutions. Another goal is to develop the technical capabilities of the NPHRL by providing the aforementioned technical assistance.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	10074		
Mechanism Name:	Partnership with HHS/CDC to Assist PEPFAR-built Quality Laboratory		
Prime Partner Name:	Association of Public Health Laboratories		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Governance and Systems	HLAB	50,000	0

Narrative:

The Association of Public Health Laboratores (APHL) will continue to manage this partnership and provide other technical assistance to the Ministry of Health (MOH) and National Public Health Reference Laboratory (NPHRL), as requested. APHL will continue to provide technical assistance the implementation of the 5-year national laboratory strategic plan for Guyana. APHL will also explore the feasibility of installation and implementation of a laboratory information system for the reference laboratory network systems to support ART program implementation in the country. Under the twinning partnership, APHL and North Carolina State Laboratory of Public Health (NCSLPH) will continue to provide mentorship and technical assistance in the areas of quality management systems and biosafety. In addition, assistance will be provided in building capacity for the NPHRL to perform rapid high-complexity laboratory methods that will help to identify HIV-related illnesses faster. APHL will continue to also provide travel for key NPHRL staff to attend trainings and workshops that will aid in the performance of their job duties. As a continuation from FY11, APHL will perform the following activities: 1.

Provide continued mentorship to the NPHRL by holding routine conference calls (frequency to be determined) between NPHRL and NCSLPH staff to discuss relevant issues pertaining to daily operations of the laboratory. facilitate a mechanism by which relevant staff of NCSLPH review and provide feedback on NPHRL policy and process and procedure documents, particularly those pertaining to quality systems and biosafety. 2. Facilitate travel and participation in international trainings or workshops on technical aspects of testing and quality systems for NPHRL key staff.3. Continue process of development of 5-year Strategic Plan for the NPHRL using the National Strategic Plan for Medical Laboratories 2008-2012 as overarching frame of reference. In FY12, APHL will also provide an assessment of the NPHRL for the installation and implementation of a laboratory information system (paper or electronic) so that laboratory tests can be easily tracked and recorded

Implementing Mechanism Details

Mechanism ID: 10076	**Mechanism Name: Ministry of Health**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Ministry of Health, Guyana	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: PR/SR	
G2G: Yes	Managing Agency: HHS/CDC

Total Funding: 913,750	
Funding Source	**Funding Amount**
GHP-State	913,750

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The Guyana Ministry of Health works to combat HIV are through promotion of informed and responsible behaviors and healthier lifestyles, reduction of morbidity/mortality due to STI/HIV/AIDS and reduction of the psycho/social/economic impact of STI/HIV/AIDS, especially in pregnant women, blood donors, TB infected patients and MARPS. The program spans all ten administrative regions of Guyana with a network of 165 facilities. In FY 12, this IM will specifically support the MOH in improving sexual health for the people of Guyana, improving program management and coordination, promotion of safer sexual practices through IEC programs, improving

surveillance, care and treatment, establishing special HIV/AIDS prevention and control programs and effective management and evaluation the HIV/AIDS programs.
Over time, the MOH will increase efficiency through decentralization of HIV care and treatment, training and empowering a diversified cadre of workers to deliver HIV care and treatment to the population with universal coverage and utilizing evidence based and cost efficient methods to deliver services. The MOH will also assume more responsibility and eventually take complete ownership of the program. Training of staff at the National AIDS program Secretariat and other facilities in monitoring and evaluation will intensify during FY 12 and 13 so that provision of care will be more evidence based and accountability will improve.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	118,750

TBD Details

(No data provided.)

Key Issues

Implement activities to change harmful gender norms & promote positive gender norms
Increase gender equity in HIV prevention, care, treatment and support
Child Survival Activities
Mobile Population
TB
Family Planning

Budget Code Information

Mechanism ID:	**10076**		
Mechanism Name:	**Ministry of Health**		
Prime Partner Name:	**Ministry of Health, Guyana**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**

Care	HBHC	42,906	0

Narrative:

The Cooperative Agreement of CDC with Ministry of Health supports HIV adult care and support in facilities and community settings. The main types of care and support services provided to persons living with HIV/AIDS are Home – based care for clients who are in need, provision of pharmaceuticals for illnesses such as diarrhea and Opportunistic Infections, laboratory investigations, pain and symptom relief, psychological and spiritual support and end -of- life care and bereavement services, safe water interventions, nutritional assessment and counseling support. Preventive services include partner/couples counseling, testing and support, STI diagnosis and treatment and family planning, counseling and condom provision. All of these types of services take place at the community or health facility settings. At the health facility level services such as provision of pharmaceuticals, clorosol and provision of IEC materials for safe water. Home based care nurses provide services in the community. These include psychological and spiritual support and end of life care. Community support groups some non-governmental organizations, relatives of clients and home based care nurses form linkages between program sites and non-HIV specific services such as food support.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVTB	75,000	0

Narrative:

In previous years PEPFAR's, support for TB/HIV was mainly through technical support provided by the local CDC office and funding through implementing partners such as PAHO and FXB. For FY2011 the NTP will continue to receive direct funding as part of the Ministry of Health CoAg to "expand and strengthen the quality of services and information related to the TB/HIV activities in-country, with coordination from CDC and their implementing partners".

The National Tuberculosis Program (NTP) in collaboration with the National AIDS Program Secretariat (NAPS), and its partners has developed the country's strategic plan as well as set guidelines for TB, HIV and TB HIV patients.

The NTP plans to scale up the DOT HAART initiative to improve the management of dually infected patients in at least 6 of the 10 regions in Guyana.

This will include the supervision of the administration of TB medications as well as at least one dose of ARVs and ongoing monitoring of the clinical status of co-infected patients. The funding will continue to support the recruitment of a DOT HAART supervisor and a social worker as well as facilitate the training of existing DOT workers.

The NTP through their surveillance, monitoring and evaluation of TB/HIV collaborative activities has been able to

report data and track progress towards stated objectives.

From the reports received there has been achievement in the percentage of TB patients who had an HIV test result recorded in the TB register of 90%.

The care of HIV patients co-infected with TB at the TB clinics needs to be improved as well as the care of HIV patients who has latent TB at the HIV care site needs to be improved. The TB patients who are diagnosed will continued to be managed at the TB clinics with their appropriate ART while there will be the implementation of IPT at HIV care sites for the HIV patients with latent TB.

In COP 12 MOH will renovate one of the buildings in the hospital compound in Georgetown to provide step down care for Multi Drug Resistant (MDR) TB, including those co-infected with HIV and other complicated TB cases. MDR TB is an emerging phenomenon in Guyana. The National TB Program (NTP) has developed a draft strategic plan to prevent and control the emergence of MDR TB in Guyana in response to the emergency. The step down care facility is an integral component of the plan to combat MDR TB. It will not only allow for the inpatient care for MDR TB cases for at least 4 months but will also assist in the rehabilitation of patients through stepwise re-integration into the community.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	10,625	0

Narrative:

COP 12 and 13 will continue to support the MOH in its provision of pediatric care and support in its facilities. The target population for pediatric care and support will be all HIV exposed infants and HIV infected children and adolescents who are not on ART. The MOH will intensify Early Infant Diagnosis of HIV through DNA/PCR testing of Dry Blood Spots on exposed infants between six and eight weeks of age. This will be facilitated by full implementation of the Case Tracking System. Scale-up in diagnosis also include intensifying antibody testing of children for HIV at 12 and 18 months of age and beyond or those who may have missed earlier diagnosis and occasionally for those who were being breastfed. The COP supports provision of cotrimoxazole to exposed infants as prophylaxis from six week of age until they are diagnosed HIV negative and for HIV infected infants to prevent opportunistic infections. In COP 12 and 13 screening for TB and Pneumonia will be an important activity during the pediatric period.

Adolescents who are HIV-infected are educated about the disease once disclosure is made to them about their illness. Particular emphasis is placed on adherence counseling and Prevention With Positives counseling as they prepare to enter into adulthood. Nutritional evaluation will be continuously done.

The Ministry of Health will continue to support activities that support improved quality of care and strengthening of health services including constant review of data and records, ensuring that those in care are not lost to follow-up. The Case Tracking System will ensure that clinic attendances are improved.

Activities that the MOH will use to promote integration of pediatric care, nutrition services and MCH services

include taking anthropometric measurements, laboratory assessments , nutritional evaluations in children attending MCH clinics with Provider Initiated Counseling and Testing when necessary. Nutritional support counseling of mothers/guardians will be intensified. The MOH will continue to strengthen its health facilities to provide laboratory support so that diagnoses of co-morbidities can be made.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HLAB	100,000	0

Narrative:

The Ministry of Health will continue efforts to strengthen laboratory services and infrastructure in Guyana. The goal of the MOH laboratory activities in COP12 and COP13 will be to improve the quality of life and survival of PLHIV by providing access to quality assured laboratory services for HIV diagnosis, care, and treatment.

The quality of laboratory services at both the national and regional levels will be enhanced with the Health Facilities Licensing Act which came into effect in April 2008 and which requires all laboratories to be certified by the Guyana National Bureau of Standards (GNBS). NPHRL is already certified by the GNBS to GYS170:2003 (based on ISO17025) and is currently working towards international accreditation. Two of the regional laboratories Linden and New Amsterdam are working towards GNBS certification by the end of FY12. In COP12 and13 MOH will continue to participate in international and local External Quality Assurance (EQA) programs. Additionally in COP12 and 13 MOH will support QA managers at NPHRL to travel to regional/district laboratories and HTC sites to provide oversight, training and assessment in compliance with QA programs.

The coverage of public laboratory services extends to five levels: health post, health center, district hospital laboratory, regional hospital laboratory, and tertiary laboratory. Health posts and centers which are also VCT sites are found throughout Guyana and provide other services such as malaria smears and possibly hemoglobin, while district level facilities perform basic testing such as hemoglobin, complete blood count (CBC), urinalysis, and blood glucose. At the regional level there are 4 regional laboratories in Guyana (Linden, Suddie, West Demerara, and New Amsterdam).These regional laboratories are all located on the coast of Guyana where the HIV epidemic is more prevalent. In addition to HIV testing the regional laboratories have the capacity to provide automated chemistry and hematology. All diagnostic and clinical monitoring functions such as CD4, Viral Load and Early Infant Diagnosis for PEPFAR programs are performed the NPHRL which is the only tertiary laboratory in the country.

Training activities have been developed to ensure continuous improvements in human resources. Laboratorians from Microbiology, TB, Molecular Biology and Serology departments will be trained in validation of new techniques including Nitrate Reductase Assay and Line Probe Assay for TB, EIA for toxoplasmosis and CMV, and

fluorescence microscopy for PCP. Furthermore QA managers at NPHRL will conduct remedial training in quality assurance and laboratory testing while senior staff at NPHRL is expected to be trained in laboratory management.

In COP12 and 13, MOH laboratory activities will continue to be aligned to the objectives of the National Strategic Plans for Medical Laboratories 2008-2012 and 2012 – 2020. To facilitate seamless transition and sustainability CD4 testing for the two faith-based institutions i.e. St Joseph Mercy Hospital and Davis Memorial hospital will continued to be provided by NPHRL even as CRS (AIDsRelief) transition expansion of ARV therapy programs including expansion of high quality HIV care, prevention and treatment activities in faith based-affiliated sites.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HVSI	100,000	0

Narrative:

In FY 2012, CDC will continue support MOH SI in following 3 categories:

1. Personnel: support staff needed for implementing surveillance system and institutional review board (IRB);
2. Training: continue support trainings of surveillance staff and IRB members.
3. Supplies for Management of IT and Surveillance system, this include the overall required electrical infrastructure and support for the WAN deployment within the MOH Brickdam complex and across its external administrative sites, the implementation of the virtual library infrastructure and an internal network, as well as stationary supplies for the surveillance of the Ministry of Health

CDC will continue to work in close collaboration with the Ministry of Health (MOH) including the National AIDS Programme Secretariat (NAPS) office, the National Blood Transfusion Services (NBTS), and Implementing Partners to strengthen and support strategic information (SI) activities including health management information systems (HMIS), surveillance, monitoring and evaluation (M&E), and programmatic research. In FY12, CDC will emphasize improving SI systems in the MOH and at NAPS, will work to improve coordination between the national statistics unit and various program areas, and provide technical assistance to the Government of Guyana technical committee for the review of Prevention of Mother to Child Transmission (PMTCT) data collected at Antenatal Clinics (ANCs).

CDC will provide technical assistance to the MOH for use of the National Patient Monitoring System (PMS). CDC will assist the MOH in completion of the National Epidemiologic Profile begun in FY07. In addition, CDC will collaborate with USAID and GHARP II to assist the Government of Guyana to revise the National HIV/AIDS M&E Plan and National Strategic Plan (NSP) on HIV/AIDS. Specific support to the MOH includes short-term technical assistance (TA) and targeted trainings in data management, surveillance, M&E and research methodology and

planning.

Since FY2009, CDC provided ethics and research training for over 50 persons in Guyana and assisted with MOH with the establishment of Guyana's first Institutional Review Board (IRB). In FY2012, CDC will continue to provide guidance to the MOH IRB.

Lastly, CDC will continue to work with MOH to strengthen routine program reporting utilizing standardized reporting systems that minimize redundant efforts for different reporting pathways. In recognition of the human resource shortages that inhibit strong SI programs in country, CDC will assist with training and mentoring of MOH staff. A portion of the CDC direct-hire Epidemiologist position and the National Alliance of State & Territorial AIDS Directors are supported through the SI program activity.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	OHSS	118,750	0

Narrative:

Build institutional capacity of public MCH clinics to provide care of HIV exposed infants through training, technical assistance, task shifting from physicians to medex and nurses, and development of appropriate SOPs. Support for updating of National Blood Safety Strategic Plan and Quality Management.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HMBL	131,250	0

Narrative:

The National Blood Transfusion Service (NBTS) of the Ministry of Health will continue to improve in areas that are critical to the safety, quality and availability of blood products. Primary objectives for FY2012 include blood collection that will encompass revision of policies and procedures to have quality systems in place while at the same time implementing best practices and evidence based strategies. Additionally training and mentoring of new staff and further training for collaborators and volunteers will be done during the next two years. To ensure efficient blood collection blood donor recruiters and the management of NBTS will coordinate and schedule a number of blood drives with projected numbers of collection. The implementation in 2011 of the Delphyn, blood banking data management system from Diamed is critical to ensure process control and standardize processing. With regards to Testing and Processing, during 2012 and 2013 all blood collected by the NBTS network will be tested for Syphilis, HIV, HBV, HCV, Malaria, Micro-filaria and HTLV 1&2 and Chagas, all testing for TTIs will continue to be centralized at NPHRL; testing, processing and preparation of components will be done by NBTS.Integration of blood safety with other HIV/AIDS servicesBlood safety activities are closely integrated with the Laboratory Infrastructure program the Director of the National Public Health Reference Laboratory (NPHRL)

is tasked with managing the daily operations of the NBTS and all testing for transfusion transmitted infections (TTIs) is done at the NPHRL. Blood safety also has linkages to maternal health aspects of the PMTCT program, patient referral systems and confidentiality issues under counseling and testing: and data management and collection under Strategic Information.Coverage and scope of blood safety activities including geographic coverage There has also been an increase in the number of voluntary non-remunerated blood donation during the period 2004-2010 with a concurrent decrease in the number of family/replacement blood donations. Blood collection and storage is currently performed at six public sites in Guyana. Six private hospitals access blood for transfusion directly from the NBTS. Twelve (12) public and private hospitals perform blood transfusions. These sites are located in regions 2, 3, 4 (includes the capital, Georgetown), 6, and 10.

Target Populations: Healthy adults, principally youth, are targeted for recruitment as blood donors. Women and children with anemia due to malaria, complications of surgery or childbirth and trauma accident plus patients who become anemic as a result of HIV antiretroviral medication will be the primary beneficiaries of a safe blood supply. How blood safety activities foster country ownership and sustainability.

The NBTS will work in collaboration with the CDC/GAP Guyana office, to achieve program outcomes. All activities implemented under this program will follow national policies and guidelines for the delivery of blood safety interventions. During 2012, Supply Chain Management System (SCMS) will transition the procurement of materials and consumables (e.g. test kits and reagents) to the MOH, Materials Management Unit (MMU).

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	15,000	0

Narrative:

The Ministry of Health through COP 12 will support targeted provider initiated testing and counseling of patients and partners seen in STI, TB and HIV care and treatment sites. The clinical facilities that will be supported for these activities will be The National Care and Treatment Center, the Georgetown Chest Clinic and the mobile medical clinic that services the hinterland communities.

The testing algorithm used will be similar to the national algorithm.

MOH will intensify activities to ensure that clients who are tested HIV positive are enrolled in care and treatment through intense counseling, emphasizing the importance of starting treatment early.

Quality assurance of testing and counseling will be done by ensuring that counselors and testers are adequately trained and periodically retrained and their performance monitored through Quality Assurance methods.

The uptake of Counseling and Testing by couples will be used as a measure of effectiveness of HTC.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	43,750	0

Narrative:

STI management of at risk youth and pregnant women. Targets geographic areas with high STI morbidity.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	118,750	0

Narrative:

In COP 2012 Ministry of Health, Guyana will continue to support the PMTCT program to effectively screen pregnant women and their partners to prevent the transmission of HIV and provide adequate care and support for those already infected. PMTCT HIV counseling and testing services are now available at 157 sites countrywide, including antenatal clinics and labor and delivery wards, however, there are only 19 HIV care and treatment sites that are capable of providing prophylaxis treatment for HIV-infected pregnant women. During FY 2011, 82.9% of pregnant women knew their HIV status, unfortunately, many of those who are HIV infected do not receive a complete course of ARV's prior to delivery. Some clients still experience problems in accessing care because of long distances that they need to commute in order to receive prophylaxis at one of the 19 care and treatment sites. To address this issue, during COP12 the MOH will further decentralize care, build capacity and empower more staff.

During the scaling–up of PMTCT program, the high cost of hiring International facilitators, advisors and travel and subsistence to low prevalence hinterland areas contributed significantly to the high cost per patient for PMTCT services. Measures that can decrease the unit cost for reaching patients include further decentralizing PMTCT service. The MOH has begun to address this by training MEDEX to deliver service to the hinterland regions. In addition there are now more trained local staff available to deliver services. The MOH will continue to encourage partner testing for HIV, discordant couples counseling and testing and consistent family planning for HIV – positive mothers. The MOH will enhance and evaluate their Case Tracking and Management system. This system entails Case Managers tracking infected mothers and their newborn infants after delivery. Several PMTCT activities are well integrated into MCH, including HIV counseling and testing, Rapid Testing at Labor and Delivery wards and ELISA testing for HIV at the National Public Health Reference Laboratory. However, provision of ART is not well integrated. The MOH will address this barrier by further decentralizing PMTCT services.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXS	125,844	0

Narrative:

In COP 2012 and 2013 the Ministry of Health will continue to build on successes under COP 2011 and provide training to clinicians. Training will involve mainly physicians who graduate from the University of Guyana and graduates from Cuba. Physicians will be trained under the guidance of the National AIDS Program Secretariat and National Care and Treatment Canter (NCTC) in all aspects of ART of People Living with HIV/AIDS. These physicians will receive didactic as well as mentorship by experienced physicians to ensure appropriate application of skills to the clinical setting. The MOH will also train MEDEX, a category of clinical health assistants, nurses and community health workers in ART.

The Ministry of Health under the COP provides on-site supervision at the NCTC and through the mobile unit to treatment sites in the hinterland regions of Regions 1, 7, 8 and 9. Supervision is done by senior MOH physicians to junior physicians and in the case of the hinterland regions to MEDEX as well. The MOH tracks clinical outcomes by using the data of clinical examinations and laboratory monitoring, through routine CD4 and Viral Load testing. While the majority of adults currently on first line ART have good outcomes a small minority experience treatment failure and are on second line ART.

At the site level, performance measurement data is examined and discussed periodically by multidisciplinary teams who assess the data from different perspectives and take corrective measures.

The MOH supports several activities aimed at retention of patients on ART. These activities are geared to ensure that patients are not lost to follow-up. They include encouragement of treatment buddies, linkage to home-based care nurses and social workers.

PEPFAR supports the MOH to implement measures to maximize adherence. These include intense pre-initiation adherence counseling by pharmacists, social workers and clinicians and at least one session involving a group of patients for initiation. The first clinic attendances after initiation are shortened, usually two weeks apart and patients are closely followed and advised how to deal with adverse drug reactions and other issues. At every subsequent visit adherence counseling is given and the recall method is applied and in some cases pill counts are done. These activities are generally successful in achieving a high level of adherence.

The target population for ART for the MOH is all adults who meet clinical criteria for ART, including pregnant women, adults with high risk behaviors, patients co-infected with TB and other opportunistic infections. All HIV-infected patients are screened for TB and cotrimoxazole prophylaxis is widely applied according to treatment guidelines in all patients co-infected with TB disease.

Some activities that the MoH has undertaken in order to improve programmatic efficiencies to allow for continued expansion of services include rationalizing the frequency and schedule of laboratory investigations e.g. viral load testing commences in adults at six months after initiation of ARVs and is repeated at six month interval thereafter. Other activities are training of MEDEX to manage and treat HIV infected persons in the hinterland communities and decentralizing HIV treatment activities.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	PDTX	31,875	0

Narrative:

The Ministry of Health revised Pediatric Treatment Guidelines for HIV in COP 2011. These guidelines are now in effect in the National Care and Treatment Center which is the main facility for pediatric HIV/AIDS treatment in Guyana. During COP 2011, 39 males and 31 females in the 0 to 15 age dgroup were placed on ART. During COP 2012 and 2013, treatment targets in this age group will be 8o and 90 respectively.

In COP 2012 and 2013 the Ministry of Health will continue to train clinicians to deliver pediatric care and treatment at all treatment sites. The National Care and Treatment Center will be the main facility where mentoring

of physicians for pediatric treatment will take place. Other categories of health care workers such as nurses, counselors, social workers, MEDEX, pharmacists, community health workers will also be trained to build a cadre of caregivers for all MOH treatment facilities. *The MOH will continue and intensify training and retraining of program supervisors at the national, regional and district clinical site levels to routinely collect data and monitor the quality of service. In this regard, in COP 2012 there will be training and support of supervisors in monitoring and evaluation.* *The MOH will intensify adherence counseling to parents/guardians of children and adolescents on ART. During COP 2012 and 2013 full implementation of the Case Tracking System will significantly minimize the loss to follow-up of mother/infant and other children on treatment. Full integration of pediatric care to MCH services in addition will improve the retention of infants and children on treatment.* *The MOH will continue to promote integration of pediatric treatment services into MCH platforms of service delivery and other services in the community. The integration of PMTCT program into MCH services will ensure that infected children receive the care that uninfected children receive, including evaluation and intervention for nutritional deficiencies.* *Training and retraining of staff in the technique of sample collection through Dried Blood Spots will continue in the COP 2012 and 2013. Care providers will be trained at central, regional and district levels in PITC so that siblings of HIV infected children, children of HIV-infected mothers and adolescents will be evaluated. CD4% and Viral Load testing will be done according to guidelines for pre-ART pediatric clients and those on ART. CD4 testing is decentralized to 2 regional hospital laboratories and will be further decentralized. Since Viral Load testing is done only at the National Public Health Research Laboratory, samples will be collected from children on treatment from all MOH facilities and taken there for analysis.* *The MOH will ensure that adolescents in treatment will receive intense education and counseling to understand the significance of HIV/AIDS and their condition, emphasis being placed on the importance of adherence and how they can improve their quality of life. As they transition to adulthood, they will be given Prevention With Positives counseling.* *The MOH will intensify training in Strategic Information for its staff at the various levels in collaboration with CDC. Systems for data collection and analysis will be implemented and strengthened at all levels.*

Implementing Mechanism Details

Mechanism ID: 13175	**Mechanism Name: Hinterland Initiative (Expanding HIV/AIDS services to indigenous Amerindian Communities)**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Remote Area Medical	

Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 48,000	
Funding Source	**Funding Amount**
GHP-State	48,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Remote Area Medical (RAM) Guyana, as a partner in the Hinterland Initiative, will take a regional approach to the HIV/AIDS response with a "one stop shop" methodology incorporating HIV/AIDS services with other health services in order to maximize efficiency and reduce stigma and discrimination of HIV/AIDS services. With the goal of achieving primary prevention of HIV infection in Region 9 of Guyana, the objectives of the RAM project are to: scale up counseling and testing services through establishment of fixed site (Lethem Eye Clinic/RAM office) as well as an extensive mobile program; to improve upon and utilize existing transportation and infrastructure required for services and activities such as VCT and education; to educate vulnerable populations' delay of sexual debut, safe sexual practices, and reduction in alcohol use. By extension these services will improve upon and make better use of existing referral network through the CDC/MOH mobile care and treatment team; to inform and engage residents of Region 9 at the local level about the need for care and psychosocial support and the effects that stigmatization and discrimination have on care and treatment, with the goal of strengthening the capacity of regionally-based structures and organizations to respond to the epidemic in a coordinated and informed manner. RAM will coordinate and collaborate with a wide range of stakeholders to foster local ownership of, and participation in activities; to reduce overlap and cover gaps in services provided through active information sharing and promotion of regional coordination mechanisms; and to improve strategic information activities and develop materials that are demographically and geographically relevant and beneficial to both regional and national decision makers.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Key Issues

Increase gender equity in HIV prevention, care, treatment and support

Mobile Population

Budget Code Information

Mechanism ID:	**13175**
Mechanism Name:	**Hinterland Initiative (Expanding HIV/AIDS services to indigenous Amerindian Communities)**
Prime Partner Name:	**Remote Area Medical**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	48,000	0

Narrative:

Activities to be undertaken by RAM Guyana through the RPH project under the Hinterland Initiative will include working in close collaboration with the CDC Guyana office to develop strategies and activities in FY12.This will include monitoring and review of ongoing program activities; RAM will also collaborate with the National AIDS Program Secretariat/Ministry of Health and national stakeholders to plan for VCT expansion activities , training, and follow up; continuing Regional AIDS Committee meetings to generate continued support for the project and to identify areas of collaboration.

RAM will also continue to engage and sensitize the indigenous population at the village-level regarding issues such as Stigma and discrimination, psychosocial support, VCT mobilization, community feedback, and program ownership. RAM will also work collaboratively in the areas of VCT and Edutainment to ensure community groups and partners build local capacity.

Implementing Mechanism Details

Mechanism ID: 13245	**Mechanism Name: Capacity-Building Assistance for Global HIV/AIDS Microbiological Laboratory**
Funding Agency: U.S. Department of Health and	Procurement Type: Cooperative Agreement

Human Services/Centers for Disease Control and Prevention	
Prime Partner Name: American Society for Microbiology	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 50,000	
Funding Source	**Funding Amount**
GHP-State	50,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The American Society for Microbiology (ASM), in coordination with the Centers for Disease Control and Prevention (CDC)-Guyana, the Guyana Ministry of Health (MOH), the National Tuberculosis Programme (NTP), and other local partners, will continue to expand its technical assistance (TA) to the Guyanese public health laboratory network, with emphasis on tuberculosis (TB) and other microbial opportunistic infections (OI). The specific objectives for FY12 are: 1. Continued improve human resources and laboratory infrastructure (including biosafety) for diagnosis of TB at National Public Health Reference Laboratory (NPHRL) and select peripheral laboratories. 2. ASM's TA will continue to concentrate primarily on the NPHRL. However, during the annual visit by the ASM Program Manager, a plan will be developed to expand assistance to other TB laboratories in Guyana, taking into consideration the lessons learned during the previous year at the NPHL. To make better use of the scarce resources allocated to this program, ASM will coordinate its efforts with other partners, such as PAHO, to avoid duplication of activities; and also build on the lessons learned from FY11 activities. ASM will also continue to pull from its multiple in-house programs (fellowships, professorships etc) and resources (books etc) to help build local scientific capacity. ASM will continue to emphasize M&E as a means of routinely tracking the key elements of program performance and proposes to optimize efforts by developing more standardized and harmonized tools for data collection and reporting, which should be aligned with Guyana's existing data collection systems. This would minimize parallel M&E efforts and diminish reporting burden. These activities will be overseen by a staff M&E specialist.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Key Issues

TB

Budget Code Information

Mechanism ID:	**13245**
Mechanism Name:	**Capacity-Building Assistance for Global HIV/AIDS Microbiological Laboratory**
Prime Partner Name:	**American Society for Microbiology**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HLAB	50,000	0

Narrative:

For FY12, the ASM consultant will continue to train National Public Health Reference Laboratory (NPHRL) laboratorians in tuberculosis (TB) solid culture, and newly implement multi-drug resistant TB identification and drug susceptibility testing (DST); and expand this training to other labs in the country. S/he will also assist with the introduction of new diagnostic methods, such as Capillia and line probe assays. ASM consultants will also continue to train NPHRL and regional laboratorians on opportunistic infection (OI) diagnostic techniques indentified as being needed by the national HIV care and treatment program in FY11.

Implementing Mechanism Details

Mechanism ID: 13246	**Mechanism Name: Infectious Disease Control Program**
Funding Agency: U.S. Department of Health and	Procurement Type: Cooperative Agreement

Human Services/Centers for Disease Control and Prevention	
Prime Partner Name: University of Maryland	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 486,562	
Funding Source	**Funding Amount**
GHP-State	486,562

Sub Partner Name(s)

(No data provided.)

Overview Narrative

University of Maryland (UOM) will continue to strengthen institutional capacity of key public institutions in Guyana in the training of medical students and residents in the diagnosis, evaluation and management of patients with HIV and other infectious diseases and their co-morbid conditions. In order to achieve this goal, the UOM will focus on the following key objectives: 1. Strengthening of the pre-service education institution through the professional development and training of University of Guyana (UG faculty); renovation and upgrading of laboratories; training and mentorship of medical students during their hospital rotations and lab practicums 2. Expansion of the post-graduate medical education program at UG and GPHC by implementation of a 3-year internal medicine/infectious disease residency program in collaboration with UG and GPHC and international faculty 3. Development of a national in-service training and mentorship program with technical consultation from international experts to ensure that practicing clinicians have opportunties to improve their skills and knowledge in the care and management of patients with HIV, TB and other opportunistic infections. The UOM's program will focus on public institutions with headquarters in Georgetown/Region 4. It is envisioned that the reliance on international faculty and consultants will decrease over time as host country nationals develop the knowledge, skills and tools to better educate and mentor medical students. In addition, the University of Maryland will be working closely with the MOH to ensure that there are mechanisms in place to retain promising Guyanese residents and promotional opportunities to increase the likelihood that they will not emgirate after completion of the program.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	450,000

TBD Details

(No data provided.)

Key Issues

TB

Budget Code Information

Mechanism ID:	**13246**
Mechanism Name:	**Infectious Disease Control Program**
Prime Partner Name:	**University of Maryland**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HBHC	28,125	0

Narrative:

The University of Maryland will provide pre-service, in-service and mentorship of medical students, post-graduate residents and practicing physicians in clinical monitoring, evaluation and management of opportunistic infec.75 tions in HIV infected patients.*

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVTB	42,188	0

Narrative:

University of Maryland will provide technical consultation and guidance to the staff at GPHC on the diagnosis, clinical monitoring and treatment of TB and HIV/TB co-infected patients hospitalized at GPHC. The University of Maryland will also provide enhanced pre-service, in-service and mentoring of medical students, post-graduate residents and practicing physicians in the prevention, diagnosis and management of TB in HIV infected patients. The University of Maryland will collaborate closely with the National TB Program to explore rotational opportunities for post-graduate residents at the chest clinics and to provide assistance in updating of national

guidelines and strategic plans.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	8,437	0

Narrative:

The University of Maryland will provide pre-service, in-service and mentorship of medical students and post-graduate residents and practicing physicians in the identification and clinical care of HIV-exposed infants and children.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	OHSS	337,500	0

Narrative:

The training of medical doctors to work within the health care system in Guyana has historically relied on scholarship arrangements between the Government of Guyana and foreign countries (Cuba, the former Soviet Union etc.). It was only in 1985 that the School of Medicine was established as a department of the Faculty of Health Sciences at the University of Guyana. The Bachelor of Medicine, Bachelor of Surgery degree offered by UG is a 5-year program which includes one year internship at the Georgetown Public Hospital Corporation (GPHC). The medical students and interns conduct clinical rotations at the hospital under the supervision of GPHC clinical mentors. Only two residency programs are currently recognized at University of Guyana/GPHC - one in surgery and the other in Emergency Medicine. An average of 25 medical students graduate per year from the University of Guyana, the majority though emigrate and enroll in residency programs abroad and do not return to Guyana afterwards. In response to this inability to train and retain physicians, the GoG established a partnership with the Cuban government to educate Guyanese medical students. Approximately 500 of these Cuban trained medical students will be returning to Guyana over the next few years but most of them have had little to no clinical exposure. Although the initial intent was to have these students work with Cuban specialists after returning to Guyana, the availability of these specialists is inconsistent.. Many of the returning Cuban trained physicians are sent to remote areas as medical directors of regional hospitals although they are inexperienced and ill-prepared to assume this significant responsibility. Historically, PEPFAR funding has provided high-level technical guidance, support, trainingand mentoring to the Ministry of Health (MOH) and those physicians who remain in country. Although individual capacity to provide high quality care has been built overtime, many of these physicians also emigrate or are reassigned. Currently there is very little institutional capacity that has been built and heavy reliance on international experts for updating of guidelines, consultation on complex cases, and even relatively routine program management activities continues. The University of Maryland will heavily focus on building the institutional capacity of the local government institutions (University of Guyana, GPHC and MOH) to ensure enhanced education and training for pre-clinical and postgraduate students and opportunities for

continuing medical education for practicing clinicians. It is anticipated that 10 - 15 medical students per year will have received enhanced and intensive training on infectious diseases by the end of FY 13 and that 3 - 5 postgraduate students will be enrolled in the IM/infectious disease residency program during FY 13.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXS	56,250	0

Narrative:

The University of Maryland will provide pre-service, in-service and mentorship of medical students, post-graduate residents and practicing physicians in clinical monitoring, evaluation and management of patients with HIV infection.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	PDTX	14,062	0

Narrative:

The University of Maryland will provide pre-service, in-service and mentorship of medical students, post-graduate residents and practicing physicians in clinical monitoring, evaluation and management of pediatric patients with HIV infection.

Implementing Mechanism Details

Mechanism ID: 13384	**Mechanism Name: Positively United to Support Humanity**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Davis Memorial Hospital and Clinic	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 655,864	
Funding Source	**Funding Amount**
GHP-State	655,864

Sub Partner Name(s)

Society of St. Vincent De Paul Care Centre	St. Joseph's Mercy Hospital	

Overview Narrative

In FY2012 PEPFAR funds will be used to support the Guyana's Faith-Based Holistic HIV Care and Treatment Initiative—Positively United to Support Humanity (PUSH) to continue supporting the Government of Guyana's policy to provide universal access to HIV testing, care, treatment and support services. Primary objectives for FY2012 include a comprehensive package of HIV-related prevention, clinical care and treatment services, palliative care for terminal patients, and step-down care for those with disease requiring rehabilitation services. PUSH will strengthen and create a sustainable health system with an approach inspired by WHO's six building blocks of an effective health system and a three-pronged strategy that ensures excellence in provisions for high-quality medical care, efficient site management (planning, financial and human resource management, and leadership) and use of strategic information for evidence-based decision making. Davis Memorial Hospital (DMH), in consortium with St. Joseph's Mercy Hospital (SJMH) and St. Vincent de Paul Care Center (SSVP), will provide facility-based care for HIV-infected/affected children, adults and families including prevention and treatment of opportunistic infections, clinical, psychosocial and adherence readiness assessment and support for retention in care. These partners aim to strengthen routine quality assurance and continue to use patient outcomes evaluation data for improved decision making. The focus of this partnership is to provide a continuum of care through a family-focused, women and girl-centered approach to address clinical, social, psychological and spiritual aspects of HIV/AIDS in Georgetown—Guyana's most affected region.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Key Issues

TB

Budget Code Information

Mechanism ID:	**13384**
Mechanism Name:	**Positively United to Support Humanity**
Prime Partner Name:	**Davis Memorial Hospital and Clinic**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HBHC	126,466	0

Narrative:

Facility-based care for HIV-infected adults and their families including prevention and treatment of opportunistic infections (OIS), clinical, psychosocial and adherence readiness assessments and support for retention in care. DMH and SJMP will continue to provide access to onsite laboratory service, pharmaceutical and radiologic services to HIV-infected clients. PUSH-sponsored SSVP will continue to provide access facility-based hospice/step-down care services for HIV-infected adults nationally, at no cost to the client. SSVP provides end of life care to HIV-infected adults with terminal and/or advanced HIV disease in addition to rehabilitation services to clients.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	15,000	0

Narrative:

Facility-based care for HIV exposed infants and HIV infected children and adolescents including early infant diagnosis, prevention and treatment of IOs, nutritional assessment and support and other services. Additional services include age appropriate support group meetings, adolescent/youth friendly clinics, and linkages to social support networks. PUSH-sponsored SSVP will continue to provide access facility-based hospice/step-down care services for HIV-infected adolescent and children nationally, at no cost to the client or family. SSVP provides end of life care to HIV-infected adolescents with terminal and/or advance HIV disease in addition to rehabilitation services to clients requiring the same.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HVSI	50,000	0

Narrative:

The Positively United to Support Humanity (PUSH) Consortium will assume the responsibilities from AIDS Relief

and continue support to local partner treatment facilities (LPTFs) in Guyana for activities related to strategic information. PUSH will also continue to promote programmatic and operational decision making and planning based on quality data to assure high quality HIV care and treatment. In FY2012, PUSH will contribute to strengthening the local health system by providing support and supervision to assure on e of that LPTFs use longitudinal medical record systems (electronic and paper based)to improve quality of care, patient management, and their capacity to report to donors and the MoH. PUSH will provide technical assistance through trainings and site visits, as well as continue to work collaboratively with other implementing partners and the MoH to build sustainable monitoring and evaluation (M&E) units and health management information system (HMIS).

Information usage activities at LPTFs is a key factor in addressing and reducing drop-out rates and improving ARV pick-up rates. PUSH will help strengthen LPTFs' capacity by coordinating strategic information activities that are integrated into daily clinical care and support quality improvement activities.

Activities include:
• Data collection, management and reporting
• Collection and compilation of HIV patient data using the National Registers, longitudinal medical records, and electronic patient management and monitoring systems.
• Collection and analysis of required indicators requested by LPTFs, CTCT and funding agencies; provide feedback to LPTFs and stakeholders
• TA for LPTFs to develop specific plans enabling them to easily review and analyze data (information) to enhance /improve their program, operations and patient care.
• Data quality improvement workshops
• Establish a Continuous Quality Improvement (CQI) committee in collaboration with LPTFs
• Promoting and fostering a culture for data use at local sites
• On- and off-site data usage training workshops
• On- and off-site Training workshops on defining indicators to measure quality and success of the local programs
• Developing custom reports to assess programs and services
System strengthening and sustainability
• Regional workshops to share best practices and information for evidenced-based decision making
• National workshops and collaboration with other implementing partners to strengthen Guyana's M&E System

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	15,000	0

Narrative:

PUSH sponsored faith-based care and treatment sites provide access to point of care HIV counseling and testing services with continued scale-up of provider initiated testing and counseling. The scale-up of PICT will ensure

'the timely detection of HIV, prevention of HIV transmission, and subsequent access to appropriate HIV prevention, treatment, care and support services.' PUSH-sponsored will increase PITC by 10% in FY'2012-13, with focused emphasis groups at highest risk for HIV infection including partners and children of HIV-infected clients; commercial sex worker and men who have sex with men. PUSH adapted a PICT scale-up check-list, tailoring it to the Guyana context to identify groups at high-risk for HIV infection. The PICT scale-up checklist is intended as a tool for use by hospitals, medical institutions and medical personnel to gauge how PUSH's facilities (hospital, clinic, individual departments) reach, serve, and offer PICT services to clients with unknown HIV status. This will allow PUSH an opportunity to identify institutional strengths and weaknesses, consider ways to address such weaknesses, and later to assess progress toward the scale-up of PICT services. Clients testing HIV positive will be referred into HIV care and treatment programs and prevention information, education and communication techniques will be afforded to high-risk groups identified HIV-negative through PICT.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	30,000	0

Narrative:

Offer of HIV counseling and testing to all pregnant women assessing care at Davis Memorial and St. Joseph Mercy Hospitals. Provisions for a minimum of 264 pregnant women accessing care will be afforded HIV counseling, testing and resulting services. The two faith-based facilities currently provides a full complement of prevention of mother-to-child transmission of HIV (PMTCT) services including antiretroviral therapy for pregnant HIV-infected pregnant women in accordance to national guidelines. In efforts to attain Guyana's objective of 0% mother-to-child transmission of HIV PUSH-sponsored facilities will collaborate with Ministry of Health's Maternal Child Health unit to implement a sustainable case management/tracking system to intensify support for HIV-infected pregnant women and HIV-exposed infants in ensuring access to HIV care and treatment services throughout the pregnancy and post partum period.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXS	379,398	0

Narrative:

Facility-based treatment for HIV-infected adults and their families will include support for exams, clinical monitoring, lab-related services, mentoring of medexes in remote locations and adherence support to improve treatment retention.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	PDTX	40,000	0

Narrative:

Support for holistic medical care with access to medical examinations conducted by HIV physician specialist, clinical monitoring including laboratory, radiologic services and adherence support to improve retention in treatment. The faith-based organization includes HIV physician specialist with specialized training in pediatric HIV medicine. Provisions for the management of pediatric HIV antiretroviral treatment will continue to afford the pediatric group of HIV-infected clients high-quality care. The organization will collaborate with MoH to provide high-level technical assistance and training in the area of pediatric HIV medicine.

Implementing Mechanism Details

Mechanism ID: 14260	**Mechanism Name: Peace Corps**
Funding Agency: U.S. Peace Corps	Procurement Type: USG Core
Prime Partner Name: U.S. Peace Corps	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 27,035	
Funding Source	**Funding Amount**
GHP-State	27,035

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Peace Corps (PC) works in all regions of Guyana targeting the general population with a primary focus on youth but collaborates with other USG partners to serve MARPS as well. The goals of Peace Corps Program in Guyana are: (1) To assist efforts by the relevant Ministries and NGOs, (2) To increase the effectives of these efforts by facilitating community involvement , the training of service providers and introducing new approaches to HIV/AIDS prevention and (3) To provide community service and health education outreach to target populations. As integrated members of their communities, PCVs are able leverage additional community resources to enable local, sustainable responses. As a USG PEPFAR partner, PC supports Goals 1 and 2 of the draft Partnership Framework and subsequently is in support of Guyana's transition model of limited technical collaboration as oulined in the Guyana PEPFAR's Vision Statement 2012-2017. Our strategic approach in support of greater country ownership will be in the form of interventions addressing the following: 1. Capacity building in monitoring and evaluation of impact prevention intervention 2. Support to local organizations that focus on reducing HIV transmission through

behavioral and structural approaches that address conditions underlying and influencing behavior and capacity building in advocacy leadership among NGOs/CBOs and individuals from within vulnerable populations 4. Coordinate community diagnostic information compilation by PCVs to enhance the asset mapping process piloted by MOH. Note: An additional $15,000 carryover funds from FY11 not refected in current funding sources will be used to support these activties.

Cross-Cutting Budget Attribution(s)

Gender: Gender Equality	20,000

TBD Details

(No data provided.)

Key Issues

Implement activities to change harmful gender norms & promote positive gender norms
Increase gender equity in HIV prevention, care, treatment and support

Budget Code Information

Mechanism ID:	**14260**		
Mechanism Name:	**Peace Corps**		
Prime Partner Name:	**U.S. Peace Corps**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Governance and Systems	HVSI	3,900	0
Narrative:			
Approximately 75% of health volunteers are attached to health care facilities in various Regions of Guyana. Volunteers work with their host agencies/facilities and counterparts to improve the existing collection, management and use of strategic information systems, in line with the objectives of the Ministry of Health's			

Strategic Information Systems and Central Surveillance units. Peace Corps Guyana will continue to improve the existing collection, management and use of strategic information within the health sector. This will be achieved through the efforts of both generalist and specialist volunteers by: (1) Supporting health workers for case surveillance, operational research and health information systems. (2) Collaboration with other USG agencies on targeted interventions. (3) Information Technology training for health care workers and IT personnel within the health sector. (4) Development of databases and responsive training to health staff

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	23,135	0

Narrative:

Peace Corps has 65% and 35% of its Volunteers serving in coastal and interior/indigenous communities of Guyana, respectively, with a primary focus on the youth population generally and addressing MARPS especially in the interior/indigenous locations. In support of PEPFAR interagency efforts, Peace Corps Volunteers will focus on capacity building in advocacy leadership among NGOs/CBOs and individuals from within vulnerable populations. In addition, Peace Corps will develop and implement a core set of cost-effective, context appropriate and evidence based strategies for HIV prevention focusing on the behavioral and structural strategies to address knowledge, attitudes, risk perception, and sexual behavior of MARPs and OVP. This will be achieved through: (a) Adapting evidence based/high impact prevention interventions (b) Integrating behavior change strategies into every volunteer activity while promoting HIV/AIDS awareness and evidence based behavior change interventions with OVPs (c) Collaboration with other USG agencies on targeted MARPS interventions (d) Life skills development with OVPs

Implementing Mechanism Details

Mechanism ID: 14399	**Mechanism Name: DOL**
Funding Agency: U.S. Department of Labor	Procurement Type: Cooperative Agreement
Prime Partner Name: International Labor Organization	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 0	
Funding Source	**Funding Amount**
GHP-State	0

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The DOL/ILO partnership will work on further strengthening the capacity of the national partners and will established key milestones for the sustainability of coordinated reponse to HIV in the world of work involving all the key actors in Guyana. Special attention will be given to the integration of HIV and the world of work issues in existing training curricula of established institutions as well as to the consolidation of the work understaken in the partner enterprises.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Key Issues

Implement activities to change harmful gender norms & promote positive gender norms
Increase gender equity in HIV prevention, care, treatment and support
Increasing women's legal rights and protection
Mobile Population
Safe Motherhood
Workplace Programs
Family Planning

Budget Code Information

Mechanism ID:	**14399**

Mechanism Name:	DOL		
Prime Partner Name:	International Labor Organization		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Prevention	HVOP	0	0

Narrative:

The DOL/ILO partnership will focus on the:

1. Development and revision of the HIV/AIDS workplace policy and workplace programmes in 15 partner workplaces. An assessment conducted in August 2011 in the 15 partner enterprises indicated the need for additional support to further strengthen programmes and ensure sustainability. In addition, some workplaces that started collaboration with the project in 2011 have not yet developed their workplace policy.
2. Integration of HIV-related issues into the curricula of the Critchlow Labour College and the GAWU Labour College which comes under the auspices of respectively the Guyana Trades Union Congress and the Guyana Agriculture and General Workers Union.
3. Training and skills development of lecturers from the Labour Colleges to deliver the programmes.
4. Integration of HIV-related issues in the curricula of training institutions partnering with the project.
5. Training and skills development of lecturers of the training institutions partnering with the project.
6. HIV/AIDS workplace policy and programmes development for the Upper Berbice Forest and Agricultural Producers Association.
7. "Community" Competence Training for Labour, Occupational and Safety (LOSH) Officers from the Ministry of Labour.

Implementing Mechanism Details

Mechanism ID: 14713	**Mechanism Name: National Alliance of State and Territorial AIDS Directors**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: TBD	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 100,000	
Funding Source	**Funding Amount**
GHP-State	100,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

This mechanism will provide consultation on the national surveillance strategic plan and the related implementation plan, including, most specifically, assessing the capacity building/training needs to support sustainable and Ministry of Health-led implementation. In addition to facilitating knowledge transfer in support of the surveillance implementation plan and a national monitoring and evaluation plan, this mechanism will also partner with local government strive to share emerging surveillance methods that align well with what Guyana seeks to know about their national epidemic. While focusing primarily on HIV surveillance, this mechanism will participate in and consult on the national surveillance strategic plan and implementation plan, as well as providing capacity building and technical assistance to support staged and sustainable implementation, including support via training and mentorship, initiation of prioritized HIV/AIDS surveillance work, designing and planning for staged implementation plan on HIV/AIDS, sharing community-based empowerment models, evidence-based community-driven HIV prevention and treatment adherence programs and capacity building models and curricula. Note: this IM will be funded 100% via pipeline funds.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID: 14713 Mechanism Name: National Alliance of State and Territorial AIDS Directors Prime Partner Name: TBD			
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Governance and Systems	HVSI	100,000	0
Narrative:			
This mechanism will review the Guyana Surveillance Strategic Information System and implementation plan to assess training and capacity building needs, including defining technical assistance priorities, implement framework to understand surveillance-related training and capacity building needs and create a joint work plan to establish roles, responsibilities, and deliverables. This mechanism will determine and provide didactic training with clear learning objectives and partnered applied learning.			

Implementing Mechanism Details

Mechanism ID: 14778	**Mechanism Name: Credited Institution or University**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Vanderbilt University	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 330,000	
Funding Source	**Funding Amount**
GHP-State	330,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The purpose of this program is to develop and establish a Master of Public Health (MPH) Degree Program in Guyana through the University of Guyana. The goal is to strengthen human resources in public health and epidemiologic capacity in Guyana through this MPH program that prepares graduates for leadership in public health. This MPH program will contribute to the goals of building local capacity, increased country sustainability, and local government ownership, leadership and management of the response to HIV/AIDS that are embodied in PEPFAR II. Currently there are no baccalaureate or master-level degree programs in public health in Guyana. Currently, only one trained epidemiologist working within the Guyana Ministry of Health, who received her training outside of Guyana. This mechnism will (1) develop a standardized list of competency domains that will be addressed by the academic curriculum for master's degree program in public health; (2) assist with faculty development (technical and increased teaching skills capacity) and training; (3) support the University of Guyana in recruiting and enrolling students in the Master of Public Health degree program; (4) support the University of Guyana in conferring a Master's Degree upon successful completion of the program (5) support the University of Guyana in developing a plan for transitioning the program to the Health Science Faculty of University of the Guyana; (6) collaborate with the Ministry of Health (MoH) and other relevant stakeholders to develop and facilitate the career structure for students who have successful completion of Master of Epidemiology Program. Note: this IM will be funded 100% via pipeline funds.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	330,000

TBD Details

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	14778		
Mechanism Name:	Credited Institution or University		
Prime Partner Name:	Vanderbilt University		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Governance and Systems	OHSS	330,000	0

Narrative:

The mechanism will have supported the University of Guyana in establishing a Master of Public Health program faculty by end of year 2, and each academic year thereafter support the University of Guyana in recruiting and enrolling 15-20 students in the Master of Public Health degree program annually, and by end of year 4 and each academic year thereafter, the mechanism will support the University of Guyana in conferring a Master of Public Health degree to at least 10 students through the program. The mechanism will support the University of Guyana in developing a detailed sustainability plan for transitioning the program to the University of the Guyana Health Science Faculty, support MOH and other relevant stakeholders in developing a career structure for retaining MPH graduates for the public health leadership roles in Guyana, and support University Guyana in establishing a fully functional IRB.

Implementing Mechanism Details

Mechanism ID: 14779	**Mechanism Name: State**
Funding Agency: U.S. Department of State/Bureau of Western Hemisphere Affairs	Procurement Type: Cooperative Agreement
Prime Partner Name: U.S. Department of State	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 12,800	
Funding Source	**Funding Amount**
GHP-State	12,800

Sub Partner Name(s)

(No data provided.)

Overview Narrative

During FY 2012, State will increase its focus in supporing the transition process of the USG PEPFAR program from direct service to limited technical assistance model. In addition, State will continue its support of World AIDS Day activities, in coordination with the Minstry of Health and other stakeholders, such as printing and distribution of BCC materials and other activities that will be decided in collaboration with other stakeholders. In addition, with the onboarding of a PEPFAR/State Strategic Information Specliast, there will be increased efforts to strengthen the gathering and application of data for evidence-based decision making, including at the national policy level. These activities are meant to support the process of transitioning PEPFAR activities to the GOG and other stakeholders as outlined in the USG five-year vision statement in a systematic and coordinated fashion.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**14779**
Mechanism Name:	**State**
Prime Partner Name:	**U.S. Department of State**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HVSI	12,800	0

Narrative:

An increased emhpasis on strategic information for planning and decicion-making purposes will include the support of national level indicator target-setting workshops, a size estimation national dissemination meeting, and support for national quarterly meetings of the MOH M&E/SI TWG.			
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Prevention	HVOP	0	0
Narrative:			
In coordination with the Ministry of Health and other stakeholders, World AIDS Day activities will continue to be supported through the printing and distribution of posters and other BCC materials that will focus. Efforts will be made to focus these BCC materials and other events and activities for World AIDS Day on MARPs and other OVC.			

Implementing Mechanism Details

Mechanism ID: 16971	**Mechanism Name: UNICEF**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: United Nations Children's Fund	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: Yes
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 0	
Funding Source	**Funding Amount**
GHP-State	0

Sub Partner Name(s)

(No data provided.)

Overview Narrative

UNICEF headquarters and CDC headquarters have entered into a Cooperative Agreement with a broad scope of work that includes HIV pediatric care and treatment and Preventing Mother to Child Transmission of HIV (PMTCT) for interested PEPFAR countries. Utilizing this central mechanism CDC and UNICEF in Guyana are embarking on a cooperative agreement to address Pediatric Care and PMTCT in Guyana for COP 13. The overall

goal of this cooperative agreement is to improve the care of HIV exposed infants (HEIs). This agreement involves UNICEF providing Technical Assistance in the following areas: (a) Integration of care of HEIs into MCH services, (b) Development of a Monitoring and Evaluation system for the Case Management system that currently exists in the PMTCT program Guyana. The case management system was established to track HIV infected mothers and their newborn HEIs from delivery until the infants are 18 months old if not HIV infected to ensure that they are managed appropriately and are transferred to the well-baby clinic. MoH data reveal that the care of HIV exposed infants (HEIs) in Guyana is not optimally addressed. Specifically, the uptake of cotrimoxazole prophylaxis among HIV exposed infants by two months of age was merely 54% or 130 of 242 infants in Year 3 of the MoH / CDC Cooperative Agreement as stated in the MoH Annual Progress Report of 1st September 2011 to 31st August 2012. Similarly the percentage of HEIs who receive a HIV test by 12 months of age has been reported to be 60.7% or 147 out of a possible 242 infants during this period. This percentage is even less in infants less than 2 months of age.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Key Issues

Child Survival Activities

Budget Code Information

Mechanism ID:	**16971**
Mechanism Name:	**UNICEF**
Prime Partner Name:	**United Nations Children's Fund**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	0	0

Narrative:
In COP 13 CDC is entering into a Cooperative Agreement with UNICEF which will utilize the cooperative agreement that currently exists between UNICEF Headquarters and CDC Headquarters that includes a broad scope of work including HIV Pediatric Care and Treatment and Prevention of Mother to Child Transmission of HIV (PMTCT). The activities that UNICEF will be conducting will include Technical Assistance in improving supervision, improving quality of care and strengthening of the health services in order to achieve improvement in Pediatric Care. There were 242 exposed infants during FY 12 (September 2011 to August 2012). Of these HEIs only 60.7% received a HIV test by 12 months of age and only 54% received cotrimoxazole prophylaxis by 2 months of age. These statistics indicate that a significant percentage of HEIs are not receiving care in accordance with national guidelines.Currently parents of HEIs are required to schedule well-baby and follow-up care at MCH clinics and HIV care and treatment clinics. There is little communication or coordination of care between these two clinic settings, in fact, sometimes these clinics are located in different facilities with different staffing and charts. This cooperative agreement expects to improve the uptake of pediatric services by HEIs is integration of EID care into the MCH services which would entail training and capacity building of nurse midwives. UNICEF through this Cooperative Agreement will develop Standard Operational Procedures (SOPs) for the integration of Pediatric Care into MCH services. This would improve the percentage of HEI's with DBS specimens collected during the first 2 months of life and uptake of CTX since infants would receive these services in well-baby clinic.UNICEF will also assess the current practice of laboratory diagnosis of HIV exposed infants and make recommendations for improvement so that the uptake of early infant diagnosis will be improved from its current state. The Case tracking system has been instituted in the PMTCT program to monitor the HIV positive pregnant women and their infants, with a goal of ensuring that they attend clinic and receive the appropriate care and treatment according to the National HIV care and Treatment guidelines. UNICEF will provide Technical Assistance to develop and implement a monitoring and evaluation system for the Case Tracking system and make recommendations for its improvement.

Implementing Mechanism Details

Mechanism ID: 17122	**Mechanism Name: Advancing Partners and Communities Project**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: John Snow Inc (JSI)	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: Yes
Global Fund / Multilateral Engagement: No	

G2G: No	Managing Agency:

Total Funding: 1,900,000	
Funding Source	**Funding Amount**
GHP-State	1,900,000

Sub Partner Name(s)

FHI 360	International Center for Research on Women	

Overview Narrative

APC is the follow-on mechanism to the Guyana HIV/AIDS Reduction and Prevention (GHARP II) project and Community Support and Development Services Incorporated project. Activities previously performed by both contractors will now be implemented by APC. APC will continue to provide institutional capacity building in the public and private sectors to sustain an effective response to HIV/AIDS. With CSOs accounting for over 90% of national prevention efforts targeted to MARPs, TA is needed to strengthen the current program in order to effectively promote behavior change and facilitate regular access to HIV prevention services and products. Organizational strengthening and technical capacity building will be provided to a network of NGOs undertaking activities designed to reduce the incidence and prevalence of HIV/AIDS transmission among MSM, female sex workers and their clients, and mitigate its impact on PLWHA and their families. Special focus will be on helping NGOs to reach key and other vulnerable populations and to sustain efforts over the long term. These include building NGO financial and organizational capacity, disbursing and managing grants, developing effective program approaches for MARPs, and developing a robust system for monitoring program quality and effectiveness. It also includes working closely with the MOH to develop a transition plan that delineates the specific steps to transition key services to the government and to other stakeholders to ensure the continuum of care for people infected and affected by HIV/AIDS, as well as building NGO skills to advocate for policy change. APC will also assist the MOH to develop a system that formally recognizes the role of NGOs so that community-based services can complement facility-based services.

Cross-Cutting Budget Attribution(s)

Economic Strengthening	200,000
Education	150,000
Gender: GBV	100,000

Gender: Gender Equality	100,000
Key Populations: FSW	250,000
Key Populations: MSM and TG	300,000

TBD Details

(No data provided.)

Key Issues

Implement activities to change harmful gender norms & promote positive gender norms
Increase gender equity in HIV prevention, care, treatment and support
Increasing women's legal rights and protection
Mobile Population
End-of-Program Evaluation

Budget Code Information

Mechanism ID:	**17122**
Mechanism Name:	**Advancing Partners and Communities Project**
Prime Partner Name:	**John Snow Inc (JSI)**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HBHC	567,535	0

Narrative:

APC will work closely with the National HIV/AIDS Program Secretariat (NAPS) and USAID-funded NGOs to strengthen the quality of services provided and to work towards sustainability. Emphasis will be placed on modified systems of community/home-based care that will focus on targeted prevention activities, linkage and adherence to care and treatment support and the broader issues of primary health care, targeting especially key and vulnerable populations. Hence to maximize USG's support to the national program in the provision of a comprehensive and integrated package of services, APC will implement the recommendations of the Care and Support Technical Working Group report (October 2012) which includes the following activities: Identify a standardized model of care aimed at addressing the needs of

clients with a specific focus on concentrated key populations which are consistent with the Guyana setting; establish a formalized bi-directional linkage system to ensure consistency across partners with a national tracking system that allows for standardized monitoring of referrals and tracking of clients; support client level reporting systems to collect, manage, analyze, and report specific information on client status, use of services, and unmet needs at the monthly clinical review meetings between home-based care (professional health worker/s) and facility staff and encourage the use of data for decision making; conduct a 'community profile' exercise to determine priority areas for targeting and budgeting future program activities, to include: HIV prevalence; population density; clinical status of the HIV-infected persons in the community as related to specific care and support service demands; types of service provided; and location of services related to HIV-infected persons; and address stigma and disclosure to enhance uptake of care and support services, particularly for key affected populations.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HKID	288,886	0

Narrative:

The community-based NGOs utilize a family centered approach to care for persons living with HIV, including OVC and their family members. NGOs provide an array of services including psychosocial support; social support, spiritual support; educational/vocational training support, and economic opportunity/strengthening support. In FY13, APC will continue to work closely with the USAID-funded NGOs and National AIDS Program Secretariat (NAPS) to strengthen the quality of services provided, and work towards sustainability. To this end, APC will provide mentoring and technical assistance to the participating NGOs to ensure adherence to guidelines and standards, as needed. Activities include strengthening the capacity of caregivers to support the emotional and social development of children/parenting skills training; strengthening the collaboration with NAPS to improve quality of services and promote networking and coordination; strengthening the referral system from the respective agencies/sites; and leveraging needed resources through the public and private sectors to strengthen and expand the existing OVC initiatives. Efforts will be made to strengthen linkages with existing Government of Guyana programs and agencies, and private sector companies for social support and educational opportunities to enhance economic empowerment. Emphasis will be placed on ensuring targeted interventions for OVC overlapping key populations sub-groups. APC will also provide financial and organizational assistance to NGO partners to implement comprehensive OVC programs.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HVSI	0	0

Narrative:

APC will support the MOH and NGOs to implement a recently developed database to track clients and service uptake at the community and national levels, requiring NGOs to record data at the client encounter level, which will be reported monthly to NAPS. APC will utilize standardized data collection forms for each program area. Achievements reported by the NGOs will be compiled in one database and compared to program area targets. Quarterly data quality assessments will be conducted for each NGO, in order to monitor the utilization of the monitoring system and the accuracy of the data collected. APC contractor will monitor and report on progress against the total program area targets and those individually set by the NGOs, in their annual monitoring and evaluation plan. APC will prepare semi-annual and annual reports, and achievements for submission to USAID for PEPFAR reporting. In this process the following are expected: Develop a monitoring and evaluation (M&E) plan, to measure the results achieved individually and collectively by the NGOs as well as to track the progress of capacity building activities of the organization within the first month of project implementation. Develop a data quality assurance plan to monitor the NGOs program monitoring systems and ensure uniform M&E systems and processes across NGOs, and the generation of high quality data within the first month of project implementation. Conduct monthly supervisory visits and quarterly data quality assurance reviews at each NGO, in order to monitor the utilization of the monitoring system, provide on-site guidance and mentoring and validate the accuracy of the data collected. Conduct an annual M&E workshop to share current M&E guidance, receive feedback and ensure uniform understanding of guidance across NGOs. Ensure NGO utilization of standardized data collection forms for each program area during M&E monitoring visits. Compile the achievements reported by the NGOs in one database and compare to program area targets. Monitor and report on progress against the total program area targets and those individually set by the NGOs/FBOs, in their annual M&E Plans. Prepare quarterly, semi-annual and annual reports on achievements for submission to USAID. Disseminate and provide technical assistance for the use of a NGO level program database. Maintain central M&E database for management of program data in order to prepare program reports to USAID.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	OHSS	0	0

Narrative:

The Government of Guyana, donors and civil society have recognized that in order to scale up the HIV response and achieve Guyana's goals, non-governmental and faith-based organizations have become important partners in the national response. While the NGOs are essential to extending the delivery of HIV/AIDS prevention, care and support services throughout the country, many of them have demonstrated inadequate capacity to rapidly scale up services as a result of their limited administrative management and financial capacity. This requires working with the NGOs in the field and maintaining

regular, even daily contact, to respond to emergency needs and monitor progress. Hence APC will meet the emerging needs of the NGOs by disbursing and monitoring grants to a network of USAID-supported non-governmental organizations (NGOs), and the NGO Coordinating Committee, while strengthening their financial and organizational management (including governance) capacity to enable them to expand HIV/AIDS services to key populations. Assistance will be provided in a targeted manner, focusing on direct management, onsite training and mentoring and other direct support, and when warranted, other formal training in the form of workshops to ensure long-term organizational sustainability. APC will also conduct the annual NGO work-plan development workshop, review all work-plans and provide technical comments to USAID.

Thus under the OHSS program area, APC will continue to build the capacity of the USAID-supported NGOs to fulfill critical governance and organizational tasks including: 1. Conducting organizational capacity assessment for each NGO and providing customized assistance. 2. Developing an accounting plan. 3. Developing action plans for each NGO with targets to meet capacity benchmarks.

On the policy front, the Guyana National Policy on HIV and AIDS emphasizes the rights of "all HIV positive individuals, regardless of nationality, race, age, religion, disabilities, gender, sexual orientation and socio-economic status . . . to the best quality of health care available without being subjected to any form of discrimination." However, policy issues such as stigma and discrimination and unsupportive legislation for key populations remain major challenges. APC will provide the NGOs with the necessary skills to advocate for the enforcement of human rights policies so that all Guyanese can access HIV services, including key populations. APC will also explore policy initiatives to be taken to ensure sustainability of NGO programming based on best practices.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	298,074	0

Narrative:

The Government of Guyana supports a mixed model of HTC. This mixed model includes both client initiated approaches such as mobile, home-based, and stand-alone counseling and testing, as well as provider-initiated approaches (PITC). In this context, home-based HTC is part of an existing community based service. Currently the program supports systematized links between HTC and HIV care, support and treatment services for clients who test HIV positive. Persons testing positive at NGO sites are enrolled in the care and support program and referred to or accompanied to the clinical site, and vice versa. However there are challenges with losses to follow up and tracking the outcomes of those referrals, especially since testing via HTC is primarily confidential, and there are no unique identifiers for each client tested. In addition, counseling and testing services need to be better targeted to those most at risk (MSM, FSWs and their clients). The MOH is leading efforts for HTC for the general population. Hence concerns related to this program area include limited testing among "high risk" and priority groups,

including MSM and FSW, partners of PLHA; poor referrals and follow-up among HIV-positive clients; the use of the existing parallel testing algorithm which is extremely expensive; limited scope of counselor/tester skills that inhibit them from providing comprehensive counseling to clients; poor coverage and coordination with the Ministry of Health and the private sector in remote and geographically-isolated locations; and low uptake among men. The contractor will therefore be tasked with providing key technical inputs to support the national voluntary counseling and testing program and work closely with NAPS to ensure quality in counseling and testing. This will be done through the following activities: Provide technical assistance to the MOH and NGO partners to increase access to and uptake of HIV services by key affected populations (particularly MSM, FSWs and their clients). This will require Innovative efforts to reach MSM and CSW to get them into testing. Provide technical assistance to NGOs to identify key affected populations living with HIV and link those individuals to anti-retroviral treatment and appropriate care and support services. This activity will help to identify effective strategies to reach these populations, get them into appropriate care and treatment or link them to other support as needed. Provide technical assistance to the NGO partners to deliver high quality and comprehensive pre- and post-test counseling services as part of HTC service delivery. Regular visits to NGO sites are required to assess the quality of services and to provide mentoring and supportive supervision as staff work toward reaching those most at risk. Work with the MOH and NGO partners to develop innovative strategies to enhance timely linkages between diagnosis and HIV care and treatment by strengthening the use of the bidirectional referral/reporting forms as a means of tracking clients referred for enrollment into HIV clinical care and treatment; and strengthen the current GBV screening in the HTC programs.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	745,505	0

Narrative:

Targeted approaches for key and other vulnerable affected populations, especially MSM, CSW and their clients, including counseling and testing will continue to be a major focus of our program. Significant attention will continue to be placed on providing appropriate services and products to this population. The contractor will work with the National HIV/AIDS Program and with the USAID-funded NGOs to refine strategies to reach this population with effective behavior change messages and with referrals for services including counseling and testing. The minimum package of services for both MSM and CSW will include: peer education and outreach, risk reduction counseling, condom and lubricant promotion and distribution, testing and counseling (HTC), support groups, and referrals for STI screening and treatment. In addition to these services, the comprehensive package of services for both MSM and CSW will include referrals for domestic violence, mental health, substance use treatment, other health, social, economic and legal services, and Positive Health Dignity and Prevention interventions. In addition, for female sex

workers (FSW), linkages to economic strengthening programs, parenting skills training, and referrals for sexual and reproductive health services will be conducted. Emphasis will be placed on strengthening the referral system to HIV care and treatment, other health and social services and to ensure that the referrals occur. APC will promote and develop initiatives to provide alternatives to sex work. Linkages will be made to existing Ministry of Health Agencies for income generating activities. Activities to decrease stigma and discrimination in the health sector will continue, with NGO staff taking the lead. In collaboration with the Ministry of Health and NGOs, APC will advocate for an enabling environment of supportive laws, regulations, policies and social norms, in order to facilitate meaningful access to HIV services by key populations without discrimination or loss of confidentiality at both the facility and community level. APC will also collaborate with the MOH and NGOs to address violence among key affected populations that increase their risk for HIV. APC will also provide short-term technical assistance, upon request, to the MOH to assist in developing (where none exists) and implementing strategies and guidelines, as well as service delivery for key affected populations. Ensuring that key populations are involved in planning and implementing programs that affect their lives will be a major focus.

USG Management and Operations

Assessment of Current and Future Staffing.

Redacted

Interagency M&O Strategy Narrative.

Redacted

USG Office Space and Housing Renovation.

Redacted

Agency Information - Costs of Doing Business

U.S. Agency for International Development

Agency Cost of Doing Business	GAP	GHP-State	GHP-USAID	Cost of Doing Business Category Total
ICASS		74,550		74,550
USG Staff Salaries and Benefits		428,150		428,150
Total	**0**	**502,700**	**0**	**502,700**

U.S. Agency for International Development Other Costs Details

Category	Item	Funding Source	Description	Amount
ICASS		GHP-State		74,550

U.S. Department of Defense

Agency Cost of Doing Business	GAP	GHP-State	GHP-USAID	Cost of Doing Business Category Total
ICASS		8,140		8,140
Staff Program Travel		6,000		6,000
USG Staff Salaries and Benefits		35,860		35,860
Total	**0**	**50,000**	**0**	**50,000**

U.S. Department of Defense Other Costs Details

Category	Item	Funding Source	Description	Amount
ICASS		GHP-State		8,140

U.S. Department of Health and Human Services/Centers for Disease Control and Prevention

Agency Cost of Doing Business	GAP	GHP-State	GHP-USAID	Cost of Doing Business Category Total
Capital Security Cost Sharing		204,091		204,091
Computers/IT Services	204,000			204,000
ICASS		355,039		355,039
Management Meetings/Professional Developement	56,300			56,300
Non-ICASS Administrative Costs		126,162		126,162
Staff Program Travel		1,000		1,000
USG Staff Salaries and Benefits	605,439	133,138		738,577
Total	**865,739**	**819,430**	**0**	**1,685,169**

U.S. Department of Health and Human Services/Centers for Disease Control and Prevention Other Costs Details

Category	Item	Funding Source	Description	Amount
Capital Security Cost Sharing		GHP-State		204,091
Computers/IT Services		GAP		204,000
ICASS		GHP-State		355,039
Management Meetings/Professional Developement		GAP		56,300
Non-ICASS Administrative Costs		GHP-State	DHL 500; telephone 18,022; office cleaning 7,200;	126,162

			advertisement 1,500; reference mat. 500; office lease 51,600; office/equip. repairs 15,000; office/custodial supply 10,000; IT supplies 10,800; security 11,040	

U.S. Department of State

Agency Cost of Doing Business	GAP	GHP-State	GHP-USAID	Cost of Doing Business Category Total
ICASS		26,217		26,217
Management Meetings/Professional Developement		0		0
Non-ICASS Administrative Costs		0		0
Staff Program Travel		0		0
USG Staff Salaries and Benefits		25,000		25,000
Total	**0**	**51,217**	**0**	**51,217**

U.S. Department of State Other Costs Details

Category	Item	Funding Source	Description	Amount
ICASS		GHP-State		26,217
Management Meetings/Professional Developement		GHP-State		0
Non-ICASS Administrative Costs		GHP-State		0

U.S. Peace Corps

Agency Cost of Doing Business	GAP	GHP-State	GHP-USAID	Cost of Doing Business Category Total
Peace Corps Volunteer Costs		101,085		101,085
Total	**0**	**101,085**	**0**	**101,085**

U.S. Peace Corps Other Costs Details