United States Department of State

Washington, D.C. 20520

FY 2015 Guyana Country Operational Plan (COP)

The following elements included in this document, in addition to "Budget and Target Reports" posted separately on www.PEPFAR.gov, reflect the approved FY 2015 COP for Guyana.

1) *FY 2015 COP Strategic Development Summary (SDS)* narrative communicates the epidemiologic and country/regional context; methods used for programmatic design; findings of integrated data analysis; and strategic direction for the investments and programs.

   Note that PEPFAR summary targets discussed within the SDS were accurate as of COP approval and may have been adjusted as site-specific targets were finalized. See the "COP 15 Targets by Subnational Unit" sheets that follow for final approved targets.

2) *COP 15 Targets by Subnational Unit* includes approved COP 15 targets (targets to be achieved by September 30, 2016). As noted, these may differ from targets embedded within the SDS narrative document and reflect final approved targets.

Approved FY 2015 COP budgets by mechanism and program area, and summary targets are posted as a separate document on www.PEPFAR.gov in the "FY 2015 Country Operational Plan Budget and Target Report."

GUYANA

Country/Regional Operational Plan

(COP/ROP) 2015

Strategic Direction Summary

APRIL 3rd 2015

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Goal Statement

Guyana is a low-prevalence HIV setting, with concentrated epidemic features. Despite 80% treatment coverage among detected cases in care, 36% of the estimated PLHIV are either undiagnosed or out of care. Reducing HIV incidence is the next step towards sustained epidemic control and PEPFAR Guyana aims to accomplish this by interrupting ongoing transmission among highest risk groups. The existing barriers to achieving this goal are (i) delayed testing and entry into care and (ii) high loss-to-follow-up for high-risk, HIV-positive individuals. The inability to monitor clients across the continuum of care compound these challenges, as patient-level program monitoring is ineffective prior to entry into clinical care.

The COP15 strategy seeks to address these barriers by (i) expanding the reach, identification and testing of higher risk individuals through peer-initiated activities at community-based organizations (CBO) and (ii) improving retention in facility-based care/treatment through enhanced care coordination between facilities and CBO. The long-term goal for the achievement of 90-90-90 and an integrated care and treatment approach where care and support activities are embedded in facility-based treatment sites. The development of a national patient monitoring system is essential for tracking patients across the HIV continuum of care and assessing progress towards the goal.

Key populations (KP) – namely, the transgendered (TG), commercial sex workers (CSW) and men who have sex with men (MSM) - are the target populations for the aforementioned strategy. Given their disproportionate burden of disease and disparate access to services, these groups drive ongoing transmission and activities targeted to them stand to have the greatest impact. A review of available data supports geo prioritizing region four, the capitol and most populated city for saturation. To realize this goal, necessary program pivots include (1) discontinuation of priority populations support – namely miners and loggers; (2) reduction in commodity procurement; (3) cessation of PMTC and TB/HIV funding; and (4) cessation of laboratory DSD to the MOH.

During the COP15 implementation cycle, key accomplishments to this end will include:

- Increased identification and testing of new KP in highest-burdened regions
- Results of CBO-supplemental care pilot for improved KP retention
- PUID pilot implementation for improved cascade monitoring;
- Availability of sub-national prevalence and KP size estimates
- Draft architecture of site-level patient monitoring system with electronic medical record (EMR) at high-volume sites
- Draft design of the co-financed national Health Management Information System (HMIS)
- Transition of HIV viral load testing equipment from ownership to a lease agreement
- No ART or RTK stock-outs under a country-managed inventory system (with technical oversight by the SCMS project);
- No more than 3 interruptions in lab services lasting more than 3 days;

Other notable shifts that informed COP15 programming include integration of the Guyana program into the Caribbean Regional Program in COP16 and the completion of Guyana's ongoing

transition from a direct service delivery (DSD) to targeted assistance/technical collaboration (TA/TC) program by COP17. DSD activities remain in KP prevention to ensure the ability to track KP program performance along the HIV cascade.

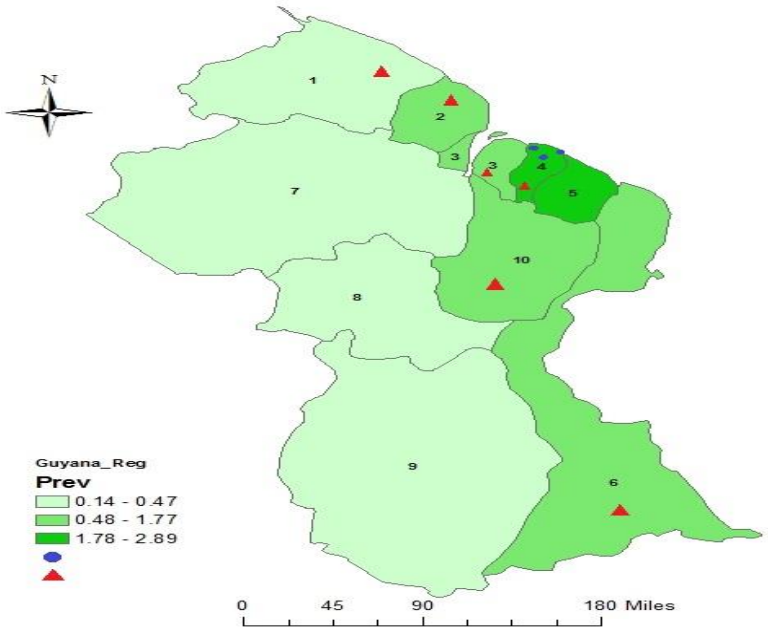
1.0Epidemic, Response, and Program Context

1.1 Summary statistics, disease burden and country or regional profile

Guyana is a lower middle-income economy, with a GDP of US$2.9 billion, extending along the northeastern coast of South America; it borders Brazil, Suriname, and Venezuela. Guyana is divided into 10 administrative regions, with four coastal regions (3, 4, 5, and 6). Most of its estimated 751,223 people are concentrated in the coastal areas (89.1%).[i] The total male-to-female population ratio is evenly distributed (i.e. 51%/49%)[ii] with 61% of the population between the ages of 15-65. The total life expectancy is 71 years. Guyana spends an estimated 6.6% of its GDP on health expenditures and the gross national income (GNI) per capita is $3750.[iii] They are the largest source of public health financing in the country with contributions from the donor community for HIV/AIDS financing.[v] At the end of 2012, Guyana's HIV budget was an estimated US$29million with PEPFAR providing 65% and the Global Fund 25%. The GoG acknowledges that PEFPAR investments are likely to decrease in the out-years.[iv]

HIV/AIDS remains one of the highest-ranking causes of disease and death in Guyana.[v]
Spectrum 2013 estimates a 1.4% HIV prevalence amongst adults aged 15-49; however, HIV prevalence rates are significantly higher among key populations[v]. A 2014 bio-behavioral surveillance study showed a 5.5% prevalence rate for sex works (SW), 4.9% for men-who-have-sex-with-men (MSM) and an 8.4% for transgendered (TG) persons. The HIV epidemic has substantial variance by region (Figure a). Region four accounts for the largest proportion (75.41%) of reported HIV cases followed by regions three, six, and ten.[v]

Figure a. HIV Prevalence by Region with PEPFAR supported sites (before the pivot).



Approximately 7700 people are living with HIV in Guyana.[vii] The National AIDS Program Secretariat (NAPS) data shows highest HIV prevalence in the 20-49 age groups and almost equally distributed between men and women.

In 2013, there were 758 reported cases of HIV and 88 reported AIDS cases; these figures represent steady decreases since 2010.[v] The country's HIV treatment and care program expanded from 2012 to 2013 from 19 to 22 facilities providing national coverage. In 2013, 4,896 (51.1% female and 48.9% male) people were enrolled into care - of which 3.2% were children – a 5% increase from 4,653 in 2012.

In 2013, 4,054 HIV clients (82.8% of HIV patients) received ART, representing a 3% increase from 80.1% in 2012[v]. Of those on ART, 89.6% were on first-line therapy, reflecting a steady increase in the proportion of patients on second-line therapy (58/1611, 2006 to 422/4054, 2013). AIDS-related deaths have declined since 2002 from 9.5% to 3.6% in 2010. The 2014 Spectrum estimate for annual AIDs deaths is less than 200.

Guyana is committed to the UNAIDS global90-90-90 goal and sustained epidemic control; however fractured supply chain management and laboratory systems threaten the achievement of this goal. Moreover, the absence of quality data for program planning, monitoring and evaluation limits the capacity to routinely assess and refocus the response. The below table one details national available estimates.

Table 1.1.1 Key National Demographic and Epidemiological Data

	Total		**<15**				**15+**				***Source, Year***
			Female		**Male**		**Female**		**Male**		
	N	%	N	%	N	%	N	%	N	%	
Total Population	751,223		131,518	18	135,629	18	243,671	32	240,405	32	National Census

											2002
Prevalence (%)		1.4						0.9 (15-24)		0.6 (15-24)	Guyana Spectrum 2014 file
AIDS Deaths (per year)	<200										Guyana Spectrum 2014 file
PLHIV	7,700		<200				4,000		3,500		Guyana Spectrum 2014
Incidence Rate (Yr)		0.11 (15-49)									Guyana Spectrum 2014 file
New Infections (Yr)	<1000										Guyana Spectrum 2014 file
Annual births	14,581										MoH Statistical Bulletin 2009
% >= 1 ANC visit											
Pregnant women needing ARVs	<200										Guyana Spectrum 2014 file
Orphans (maternal, paternal, double)											
TB cases (Yr)											
TB/HIV Co-infection		25 %									NTP Annual report, 2013
Males Circumcised											
Key Populations											
Total MSM*	2,464										BBSS 2014
MSM HIV Prevalence		4.9									BBSS 2014
Total FSW	3,811										BBSS 2014
FSW HIV Prevalence		5.5									BBSS 2014
Total PWID	-										
PWID HIV Prevalence	-										
Priority Populations											

Priority Populations Prevalence											
**If presenting size estimate data would compromise the safety of this population, please do not enter it in this table.*											

* All Data based on nationally available estimates, program, and surveillance data

Table 1.1.2 Cascade of HIV diagnosis, care and treatment (12 months)[1]										
				HIV Care and Treatment				HIV Testing and Linkage to ART		
	Total Population Size Estimate (#)	HIV Prevalence (%)	Total PLHIV (#)	In Care (#)	On ART (#)	Retained on ART 12 Months (#)	Viral Suppression 12 Months	Tested for HIV (#)	Diagnosed HIV Positive (#)	Initiated on ART (#)
Total population	751,223 (2002 Census)	1.4	7,700	842	4,054	411/516 (2012-2013 cohort)		63,402	758	534
Population less than 15 years	267,147 (2002 Census)			27	184	10/16 (2012-2013 cohort)		-	11	23
Pregnant Women		1.9	<200 (estimate of women needing ARVs)		205			12,349	Total :279 121 new ; 158 known (PMTCT)	77
MSM	2,464 (BBSS 2014)	4.9 (BBSS 2014)						579 (APR 14 NGO Data)	7 (APR 14 NGO Data)	
FSW	3,811 (BBSS 2024)	5.5 (BBSS 2014)						1,006 (APR 14 NGO Data)	10 (APR 14 NGO Data	

[1] *These should be national data, if the data do not exist, PEPFAR data **may be** used if relevant.
*TA/TC operating units should create Standard Tables 1.1.1 and 1.1.2 for each country prioritized for program focus in COP 2015.
*Estimates for testing, care, treatment, retention and suppression for key and priority population groups (below grey line) should only be included if reliable data exists.

PWID										
Priority Pop (specify)										

* Data based on nationally available estimates, surveillance and program data for 2013, unless otherwise stated.

1.2 Investment Profile

Guyana spends an estimated 6.6% of its GDP on health expenditures and the gross national income (GNI) per capita is $3750 (World Bank, 2013). With the exception of HIV programs, Guyana government revenues represent the largest source of public health financing.[4] The donor community, however, primarily sustains the national HIV response. At the end of 2012, Guyana's HIV budget was an estimated US$29million. PEPFAR provided approximately 65% followed by the Global Fund (GF) at 25%. GF's phase two approved amount was US$13.5 million; this allocation will cover the period from January 2014 to December 2017. GF finances first-line antiretroviral therapy (ART); voluntary counseling and testing; support services for orphans and vulnerable children; condom procurement and distribution; home-based care for PLHIV; and behavioral prevention packages for KP, miners and loggers, which include HIV testing and linkage to care. GF also funds a portion of its sub-recipient's direct and indirect costs. GF investments support outreach in eight regions. PEPFAR's investments complement those of the GF and we will continue to work jointly to help Guyana reach 90-90-90. PEPFAR and GF will also collaborate on key health diplomacy messaging, the human rights agenda and the integrated, interoperable health management information system.

The Government of Guyana (GoG) is positioning itself to increase domestic funding for HIV/AIDS programs. The National HIV Strategic Plan (2013-2020) acknowledges the impending decrease in donor funds. The GoG is gradually absorbing donor investments. As of October 2014, for example, the GoG has begun fully funding first and second-line pediatric ARVs – ARVs that were previously funded by PEPFAR. In 2015, PEPFAR will cease funding of second-line adult ARVs – transitioning such funding to the GoG. The combined PEPFAR and GF transition will result in the MoH taking responsibility for the funding of approximately 66% of all ARVs. In addition, the GoG has undertaken the financing of all previously PEPFAR-funded human resource costs under the prevention of mother to child transmission (PMTCT) program and the national public health reference laboratory (NPHRL). The projected GOG contribution to HIV funding is expected to increase by at least 61% from US $2.3 in 2010 to US$3.7 million in 2015 (HIVISION 2020).

Table 1.2.1 Investment Profile by Program Area[1]

Program Area	Total Expenditure	% PEPFAR	% GF	% GRP	% Other
Clinical care, treatment and support	3,681,702	70.42%	25.42%	3.39%	0.77%
Community-based care	183,414	41.00%	45.01%	13.99%	0.00%
PMTCT	509,897	80.39%	0.00%	19.61%	0.00%
HTC	892,821	43.99%	41.49%	13.85%	0.67%
VMMC	-	-	-	-	-
Priority population prevention	262,779	77.38%	4.39%	4.67%	13.56%
Key population prevention	317,162	15.72%	69.30%	13.53%	1.45%
Behavior Change Programmes	160,817	1.70%	50.93%	38.85%	8.50%
Programme for Children & Adolescents	7,116	1.17%	98.83%	0.00%	0.00%

Workplace Programme	36,178	1.05%	1.06%	24.44%	73.45%
Community Mobilization	158,650	23.09%	20.36%	44.02%	12.53%
Programme for PLHIV	96,772	37.17%	59.14%	0.34%	3.35%
Advocacy	21,766	0.00%	3.07%	1.92%	95.01%
Education	48,275	0.08%	50.65%	49.27%	0.00%
Gender Programme & Stigma Reduction	989	64.41%		28.01%	7.58%
Other Prevention	2,084,952	77.97%	4.91%	17.03%	0.08%
OVC	435,619	22.12%	4.37%	9.01%	64.51%
Social Protection	531,000	0.00%	0.00%	100.00%	0.00%
Laboratory	1,990,630	18.57%	0.29%	81.12%	0.02%
SI, Surveys and Surveillance	196,515	1.91%	41.72%	26.52%	29.85%
HIV & AIDS Related Research	595,618	99.48%	0.50%	0.02%	0.00%
Planning & Coordination, Procurement & Logistics	6,522,038	86.87%	10.20%	2.43%	0.50%
AIDS Specific Institutional Development	209,557	99.98%	0.00%	0.00%	0.02%
HSS	2,137,266	93.30%	4.58%	0.04%	2.08%
Other Activities Not Classified	77,990	100.00%	0.00%	0.00%	0.00%
Total	21,159,523				

Red font indicates NAPS categories
2012 NASA Estimation

Exchange Rate Used: $200

Table 1.2.2 Procurement Profile for Key Commodities (FY 2014 expenditure)

Commodity Category	Total Expenditure	% PEPFAR	% GF	% GRP	% Other
ARVs	$1,167,372.62	28.9	71.0	0.1	0
Rapid test kits	$241,972.47	63.0	14.0	23.0	0
Other drugs	0	0	0	0	0
Lab reagents	0	0	0	0	0
Condoms	0	0	0	0	0
VMMC kits	0	0	0	0	0
Other commodities	0	0	0	0	0
Total	$1,409,345.09	35.0	61.0	4.0	0

Table 1.2.3 Non-PEPFAR Funded Investments and Integration and PEPFAR Central Initiatives

Funding Source	Total Non-COP Resources	Non-COP Resources Co-Funding PEPFAR IMs	# Co-Funded IMs	PEPFAR COP Co-Funding Contribution	Objectives
Peace Corps	Staff Transport Overhead	$0	-	$118,587	Response Volunteers KP work Training – Gender norms & S&D OVC – camps; grassroots soccer
Total					

1.3 National Sustainability Profile *[REDACTED]*

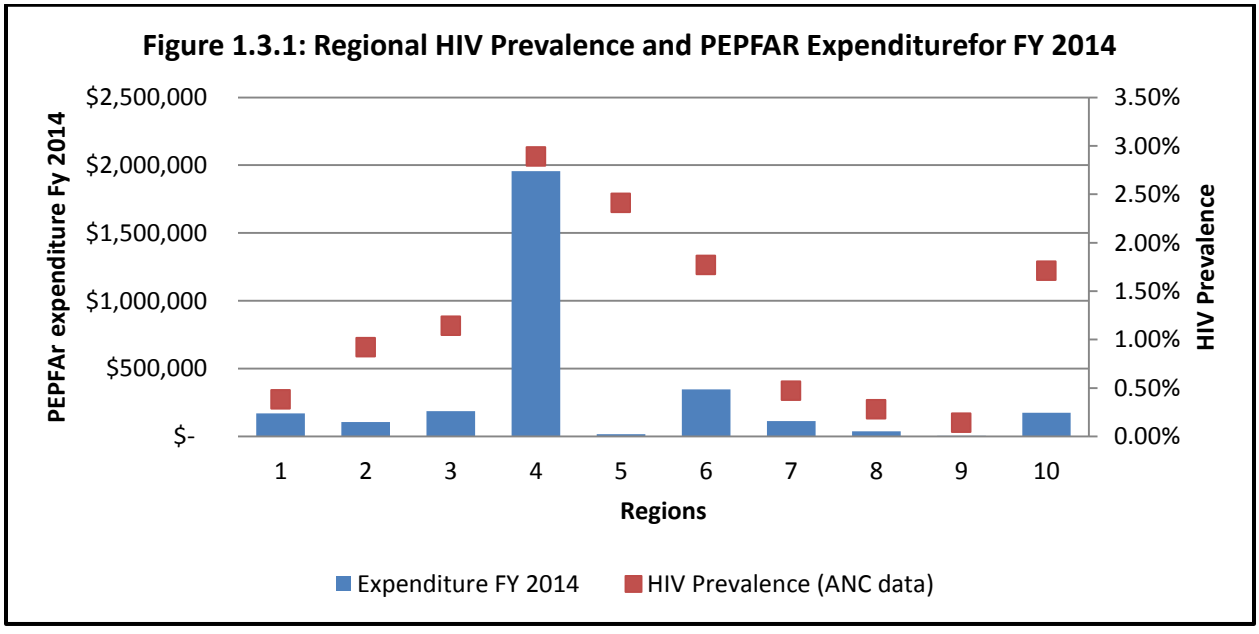
1.4 Alignment of PEPFAR investments geographically to disease burden

A review of the EA data revealed that PEPFAR regional expenditure was generally in line with HIV regional prevalence. However, low site yields for all regions except four in addition to the high cost of working in the hinterlands and the extensiveness of GF coverage, the best financial and technical investment for PEPFAR Guyana will be to focus PEPFAR efforts on saturation of region four. This pivot will support epidemic control and the GoG goal to achieve 90-90-90. The pivot will focus outreach activities, prevention, testing and counseling services for KP only in administrative region four. Analysis revealed that providing service in low prevalence regions 1 and 7, which are remote hinterland areas with highly migratory populations, requires more resources. Transportation, employment, fuel electricity and basic goods costs are higher in these regions. Therefore, USAID will cease outreach activities, prevention, testing and counseling services for key and priority populations in these regions, as well as regions 2, 3, 5, 6 and 10. In addition, community-based care and support services for PLHIV and those affected by HIV/AIDS in region 7 will be transitioned to the MOH by the end of 2015.

National level TA will be provided to implement the continuum of care and to saturate this region for KP coverage. The TA will involve capacity building and development of context specific strategies for implementation. The team expects 40% of the target achieved by FY 16 and 80% saturation by FY 17.

Figure 1.3.1 Juxtaposes national HIV prevalence rates to EA data.

Figure 1.3.1 Data is **not** available for PLHIV by region.



1.5 Stakeholder Engagement

The PEPFAR interagency team maintains ongoing communication and collaboration with key stakeholders. The National AIDS Program Secretariat/Ministry of Health, the Global Fund, CCM members, UN representatives and civil society have been consulted about: PEPFAR's investment approach to programming; enhanced site monitoring efforts; required data analysis for accountability, transparency and impact; sustainability; and PEPFAR's technical focus, including the transition of activities to the GoG. In a January 2015 joint stakeholders review, MOH/NAPS leadership reaffirmed its commitment to absorb treatment costs gradually; and, the stakeholder community discussed systemic bottlenecks, priority areas and populations focus for epidemic control, as well as the fidelity of PEPFAR's programs. In the coming cycle, stakeholders will enhance collaborative efforts (e.g. co-financing for HMIS with the GF and joint site visits); maintain routine engagement with civil society, especially with LGBT CSOs; and address discrete challenges in KP HIV service uptake.

In the coming years, PEPFAR will continue to collaborate with Guyana for sustained epidemic control focusing on discrete activities that support reducing incidence, uniquely identifying beneficiaries and seamlessly tracking them through the continuum. This approach will directly complement and support the UNAIDS 90-90-90 goals for Guyana. In COP 2016, Guyana will become part of the Caribbean regional platform, so we will not complete a CHP.

2.0 Core, Near-Core and Non-Core Activities

In light of the country context presented in the aforementioned sections, the PEPFAR interagency team conducted the Core, Near-Core and Non-Core (CNN) exercise to identify activities to support the program objectives for epidemic control and identify gaps we are uniquely positioned to address. Areas with historical investments no longer aligned with the current goals and objectives were flagged for time-bound transition to the GoG, with minimal maintenance packages where applicable. These areas include HTC outside of region four, TB/HIV and PMTCT with immediate transition, laboratory services and OVC- both for final transition in COP16. Other areas with multi-donor investment were streamlined to minimize duplicate investments by either program area or geographic coverage. The remaining critical programs underwent gap analysis to identify uncovered areas of weakness for intervention and proposed activities were prioritized using the PEPFAR Cambodia's decision tree[vi] for CNN classification.

Weaknesses	Activities*
Limited KP reach and service uptake	Increased mobile peer-initiated outreach and testing to identify new KP in region four
Late-stage diagnosis and inefficient linkages to care[2]	Opt-out HIV testing as a part of a package of KP-friendly health promotion services (STI syndromic screening, risk reduction emphasizing minimization where elimination is not viable etc.)
Suboptimal retention in treatment alongside high ART switch rates (>10%)[vii,viii;] Unclear viral suppression rates[3]	*Pilot of a multi-sectorial PUID shared by CBO and facility-based clinical sites to improve patient monitoring, defaulter tracking and documentation of linkage and retention. Results will feed the development of a national health information system for cascade monitoring; *Targeted assistance for improved CBO and facility-based adherence management for the reduction of premature ART switches to second-line therapy (peer-driven case navigation with defaulter tracking, development of a national adherence assessment toolkit, improved low-literacy adherence support tools and combination checks including pill counts, missed dose questionnaire); *Targeted assistance/technical collaboration for improved facility-based quality of care (integration of care and support activities at clinical sites, routine viral load and drug resistance testing for patient monitoring, structured care coordination between facilities and CBO with joint case conferencing)

PEPFAR also maintains PLHIV care and treatment at two private sites, whose agreements end in COP16. These sites serve roughly one-third of all PLHIV on treatment in Guyana (n= 1260), of

[2] Late-stage diagnosis as evidenced by lower nadir CD4 counts among the newly diagnosed and linked; Guyana currently uses Unlinked Anonymous Testing (UAT) in all public testing sites, limiting the ability to count the number of individuals tested and identify previous positive results among repeat testers as well as effectively documenting linkage to care

[3] Current national treatment guidelines recommend but do not require viral load testing for patient monitoring as is the case for CD4; thus it is unclear (i) what drives the selection of certain clients for viral load testing or (2) who the VL-tested group represents among all those on treatment

which 10-14% are KP[ix]. Additionally, these sites serve as quality leaders, with higher 12- and 60-month retention and survival than the national program[x]. PEPFAR is currently supporting a site-level sustainability plan, introducing a sliding scale, fee-for-service structure in COP16.

Appendix A captures the PEPFAR Guyana core activities.

3.0 Geographic and Population Prioritization

Key populations (KP) – namely, female sex workers (FSW), men who have sex with men (MSM) and transgender (TG) persons - are the target populations for the aforementioned strategy. Given their disproportionate burden of disease and disparate access to services, these groups drive ongoing transmission, and activities targeted to them stand to have the greatest impact. Additionally, the review of available epidemiologic and fiscal data supports geo-prioritization in region 4, with the highest HIV prevalence and KP testing yield to achieve saturation. To realize this goal, necessary program pivots include (1) cessation of PMTC, TB/HIV, laboratory DSD, and priority populations testing – namely miners, loggers and adjacent communities; (3) reduced military support; and (4) reduced commodity procurement while providing a "maintenance" package of services for care and support.

4.0 Program Activities for Epidemic Control in Priority Locations and Populations

4.1 Targets for priority locations and populations

Targets were set based on population, geographic prioritization and the ongoing transition of direct service delivery activities. Data assessed for target setting included: HIV prevalence by regions, prevalence among key and priority populations, past and current program achievements particularly around reach, coverage and site yield analysis.

Region 4 accounts for approximately 75% of the reported HIV cases through the HIV case surveillance system, and houses the 3 largest care and treatment clinics in the country. On this basis, targets were calculated to support saturation in Region 4, where the burden is the highest.

With a concentrated epidemic between MSM and FSW, targets were estimated based on a scale up of activities among these key populations. Using the data pack and assumptions regarding key population size estimates, ART coverage, retention rates and HTC yield, estimates for HIV testing and treatment were generated for reaching 80% saturation by FY 17, with 40% of the target achieved by FY 16.

Targets for HTC among KP reflect a shift from 9 community sites in FY 14 to 1 community site (region 4) in FY 16 and major scale up of community based testing among key populations in region 4, from 711 in FY 14 to 4,081 in FY 16 and an HTC yield of 1.3% in FY 14 to a yield of 2.7% among MSM and 3.7% among FSW in FY 16.

In addition to community HTC services for KP in Region 4, targets were also maintained for HTC among the military and provider initiated testing at the 2 private HIV clinics in region 4. Provision of direct service delivery of PMTCT services ended December 2014 with the final transition of PEPFAR supported health care worker salaries, and as a result, no targets were set for PMTCT_STAT and PMTCT_ARV in FY 15 and 16 after a gradual decrease in targets from FY 13.

In FY 16 PEPFAR will continue to support the 3 primary care and treatment facilities in region 4, with a focus on improving linkage and retention among all PLHIV particularly KP in order to achieve saturation by FY 17. PEPFAR aims to increase the number of KP currently on treatment from an estimated 111 in FY 14 to 165 in FY 16, while also maintaining high quality HIV care and treatment services for HIV positive clients identified and referred through other service streams.

While all available data was assessed for target setting and prioritization, the process was challenged by critical data gaps. With limited data available at the regional level and less available for KP, regional and KP estimates were largely derived from applying estimations and assumptions using available national data and regional and global estimates.

Table 4.1.1 ART Targets in Priority Sub-national Units for Epidemic Control

SNU	Total PLHIV	Expected current on ART (2015)	Additional patients required for 80% ART coverage	Target current on ART (inFY16) *TX_CURR*	Newly initiated in FY 16 *TX_NEW*
Region 4	**4,620**	**3,074 (67%)**	**620 (13%)**	**3,355 (73%)**	**405**
Total	**7,700 (National)**				

Table 4.1.2 Entry Streams for Newly Initiating ART Patients in Priority Districts (FY 16)

Entry Streams for ART Enrollment	Tested for HIV (in FY16)	Identified Positive (in FY16)	Enrolled on ART (in FY16)
Key Populations	**4,081**	**132**	**94**
Military	***800***		
Other (2 private hospitals and the National Care and Treatment Center)	***1,413***	**122**	**311**
Total	**6,294**	**254**	**405**

*The two PEPFAR supported private hospitals in addition to identifying positives will also receive positive clients referred from other entry streams and facilities. Testing is not supported at the NCTC but they will provide care and treatment services to positive clients that are referred.

Table 4.1.4 Target Populations for Prevention Interventions to Facilitate Epidemic Control

Target Populations	Population Size Estimate (priority SNUs)	Coverage Goal (in FY16)	FY16 Target
Female Sex Workers	**3,811**	**66**	**2,500**
Men who have sex with men	**2,464**	**81**	**2,000**
Military			**600**
Total			

Table 4.1.5 Targets for OVC and Pediatric HIV Testing, Care and Treatment

	Estimated # of Children PLHIV (<15)	Target # of active OVC (FY16 Target) OVC_SERV	Target # of active beneficiaries receiving support from PEPFAR OVC programs to access HIV services (FY16 Target) OVC_ACC	Target # of children tested (FY16 Target)	Target # of children on ART
Region 2		**162**	**105**		
Region 4		**708**	**262**	**88**	**136**
Region 6		**966**	**315**		
Region 10		**410**	**158**		
TOTAL	**<200 (National)**	**2,246**	**840**	**88**	**136**

Program Area Summaries 4.2-4.10

4.2 HIV Testing and Counselling (HTC)

A critical first step to reducing HIV incidence is closing the gap of undiagnosed infections. National program data and Spectrum estimates reveal as much as 36% of the HIV-infected population is undiagnosed or out of care. Additionally, late stage diagnoses among KP[xi] imply a delay in testing uptake.

The objectives of this program are to (i) expand identification and reach to unserved KP, (ii) increase KP uptake of HTC and (iii) facilitate earlier linkage to care for the newly diagnosed. Additional activities will be geared towards routine retesting of HIV-negative KP through sustained CBO engagement aimed at reducing late stage diagnosis. Information sources for the development of these objectives include stakeholder discussions with KP-led CSOs, KP-staffed CSOs, donor coordination discussions, expenditure analysis and BBSS data.

The BBSS (2014) utilized the PLACE[4] methodology for the first time in Guyana, providing size estimates and venue information on KP meeting locations. The target populations were FSW, MSM and other priority groups including miners, loggers and migrant workers. While not targeted, TGF questions allowed for data gathering from a nested convenience sample within the study population. FSW and MSM prevalence estimates were 5.5% and 4.9% respectively, while TGF prevalence was 8.7%[xii]. Compared to an estimated general prevalence of 1.4%, these findings support a KP-focused testing approach given their higher HIV prevalence.

In addition, a review of various data sources, such as the FY 14 data pack, the 2014 expenditure analysis, the national HIV prevalence by region, and programmatic data reveal high prevalence and positivity yield in region 4. In COP15, HTC activities will transition away from historic investments in certain priority populations and pregnant women to strategically target KP at the greatest risk for transmission in region 4 only, instead of 9 CSO sites spread across the country.

In the service delivery area, core activities to achieve the objectives include increased KP targeted HTC through partnering with 3 KP-managed CBOs utilizing various models, such as mobile services, CBO fixed sites, peer-initiated home-based testing, venue-based testing, event-based

[4] PLACE Methodology – Priority Locations for AIDS Control Efforts is a rapid assessment tool that identifies geographic areas for programmatic intervention; it is a site selection and sampling approach that requires statistical power calculations and input from local program leads to identify existing priority prevention areas

testing, index/partner testing. PEPFAR Guyana will also address supply chain issues that challenge testing such as rapid test kit stock outs. PEPFAR will procure 30% of the nation's RTK supply for use among KP exclusively. This will facilitate uninterrupted testing for this group.

4.3 HVOP - Technical Area Narrative

To expand identification and reach to unserved KP, the USG will partner with 4 KP-led CSOs, to create demand for testing and address discrete challenges in KP HIV service uptake. Barriers to effective outreach and testing currently include stigma & discrimination, harsh legislation, high levels of KP mobility and their reticence to uptake fixed-sites' services. Despite facility-and MOH-based policies against S&D, KP remains disenfranchised largely due to limited capacity for policy enforcement in the absence of a supportive legislative environment. Social isolation and threats of violence further facilitate KP loss to follow-up (LTFU), even after successful linkage to services. PEPFAR will provide ongoing training to KP peer educators and TA to CBOs for improved KP recruitment through a comprehensive prevention package. Using the social ecologic model (SEM), which is reliant on peer-educators[xiii], key activities alongside increased testing include integrating STI screening into existing service package, addressing other health needs, risk reduction with TA for a minimization versus elimination approach and enabling environments for KP.

The HVOP package of services aims to strengthen services that can increase KP engagement. Core activities include:

(i) Social Ecologic Model for Comprehensive Prevention

a. Community-based services: The PEPFAR-funded CBOs will focus on the individual, interpersonal/relationship and community domains for HIV risk mitigation. Through geo-mapping of hot spots, the 4 KP-staffed CBOs will reach their peers using peer mobilization, snowballing, event-based and social networking strategies. Individual risk reduction strategies include peer education, risk reduction counselling and provision of condoms and lubricants, encouraging consistent condom use, routine HIV/STI screening, equipping KPs to manage risk of and respond to violence, and, family planning and legal referrals as needed. Relationship risk reduction strategies include routine violence screening, condom negotiation skills, couples testing and disclosure. The predominant community-based strategies include increased efforts to change norms for health seeking behaviors within KP communities, peer mentoring for case navigation, behavioral interventions (information and education) and anti-stigma and discrimination campaigns. TA will also be provided to strengthen capacities within KP CBOs.

b. Facility-based services and National TA: Attempts to mitigate HIV risk for KP at the societal level rely heavily on ongoing TA to multidisciplinary groups involved

in the continuum of care at facilities, and GoG representatives who can drive policy revisions and advocacy in legislative forums. The PEPFAR Guyana team will address these groups through TA to service providers, program managers and government representatives (e.g. Ministers of Health, Public Service and Human & Social Service). PEPFAR will also partner with a KP-led human rights organization, the Society against Sexual Orientation and Discrimination (SASOD), to advocate against stigma and discrimination, and to hold government accountable for the provision of high-quality KP HIV prevention, care and treatment services. This TA and partnership should create an increasingly enabling environment, resulting in increased service uptake and reduced coverage gaps among KP that threaten epidemic control.

(ii) Alternate Models of Care

a. The positive impact of integrated health care on client retention is well documented. In COP14, the PEPFAR began piloting an STI control strategy at 2 key CBOs to assess the efficacy of this approach in Guyana. The VICITS Model[xiv] developed through PEPFAR –supported TA in the Central America regional office was replicated in the Guyana context. VICITS is the Spanish acronym for STI surveillance, prevention and control strategy. This intervention for key populations that includes the provision of a combination-prevention package, integrated STI diagnosis and treatment, condom promotion and distribution, HIV counseling and testing, antiretroviral treatment referral, collection and analysis of key behavioral and biological indicators, a second-generation HIV surveillance information system for the key populations and people living with HIV (PLHIV). This pilot will conclude in COP15 and the findings will feed recommendations to the national public sector program regarding the utility of this approach for improving enrolment and retention of KP.

4.6 HBHC– Adult Care and Support Technical Area Narrative

In Guyana, adult care and support (HBHC) is critical to ensuring HIV-infected and –affected populations' move smoothly through the continuum of care. As a result of the CNN exercise, the core activities for KP HIV care and support include (i) peer-based case navigation from testing to care, (ii) PHDP for risk reduction/minimization and (iii) care coordination with defaulter tracking for improved retention in care and ART adherence.

There is well-documented need for care and support from program data. Linkage to care from standalone VCT sites is challenging, due to the use of UAT. Additionally, retention rates in public clinical facilities are below 70%, and national 1st-to-2nd line ART switch rates are roughly 10%. The latter is 4% higher than other countries in the LAC region, suggesting lower adherence rates or more frequent treatment failure in Guyana.

CBOs are uniquely positioned to address these weaknesses – especially for linkage - due to the colocation of HTC and HBHC services. Extending from the previously described SEM, HBHC in CBO will focus on risk reduction at the individual, relationship and community-levels (See Figure c, p. 20). Key activities for each level are as follows:

Table: Key CBO Activities

	Individual	Relationship	Community
Activities	HTC Promotion Need-based referrals* Risk reduction** Case navigation and care coordination[xv],*** Community-based disclosure and adherence support	Conflict resolution GBV + IPV screening Condom Negotiation Skills Partner Testing Provider interpersonal development	Social support groups; Peer mentoring; Advocacy for stigma and discrimination reduction

**Substance abuse, nutrition and mental health support*
***Consistent condom and dental dam usage, lubricant orientation and tutorials, routine STI screening, sexual network reviews*
****Ensuring complete linkage with documentation, improving patient literacy, SMS appointment reminders and accessing public social support/funding for HIV services to improve retention*

Emphasis will be placed on improving linkage and retention in care and treatment for KP, from diagnosis through long-term ART administration in order to achieve epidemic control. USG will specifically concentrate on the care and treatment cascade, to ensure that patients ably navigate through the health care system, are linked to treatment in a timely manner, and are retained in care. Strategies will also pay particular attention to increased collaboration between CBOs and clinical health professionals at treatment sites.

USG has transitioned its support for economic strengthening activities and the provision of refreshments for the support groups to the private sector.

Clinical care services are provided (i) integrally at two PEPFAR-supported private sites and (ii) collaboratively through the public health sector and CBOs. In FY 15, supportive care services for MSM, TG and FSW will be provided by KP-led CBOs in region 4 where HIV prevalence and KP-testing yields are highest. The KP-led case navigators will refer and/or accompany persons testing positive to the treatment sites, for confirmatory testing and participate in the enrollment in care of the client. Treatment sites also refer to community-based care and support programs for support to the newly diagnosed client. The current bi-directional referral system, while useful, is unable to track unique individuals, this presents serious challenges in monitoring clients lost to follow up, tracking the referral outcomes and monitoring KP uptake of HIV/AIDS and other services. In FY 15, USG will pilot a systematic cross-program PUID. This will ensure that unique individuals can be identified and monitored across services within community, public and private service delivery sites.

USG will also work with the MOH and the PEPFAR-supported private sites to build concrete partnerships between clinical services and the CBOs, so that the CBOs can play a larger role in jointly providing case management for HIV positive clients. The team will work with facility care and treatment partners to strengthen integrated case management teams for delivering high quality complementary services. This will be facilitated by joint case conferencing between the three highest volume treatment sites and the CBOs, and defaulter tracking through case navigators. CBOs will participate in support group sessions at treatment sites for sustainable psychosocial and adherence support. The CBOs will also support the follow-up of patients on ART, and patients with clinical eligibility to start treatment. To improve retention in the HIV cascade the CBOs will ensure adherence through home visits, pill checks, referrals to support groups and a phone reminder system (SMS).

Technical Assistance will also be provided to review and revise mental health portions of the national care and treatment guidelines. This will ensure that a standardized and rigorous process will be implemented to systematically assess and provide quality interventions in these priority areas. It will also increase local capacity to behaviorally or clinically determine non-adherence and intervene earlier to avoid viral load rebound and sustained suppression among ART patients.

During COP14 CDC and USAID partnered in the treatment with care and support to improve linkages, retention and ART adherence. This integrated model of enhanced coordination and partnership is critical to optimizing the integrative continuum of response (CoR) approach. The results from this pilot will be available by the end of COP15 and will be used to provide guidance for case coordination activities across CBOs and facility-based care. The pilot will also yield preliminary supplemental risk data from KP that will be used to customize ongoing care and support.

4.7 Pediatric Care and Support Technical Area Narrative

Linkage and retention data for pediatric HIV cases reveal alarming trends; one out of every four HIV-infected infants suffers delayed entry into care of 6 months or greater and one in three are LTFU at the 12-month time point. In FY 15 CDC will provide technical assistance to community- and facility-based care sites for expanding the UNICEF-developed pediatric case tracking system currently in place at ANC for HEI screening. This initiative will be strategically implemented at high-yield treatment sites for pediatric care, with central monitoring at the MOH. Community-based staff will collaborate with the facility teams to track and re-engage pediatric patients LTFU. Targeted assistance for the development of pediatric-friendly adherence and support tools will also be explored.

4.8 TB/HIV

Not applicable

4.9 Adult treatment

Historically, PEPFAR's shared treatment goal in Guyana has been expanded coverage. In FY 14 USG supported the MOH in revising treatment guidelines, in keeping with the WHO 2013 technical guidance. Key revisions were the implementation of Option B+ for pregnant women and the recommendation for viral load for patient monitoring. PEPFAR also supported continued decentralization of treatment services to expand geographic coverage. These and other changes have seen steady increases in the treatment population sustained through 2014.

Despite these successes, treatment failure rates are high at roughly 11%. High rates of treatment interruption and chronic LTFU (33% at main public site) underscore a systemic challenge with treatment retention in Guyana. Additionally, as strategic prevention activities, targeting KPs in COP15 yield additional treatment cases; there is a renewed need for improved KP-improved retention strategies.

Consequently, COP15 will see increasing priority on optimizing treatment outcomes. Alongside increased KP ART enrollment through improved linkages as previously described, key strategies in treatment support services include:

(i) improved retention through peer-based case navigation (appointment reminders, defaulter tracking, need-based appointment accompaniment,
(ii) improved care coordination between public facilities and CBO (facilitated through joint case conferencing, assignment of coordinating case managers at participating sites, improved information sharing)
(iii) strengthened adherence assessments at CBO and (by adopting a national strategy, multiple tools to meet KP's diverse needs).
(iv) Integrated care and support at clinical service delivery sites (phased approach under the guidance of 2 private PEPFAR sites currently offering collocated care and support and skilled CBO currently delivering care and support offsite)

The continuous quality improvement (CQI) program HEALTHQUAL as well as SIMS visits will be scaled up to provide program managers with information for quality management and improvement. USG will also provide technical assistance to further revise the current guidelines to include treatment for KPs. Technical assistance from CDC will support the development of SOPs for routine viral load and HIV drug resistance testing, with specific algorithms for patient qualifying criteria.

CDC increase KP quality-of-care capacity building through interdisciplinary trainings offered to clinical service providers from treatment and care/support sites. Such trainings will focus on (i) performing risk assessments and providing KP-friendly risk mitigation (risk minimization vs elimination where necessary); dignified approaches to clinical exams for KP; initiatives to improve linkage at the facility level and; activities to promote KP retention prior to treatment initiation. These sessions remain critical to maintaining a trained cadre of service providers to provide quality care.

Cascade monitoring and patient tracking is a critical component of treatment programming. CDC will provide targeted assistance to the MOH/NAPS for the implementation of viral load testing for patient monitoring at all treatment sites and pilot HIVDR testing for the largest public and private treatment sites. Additional support for improved patient tracking will occur through the launch of the cross-sectorial, robust patient unique identifier. This will provide the mechanism to assess the impact of this joint training and service delivery model over time. This is described in the strategic information section of this document.

USAID/SCMS project will continue to support the procurement of only one adult second line ARV. The other adult second line and all pediatric ARVs have already been transitioned to the MOH. TA will be provided towards a coordinated procurement planning process involving donors and the MOH. This includes the development of a rolling five-year forecast and an 18-month national supply plan and review the supply plans on a quarterly basis to ensure continued availability of commodities.

USAID will continue to build system and capacity both centrally and regionally for optimizing commodity management for ART service delivery by providing technical assistance and mentoring as needed to develop forecasting and supply planning capacity in the Logistics Management Unit. This will ensure ready access and supplies of essential treatment commodities at the facility level. It must be highlighted that there is a need for the MOH to absorb and support some critical activities this year to allow full transitioning to occur. If this does not occur, then, there is a risk that all forecasting and supply planning processes will be inefficiently managed.

4.10 Pediatric Treatment

While pediatric ARVs are no longer procured through PEPFAR support, poor retention rates highlight the importance for sustained intervention through the end of COP15. The aforementioned treatment retention strategies will be tailored the pediatric patient population and implemented at high-volume sites for pediatric cases. This activity will require coordination with 11 high-yield PMTCT site for HIV-infected infants, as this is the point of diagnosis for HEI. Particular emphasis will be based on expanding the UNICEF case tracking system to treatment sites for improved pediatric defaulter tracking and the development of age-appropriate adherence support tools.

5.0 Program Activities to Maintain Support for Other Locations and Populations

5.1 Maintenance package of services in other locations and populations

PMTCT
While no additional investments will be made into the PMTCT program, TA for systems expansion will be provided to facilitate improved linkage from ANC where HEI-positive infants

are diagnosed to care and treatment sites. The PEPFAR-supported case tracking system currently used to screen HEI through their final diagnosis will be extended to treatment sites

HBHC

Currently care and support services are provided by 7 CBOs in 5 regions (2, 4, 6, 7 and 10) for PLHIV. Given the geographic shift to region 4, PEPFAR will maintain quality care and support for non-KP in 4 regions (2, 4, 6 and 10) until September 2016, when these services will be transitioned to the Ministry of Health (MOH). Region 7 will be transitioned at the end of this fiscal year since there are a small number of persons receiving care and support. Thus, in FY 15 emphasis will be placed on graduating PLHIV who are managing self-care while supporting adherence and retention for those PLHIV in regions 2-60 adults; 4-250 adults; 6- 300 adults; and, 10-100 adults, to ensure a seamless transition to the MOH. The maintenance package will include: HIV peer support and psychological counseling to promote healthy living; PHDP services to enable PLHIV to care for themselves, while protecting themselves from reinfection and others from HIV; defaulter-tracking for improved retention in care and ART adherence; appointment reminders, including need-based accompaniment; and facilitation of linkages to economic strengthening activities, and other social support programs.

Orphans and Vulnerable Children

USG commenced phasing out its OVC program in FY 2014, based on OGAC's guidance; hence, minimal PEPFAR support for OVC was provided. By the end of FY 14 vocational skills training, OVC care packages, and refreshments for support groups were transferred to existing Government agencies and the private sector. Community volunteers and Peace Corps volunteers attached to schools in the regions conducted the after-school educational session. In FY 15, the CBOs will continue limited service delivery to OVC with the majority of support coming from the private sector. PEPFAR envisages that with the focus on regionalization and KP, OVC support will end in FY 16.

In communities, 7 CBOs provide family centered care, linking HIV affected families with OVC services, (such as educational/vocational skills training, parenting skills training, psychosocial support, adherence support, age appropriate risk reduction counselling, referrals to youth-friendly services), and strengthening capacity of the family unit to care for children. The PEPFAR-supported CBOs are the only ones providing services for OVC, since the NGOs supported by the GFTAM are merely involved in prevention activities. In FY 15, emphasis will be placed on retention and adherence to treatment for those OVC already in the care program, as well as building the skills of parents/guardians to care for their children.

Hence limited core services to be funded by PEPFAR in FY 15, with support from the private sector include: individual and support groups to address the psychosocial health needs of children and their caregivers; adherence support (clinic reminders, pill/bottle counts); building health, nutritional knowledge, treatment literacy in caregivers to care for OVC; conducting

positive parenting training to include discipline, communication on adolescent risk and HIV disclosure; collaborating with child protection services to report instances of neglect, abuse and other forms of vulnerability; encouraging testing of all children affected by HIV and making the appropriate referrals; conducting succession planning and permanency support, and developing SOP to support succession planning for OVC; supporting issues affecting adolescents, particularly girls and making the appropriate referrals such as to sexual and reproductive health services.

These services are complemented by the following integrated near core components:

- Ensuring children stay in school, and routinely track enrollment, attendance and progression; and develop procedures for assessing barriers to education that take into account difference between boys and girls;
- Conduct after-school educational sessions through Peace Corps volunteers and link adolescents to vocational skills training programs via referrals to existing line Ministries and the private sector;
- Support linkages to social, legal and other supportive care services.

The Ministry of Health/National AIDS Program Secretariat (MOH/NAPS) will continue to be supported in its efforts in prioritizing and focusing interventions that address children's most critical care needs, and provide access to information, education and life skills tools to OVC in order to reduce their vulnerability and help them to develop to their full potential. Partnerships with existing public sector social services and UNICEF will be strengthened. USAID's implementing partner will continue to integrate and strengthen OVC services within the continuum of care and treatment, and collaborate with prevention partners to include OVC families in the implementation of age appropriate prevention initiatives in the community.

Standard Table 5.1.1 is required, except in TA/TC contexts where there has not been any historical PEPFAR direct service delivery investments outside of priority geographic areas or key populations.

Table 5.1.1 Expected Beneficiary Volume Receiving Minimum Package of Services in Non-priority Districts

Maintenance Volume by Group	Expected result APR 15	Expected result APR 16	Percent increase (decrease)
HIV testing in PMTCT sites	***0***	**0**	**0**
HTC (Military)	***800***	**800**	**0**
OVC (non-priority districts)	***244***	**257**	**5**

5.2 Transition plans for redirecting PEPFAR support to priority locations and populations

Miners, loggers and populations adjacent to mining and logging communities that were previously considered priority populations will no longer be a focus of the program given the low positivity rate among this population based on the Guyana BBSS report of December 2014 – 1.2% for loggers and 1.0% for miners. Moreover, the International Organization for Migration (IOM), a sub-recipient of the GFATM HIV grant started to work with miners, loggers and adjacent populations. Thus, USG transitioned support for miners and loggers to the IOM and the Ministry of Health/National AIDS Program Secretariat (MOH/NAPS) this fiscal year.

Effective October 1, 2014, the Government of Guyana/Ministry of Health (GOG/MOH), commenced procurement of the first and second line pediatric ARVs, previously funded by PEPFAR, and will commence procurement of second line adult ARVs in 2015, using a phased approach. In FY 2017, it is expected that ARV procurement will be fully transitioned to the GOG/MOH. The GOG/MOH already commenced procurement of 23% of rapid test kits in 2014, and will continue absorbing the RTKs cost until 2017 with co-financing from PEPFAR.

By the end of FY 2014, economic strengthening activities/vocational skills training, OVC care packages, and refreshments for support groups were transferred to existing Government agencies and the private sector. PEPFAR will continue to provide limited support to OVC, which will end in FY 2016. USG will continue to engage the MOH/NAPS to transition these activities since the PEPFAR-supported NGOs are the only ones providing comprehensive care and support services for OVC.

6.0 Program Support Necessary to Achieve Sustained Epidemic Control

6.1 Laboratory strengthening

After considerable PEPFAR investments in developing Guyana's laboratory infrastructure and capacity, COP15 will be the final year of targeted assistance. As of COP16, PEPFAR support will shift to a maintenance package aimed at sustaining quality gains in lab services. COP15 deliverables for lab support include (i) TA/TC for transitioning the SLAMTA quality management implementation and monitoring from PEPFAR to the MOH's Technical Bureau of Standards and (ii)TA/TC for reducing HIV lab services interruption based on the results of COP14's operations assessment.

The COP 15 SLAMTA Quality Management Systems Implementation at decentralized labs will focus only on geo-prioritized regions in keeping ensuring quality HIV-related testing for KP in key geographic areas. This expansion will also back-up the central reference lab during service interruptions. Additional recommendations include transitioning from ownership to leasing for HIV-related test equipment. Laboratory personnel's training is recommended for four Guyana Defense Force (GDF) laboratory phlebotomists to strengthen and maintain skills and capabilities.

1. Brief Activity Description	**Deliverables**		**Budget codes and allocation ($)**		**6. Implementing Mechanism(s) ID**	**7. Relevant Sustainability Element and Score**	**Impact on epidemic control**				
	2. 2015	**3. 2016**	**4. 2015**	**5. 2016**			8. HIV Testing	9. Linkage to Care (LTC)	10. ART uptake	11.*Other Combination prevention	12. Viral suppression
To provide technical assistance for the MOH's absorption of QM/QI	Laboratory quality standards integrated into MOH BTS with assessment schedule for central + regional labs		HLAB 60,000	HLAB 20,000	17595					X	

To reduce HIV test service interruptions	Uninterrupted viral load, CD4 and EID services	Maintenance	HLAB 139,000	HLAB 30,000	17577		X				X

6.2 Strategic information (SI)

PEPFAR will continue to invest in strategic information with the goal of improving the availability and access to high-quality data for decision-making. In FY 15 CDC will work with HIV program staff to review and identify strategies for improving the quality of HIV case-based surveillance data particularly for KP. This includes the completion of risk behaviours for classification of the newly diagnosed and allocation into their appropriate KP, if applicable.

PEPFAR will also support the development of a national HIV cascade to be used for program monitoring and evaluation. This activity relies on robust, de-duplicated patient-level data from service delivery sites. The established PUID from NASTAD's work in COP14 will be piloted at select high-volume treatment sites as well as care and support CBO. CDC will provide TA to both site types to use the data for patient monitoring. The additional support to MOH for data triangulation will be described in the health systems strengthening section, as the data will be cross-site and national.

Maintaining high quality HIV data is critical to the national response and its ability to sustain high-quality interventions and demonstrate impact beyond this era of donor support. MOH/NAPS will be supported to conduct routine data quality assessments at the facility, regional, and national level. In order to do this effectively, PEPFAR will train the MOH/NAPS staff in the Routine Data Quality Assessment (RDQA) methodology. TA will support the customization of the RDQA tool and user manual and adapt RDQA curriculum to strengthen the technical capacity of the MOH and NAPS in Guyana. With these RDQA tools, the MOH/NAPS will be able to assess the quality of their data internally, and to strengthen their data management and reporting systems.

Through USAID, PEPFAR will support an analysis of data from the BBSS and the Priority Location for AIDS Control Efforts (PLACE) to characterize the HIV epidemics among key populations and describe the adequacy of existing programs and program gaps. The review will include initial regional size estimates for MSM, sex workers and transgender persons, and regional prevalence rates. These data will be used to estimate the continuum of care cascade for each key population. Location and other features, such as type of sex work, will characterize the HIV epidemic clusters among sub-groups of key populations. Identification of these clusters will provide valuable

information to prevention and treatment programs and service delivery providers in these areas. Further analysis of the BBSS data and additional data collection will identify areas that are likely to have currently undetected clusters of infection.

PEPFAR will continue to build capacities among civil society and community-based organizations in community-led M&E. This is essential for building community systems and will provide information to guide decision making for planning, management and improving community-led programming for KPs and PLHIV, and formulating policy and advocacy messages.

At the facility level, PEPFAR will continue to rollout a standardized paper based Logistics Management Information System (LMIS) to gather consumption and demand data at a site level on a monthly basis. USG will support the MOH with the operation of the newly established MOH's Logistics Management Unit in collecting and analyzing the facility LMIS reports, as well as communicate with the sites regarding supply planning and demand management.

DoD Headquarters will continue its technical support, for recently deployed health information management system (HIS), to ensure the system is fully adopted and utilized to its full capacity, especially for data collection and databased decision making.

1. Brief Activity Description	**Deliverables**		**Budget codes and allocation ($)**		**6. Implementing Mechanism(s) ID**	**7. Relevant Sustainability Element and Score**	**Impact on epidemic control**				
	2. 2015	**3. 2016**	**4. 2015**	**5. 2016**			8. HIV Testing	9. Linkage to Care (LTC)	10. ART uptake	11.*Other Combination prevention	12. Viral suppression
Facilitate joint case conferencing between facility and community sites	Regular mechanism for data sharing for case coordination	Preliminary data findings from care coordination around populations and factors associated with default	HVSI $75,859	HVSI $50,000	13384 17595	Domain A3. Performance Data - 18.0		X	X	X	X

1. Brief Activity Description	Deliverables		Budget codes and allocation ($)		6. Implementing Mechanism(s) ID	7. Relevant Sustainability Element and Score	Impact on epidemic control				
	2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care (LTC)	10. ART uptake	11.*Other Combination prevention	12. Viral suppression
Revise routine data systems for better KP monitoring (case-based surveillance)	10% increase in completion of case reporting form's risk profile data among total newly reported case in 2015 from 2014	10% increase in completion of case reporting form's risk profile data among total newly reported case in 2016 from 2015	HVSI 107, 858	HVSI 75,000	13384 17595	Domain B4 Access and Demand-15.2	X		X	X	
Implement PUID at pilot sites with routine TA and quarterly data checks; Collection of KP data from pilot sites for operational research	Implementation at 2 treatment sites (1 public 1 private) and 1 CBO in region 4; 2 data triangulation exercises	Implementation at remaining treatment site; Integration into HMIS system design; Pilot in another related program (MCH, TB)	HVSI 240, 200	HVSI 170,000	17577	Domain B4 Access and Demand-15.2		X	X	X	
Analysis of the BBSS III and PLACE Survey among MSM, CSW, TG to include regional size estimates and prevalence rates.	Study protocol completed Size estimates and prevalence rates by region completed. Epidemic appraisal for transgender persons	Final report	HVSI 100,000	HVSI 50,000		Domain A -1. Epi and Health data	x	x	x	x	

1. Brief Activity Description	Deliverables		Budget codes and allocation ($)		6. Implementing Mechanism(s) ID	7. Relevant Sustainability Element and Score	Impact on epidemic control				
	2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care (LTC)	10. ART uptake	11.*Other Combination prevention	12. Viral suppression
	completed. List of high-risk/high-prevalence clusters completed.										
TA to MOH/NAPS to strengthen data management and reporting, and improve data quality using the Routine Data Quality Assessment (RDQA) methodology,	Customized RDQA tool, and user manual completed, and curriculum completed.	Data quality training of regional M&E officers, MOH and NAPS staff completed.	HVSI 35,000	HVSI 15,000		Domain A – 3: Performance Data	x	x	x	x	x
TA to the Ministry of Health's Materials Management Unit to strengthen the Logistics Management Information	LMIS established.	LMIS fully functional.	HVSI 75,000	HVSI 25,000	7218		x		x		

1. Brief Activity Description	Deliverables		Budget codes and allocation ($)		6. Implementing Mechanism(s) ID	7. Relevant Sustainability Element and Score	Impact on epidemic control				
	2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care (LTC)	10. ART uptake	11.*Other Combination prevention	12. Viral suppression
System.											
DoD Headquarters continued technical support for recently deployed Military e Health information Network (MeHIN) to ensure the system is fully adopted and utilized to its full capacity, especially for data collection and databased decision making.	•MeHIN deployment and adoption in select sites	Improved utilization of MeHIN and mil adaptation for sustainability	HVSI								

6.3 Health System Strengthening (HSS)

The scale-up of KP-specific HIV services in Guyana complements proposed increases in the collection of health information. USG, with co-financing from GFATM and the MOH, will develop a modular health management information system at the national level with a complementary electronic medical record system for site-level data collection (see Strategic Information section). This system builds on the new PEPFAR III tenets of using high quality, real-time data for strategic programming. The data generated will identify emerging higher-risk subgroups within KP for programmatic targeting. These data also support timely patient- and cascade monitoring. An important requirement for an effective system is confidentiality and data security assurances. TA will be provided by CARPHA to the MOH, building on other support in the region for policy and legislative revisions around electronic and data security.

The MOH will receive TA for the design and data flow of the health management information system from the site level through de-duplication across sites to the national level. Congruent SOP and policies to support the system will also be developed and reviewed at the national level. A critical component to the design of this system is the integration of the cross-sectorial PUID for confidentiality and efficient data triangulation. These steps are critical to the selection of appropriate forms and platforms for electronic data management, which form the foundation of a functional pilot and implementation in COP16 and beyond.

To ensure that quality medicines and healthcare commodities reach KPs and PLHIV in a timely manner, USAID/SCMS project will continue to build supply chain management capacity within the MOH's Materials Management Unit (MMU). In FY 2015, USG will provide TA for accurate data collection and analysis for use in forecasting and supply planning, and continue to provide warehousing and logistics technical services for HIV/AIDS commodities until September 2015, when this activity will be transitioned to the MOH/MMU staff and SCMS will provide supportive supervision. TA will be provided to improve the accuracy of national quantification of core commodities for the GFATM, as well as the MOH essential medicines and consumables. Efforts will be made to utilize the MOH's Quantification Technical Assistance Group and revive the National Procurement Oversight Committee in order to facilitate the transition of quantification activities to the MOH. USG will continue to support the MOH in its efforts to transition its public sector supply chain from the current MOH's MMU-managed system to one that leverages outsourced service providers in the delivery of supply chain services and the establishment of a Logistics Management Unit within the MOH.

As with many of the SCMS activities, it is critical that the MOH complete their transitional responsibilities in a timely manner to allow for complete transition by September 2016. There is a real risk that not all required personnel will be in place to allow thorough capacity building activities to be completed and that this failure will put the national health supply chain in jeopardy of failure.

1. Brief Activity Description	Deliverables		Budget codes and allocation ($)		6. Implementing Mechanism(s) ID	7. Relevant Sustainability Element and Score	Impact on epidemic control				
	2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care (LTC)	10. ART uptake	11.*Other Combination prevention	12. Viral suppression
TA to develop patient privacy and confidentiality policy to better manage client information ethically and confidentially	Identify critical Policy Issue(s)/ Problem(s)	Develop Draft Policy Intervention & Document	OHSS $ 73, 413	OHSS $50,000	MoH	Domain A1: Epidemiologic and health Data -13.3	X		X		
Develop design for multi-level National Health Management Information Systems with Site-Level EMR; using systematic cross-program PUID	Develop draft system design and site-specific medical record strategy	Develop Draft Concept Note	OHSS $ 73, 413	OHSS $50,000	MoH	Domain A1: Epidemiologic and health Data -13.3				X	X
TA for supply chain management to	- Forecasting and supply planning of	MOH's Materials Management Unit staff trained	OHSS $84962	OHSS $175000	7218	B.Domestic Services –	x		x		x

support forecasting, warehousing, quantification and distribution of ARVs and other HIV related commodities.	antiretrovirals (ARVs) and rapid test kits (RTKs) completed - ARV and RTK procured. -Mini-lab for QA control established. -Standard Treatment Guidelines for Primary Health Care (2nd edition) distributed.	in warehousing and stock management services for all HIV/AIDS commodities.				6.Commodity Security and Supply Chain					

7.0 Staffing Plan

Each USG agency assessed its staffing needs based on transition from a DSD to a TA/TC country, the ability to implement PEPFAR's new requirements, and integration into the Caribbean regional platform. Guyana will maintain in-country technical staff once regionalized, but the overall staffing footprint will decrease.

CDC will maintain in-country local staff once regionalized. The agency completed a reduction in force in 2014, moving from 3 FTE to 1 and 13 LES to 5. CDC's remaining staff are essential to support to its priority areas; clinical retention for key populations, KP strategic information systems, and care and treatment. Additionally, in-country support is required for the management of the sole G2G PEPFAR agreement totaling US$600,000 annually. In FY 15 and 16, 2 technical staff will collocate with the MoH at 100% effort, while the remaining staff will dedicate 49% of their time on MoH TA/TC and 51% at the Embassy supporting other grantees and cross-partner initiatives such as SIMS and DATIM data entry.

USAID has already moved its administrative functions to the regional platform maintaining minimum in-country staff. USAID activities require two technical staff in Guyana to manage on-going activities, PEPFAR's new SIMS, Expenditure Analysis and DATIM requirements, as well as to liaise with in-country stakeholders. In FY 2016, one FTE (US/TCN PSC) position will be transitioned to a LE staff position, so there would be two LE technical staff positions, and a .5 LE administrative assistant position. The US PSC General Development Officer will support in-country programs at 11% cost to PEPFAR/Guyana.

DOD will maintain its technical program manager, who is a direct implementer of the program and allows DOD to maintain a low-cost program where high levels of programmatic and financial responsibility have been taken on by the GDF; removal of this position would necessitate a contract with a grantee as well as travel for SIMS visits, which would ultimately drive up the cost, and likely decrease efficacy, of the DOD program.

PEPFAR does not fund Peace Corps staff positions but supports travel costs for its in-country PEPFAR Focal Point, which allows for SIMS Visits and overall management of the PEPFAR Funded Response Volunteers located in various regions of Guyana.

The interagency team supports the continuation of a PEPFAR Coordinator through regionalization and up to FY 18 but acknowledges staffing needs will be re-assessed once with regionalization. The SI liaison position is one that the team feels essential for the life of PEFPAR in country. The SI liaison plays a key role in managing and triangulating program and national data. Once within the regional platform, it is expected that even greater advanced data analysis will occur.

In conclusion, the numbers of PEPFAR FTE are aligned to program scope and core and near core activities proposed for COP 15. Other considerations include transition from DSD to TA/TC, the level of coordination required for this transition and GoG absorption of PEPFAR funded activities, as well as integration into the Caribbean regional program.

APPENDIX A

Table A.1 Program Core, Near-core, and Non-core Activities for COP 15

Level of Implementation	Core Activities	Near-core Activities	Non-core Activities
Site level	Improved patient tracking across clinical and community-based sites Improved care coordination between CBO and clinical facilities via joint case	TA for VCT sites to collect names and use a confidential system for positives (vs anonymity post diagnosis)	Discrete OVC Health and Stable activities to be fully transitioned by COP 16

	conferencing		
Sub-national level	KP prevention and Care & Treatment Stigma and Discrimination		
National level	Strategic information Laboratory testing – VL, HTC, CD4 Develop and pilot national health management information systems with site level eMR (using systematic cross-programs PUID	TA for development and implementation of a national adherence toolkit	

Table A.2 Program Area Specific Core, Near-core, and Non-core Activities for COP 15

	Core Activities	**Near-core Activities**	**Non-core Activities**
HTC	Peer-initiated mobile + CBO testing + FB testing Train HTC service providers for GBV/IPV screening to counsel and appropriately refer KPs who report experiencing GBV/IPV (verify in technical considerations)	TA for VCT sites to collect names and use a confidential system for positives (vs anonymity post diagnosis) Training for targeted post-test counseling and follow-up testing of military recruits who have been recently tested but not counseled with appropriate referrals	
Care and Treatment	**Core Activities** Defaulter tracking Peer-based case navigation Patient tracking across clinical and community-based sites	**Near-core Activities** TA for integration of care and support services at high-yield clinical facilities	**Non-core Activities**

	Care coordination between CBO and clinical facilities via joint case conferencing HIV-infected infant tracking Training on updated national treatment guidelines Interdisciplinary trainings for coordinated adherence support at the facility and CB levels TA for the development and implementation of a robust national adherence toolkit ARV procurement (2nd line adult) with co-financing with GoG/MOH Interdisciplinary trainings for coordinated adherence support and facility- and CB-levels Interdisciplinary training for KP case management, disclosure and routine risk assessment Case management for KP disclosure and routine risk assessment	TA for ongoing provider-initiated risk assessment and risk reduction TA improved diagnostic capacity for endemic OI at the lab (e.g. fungal infections) Tool development to support reduction of first-line treatment failure Develop standardized SOP for routine HIV drug resistance testing with algorithm for eligible patients Develop SOP addendum for KP HIV clinical service delivery

Prevention	**Core Activities** Venue- and community-based peer-to-peer outreach Condom + lube promotion and distribution STI sensitization + screening Community Mobilization- Promoting enabling community-based environments PCV strengthen linkages and mobilize KP to services	**Near-core Activities** Policy development, advocacy, anti-stigma and discrimination for KP HIV prevention Training for military, especially health care providers, on stigma, discrimination, gender norms and GBV VAST Grants for in-service trainings of HCW and CB and FB staff in stigma, discrimination, GBV & gender norms to support KP programs	**Non-core Activities**
OVC	**Core Activities** Assess HIV risk/issues of sexual minority youth	**Near-core Activities**	**Non-core Activities** Health and Stable Intervention Package (Maintenance package with COP 16 transition)
Program/system support	TA for the development of a PUID TA for VCT sites to collect names and use a confidential system for positives (vs anonymity post diagnosis) TA for the design and development of a national health management information system for patient monitoring using the aforementioned PUID	TA for the development of a PUID TA for the design and development of a national health management information system for patient monitoring using the aforementioned PUID TA for proper VL monitoring	

	Gap analysis between current national HIV services and needs identified from KP survey Standardize M&E tool for CSOs KP data collection and linkage into national system to progress through cascade Develop and pilot national health management information systems with site level eMR (using systematic cross-programs PUID) Targeted TA to the national laboratory to reduce service interruptions (based on COP 14 assessment) Build capacity for SCM for national-level forecasting, warehousing, quantification, procurement and distribution of HIV-related commodities Support development of MOH Logistics Management Unit (LMIS) Support policy & advocacy to amend discrimination act to include sexual orientation, gender identity and health status (anti stigma and discrimination to address KP barriers)	implementation Laboratory TA to transition owned equipment to lease agreements Military electronic Health Information Network (MeHIN) IT and maintenance TA to be provided to ensure full adoption. TA to military for lab workforce strengthening and provision of commodities Implementation of SLAMTA Quality Management Systems at regional labs

Table A.3 Transition Plans for Non-core Activities						
Transitioning Activities	Type of Transition	Funding in COP 15	Estimated Funding in COP 16	# of IMs	Transition End date	Notes
DSD for PLHIV	Private Sector Absorption			13384		Sliding scale fee of facility will cover costs; private hospital will absorb
OVC	GoG	$89,626*earmark	$0	17122	9/30/2015	Mechanism will continue, activity will not.
Totals						

GUYANA APPENDIX B

B.1 Planned Spending in 2016

Table B.1.1 Total Funding Level		
Applied Pipeline	New Funding	Total Spend
$1,615,199	**$5,032,102**	**$6,647,301**

Table B.1.2 Resource Allocation by PEPFAR Budget Code		
PEPFAR Budget Code	**Budget Code Description**	**Amount Allocated**
MTCT	Mother to Child Transmission	$0
HVAB	Abstinence/Be Faithful Prevention	$0
HVOP	Other Sexual Prevention	$528374
IDUP	Injecting and Non-Injecting Drug Use	$0
HMBL	Blood Safety	$0
HMIN	Injection Safety	$0
CIRC	Male Circumcision	$0
HVCT	Counseling and Testing	$422672
HBHC	Adult Care and Support	$600657
PDCS	Pediatric Care and Support	$152183

HKID	Orphans and Vulnerable Children	$89626
HTXS	Adult Treatment	$485857
HTXD	ARV Drugs	$246300
PDTX	Pediatric Treatment	$151629
HVTB	TB/HIV Care	$0
HLAB	Lab	$326056
HVSI	Strategic Information	$1249247
OHSS	Health Systems Strengthening	$1021055
HVMS	Management and Operations	$1374005
TOTAL		**$6647301**

*Amounts are based on new funding and applied pipeline (see spreadsheet).

B.2 Resource Projections

PEPFAR Guyana used information from the 2014 EA results*, input from implementing partners, and agency-level pipelines to establish budget codes and implementing mechanism (IM) totals. DOD and Peace Corps have healthy pipelines and therefore require either no or limited new funding to support the new Guyana strategy. USAID will also use pipeline and new funding for maintenance packages in regions 2, 4, 6, and 10. USAID will use all new funds to support those activities needed for saturation in region four.

CDC funding will now be dedicated to seamlessly moving newly identified HIV positive KP from diagnosis through linkage to retention in KP-appropriate care and treatment with documented viral suppression. In determining the budget the agency made use of the EA unit expenditure, making the necessary adjustments to account for the shift in focus (See table below).

With PEPFAR Guyana transitioning from DSD to TA/TC, the EA tool had some limitations. A DSD model inflates costs that are no longer applicable as we move to a majority TA/TC model. With fewer sites and staff, the tool highlighted immediate 'cost savings.' One CDC IM, for example, reduced its budget by 50% and overall CDC staffing costs have reduced. As a result, funds were redirected to programs, training, and professional development.

[i] Guyana Preliminary Census Report, 2012
[ii] Global Disease Burden Profile
[iii] Presentation: Guyana HIV Update – PEPFAR Stakeholders Meeting January 2015, Dr.Singh, National AIDS Program Secretariat (NAPS)
[iv] Analysis of HIV Investments in Guyana (Draft), UNAIDS, 2014.
[v] Spectrum Modeling FY2013, UNAIDS 2014
[vi] Electronic communication. "Subject:Core/Near/Non – Cambodia – One Pager" Joseph De Goes 5 March 2015
[vii] LAC Treatment Report, PAHO 2013
[viii] Davis Memorial Hospital – 3rd Quarter Progress Report, January 2015
[ix] PUSH Chart Review 2013
[x] Guyana HIV Care and Treatment Technical Working Group's Meeting notes; 3 March 2015
[xi] Singh-Anthony, S. CDC-MOH Cooperative Agreement meeting May 8, 2014
[xii] Guyana Biologic Behavioral Surveillance Survey 2014, MEASURE Evaluation UNC Chapel Hill
[xiii] Dahlberg LL, Krug EG. Violence-a global public health problem. In: Krug E, Dahlberg LL, Mercy JA, Zwi AB, Lozano R, eds. World Report on Violence and Health. Geneva, Switzerland: World Health Organization; 2002:1–56.
[xiv] Morales-Miranda S et al Scale-Up, Retention and HIV/STI Prevalence Trends among Female Sex Workers Attending VICITS Clinics in Guatemala PLOS One Aug 2014
[xv] Sherer R. et al HIV multidisciplinary teams work: Support services improve access to and retention in HIV primary care. AIDS Care May 2010

Guyana FY15 Targets by Region: Clinical Cascade

	Number of individuals who received HIV Testing and Counseling services for HIV and received their test results	Number of HIV-positive adults and children newly enrolled in clinical care who received at least one of the following at enrollment: clinical assessment (WHO staging) OR CD4 count OR viral load	Number of HIV positive adults and children who received at least one of the following: clinical assessment (WHO staging) OR CD4 count OR viral load	Number of adults and children newly enrolled on antiretroviral therapy (ART)	Number of adults and children currently receiving antiretroviral therapy (ART)
Military Guyana	800	-	-	-	-
Region 1- Barima-Waini	-	-	-	-	-
Region 10- Upper Demerara-Berbice	-	-	-	-	-
Region 2- Pomeroon-Supenaam	-	-	-	-	-
Region 3- Essequibo Islands-West Demerara	-	-	-	-	-
Region 4- Demerara-Mahaica	5,494	393	3,913	405	3,355
Region 5- Mahaica-Berbice	-	-	-	-	-
Region 6- East Berbice-Corentyne	-	-	-	-	-
Region 7- Cuyuni-Mazaruni	-	-	-	-	-
Region 8-Potaro-Siparuni	-	-	-	-	-
Region 9- Upper Takutu-Upper Essequibo	-	-	-	-	-
Total	**6,294**	**393**	**3,913**	**405**	**3,355**

Guyana FY 15 Targets by Region: Key, Priority, Orphan and Vulnerable Children Indicators

	Number of the target population who completed a standardized HIV prevention intervention including the minimum components	Number of key populations reached with individual and/or small group level HIV preventive interventions that are based on evidence and/or meet the minimum standards required	Number of active beneficiaries served by PEPFAR OVC programs for children and families affected by HIV/AIDS
Military Guyana	600	-	-
Region 1- Barima-Waini	-	-	-
Region 10- Upper Demerara-Berbice	-	-	230
Region 2- Pomeroon-Supenaam	-	-	145
Region 3- Essequibo Islands-West Demerara	-	-	-
Region 4- Demerara-Mahaica	-	4,500	493
Region 5- Mahaica-Berbice	-	-	-
Region 6- East Berbice-Corentyne	-	-	1,132
Region 7- Cuyuni-Mazaruni	-	-	-
Region 8-Potaro-Siparuni	-	-	-
Region 9- Upper Takutu-Upper Essequibo	-	-	-
Total	**600**	**4,500**	**2,000**