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# **Rapid Assessment of USAID's HIV/AIDS Activities and Program Options in GUYANA**

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Submitted to

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Submitted by

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## **I. EXECUTIVE SUMMARY**

The AIDS pandemic has hit the Caribbean harder than anywhere outside sub-Saharan Africa. Guyana has the second highest HIV prevalence in the Caribbean next to Haiti. The general adult population's estimated prevalence is between 3.5–5.5 percent. Transmission is primarily heterosexual (80 percent); 75 percent of infections are attributed to people ages 19–35 years. AIDS now is the third leading cause of death.<sup>1</sup>

Sobering as these data are and contrasted with many African countries that have HIV prevalence levels of 25–35 percent, Guyana's infection rate is relatively low, although clearly a generalized epidemic. An aggressive prevention effort mounted now conceivably could hold Guyana's infection level down and reverse the increase in the virus' spread. Knowing what to do is not the main issue; determining how to do it is the challenge.

### **A. Findings**

Adequate policies are in place and support from senior public health leaders is frequent. The National Strategic Plan for HIV/AIDS 2002–2006 is comprehensive and builds on the National AIDS Strategic Programme Plan 1999–2001.<sup>2</sup>

While the top ranks of the public health establishment are strong, problems prevail at the at the next echelon down, where staff shortages are widespread and severe, with 25–50 percent staff vacancy rates in most categories.<sup>3</sup> Moreover, imbalances exist in staff distribution: nearly 70 percent of doctors are in Georgetown, the capital, where one quarter of the population lives. Only three pharmacists work in the public sector; 70 function in the private sector (PAHO Health Systems Profile, December 2001). The National AIDS Programme Secretariat (NAPS) Programme Manager, Dr. Morris Edwards, has few technical staff, despite a recommendation in the current Strategic Plan to strengthen NAPS staffing. As the lone, senior NAPS representative, Dr. Edwards faces a daunting workload that includes attending meetings of the Ministry of Health (MOH), donors, and various working groups.

Guyana, the second poorest country in South America and the Caribbean, had a per capita GDP of US \$770 in 1999. Per capita spending on health averaged about US \$45 through 1998<sup>4</sup>. Whereas the Government of Guyana is strapped for resources, the HIV-AIDS program potentially has substantial funding on the horizon. The World Bank has begun preliminary discussions on a \$6 million grant;<sup>5</sup> a request has been submitted to the UN Global AIDS Fund for \$30 million over 5 years, plus \$8.0 million for laboratory

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<sup>1</sup>Health Systems and Services Profile, PAHO, 2nd Edition, December 2001

<sup>2</sup>National Strategic Plan for HIV/AIDS 2002–2006, Draft, Guyana Ministry of Health, July 2002

<sup>3</sup>Health Systems and Services Profile, PAHO, 2nd Edition, December 2001

<sup>4</sup>Health Systems and Services Profile, PAHO, 2nd Edition, December 2001

<sup>5</sup>Personal communication, Salim J. Habayeb, public health specialist, Latin American Caribbean Region, The World Bank, October 8, 2002

upgrading; United States Agency for International Development (USAID) is projecting \$1–2 million per year; Centers for Disease Control (CDC) plans approximately \$2–3 million annually,<sup>6</sup> and other donors may increase their commitments.

Except for USAID and CDC funding, however, availability of funds is at least one to two years away. External reviewers regard the request to the Global AIDS Fund as ambitious; they think amount will likely to be reduced.

At USAID/Guyana, the health sector staff consists of a Johns Hopkins University Health and Child Survival Fellow, William K. Slater, MPH, who is the HIV-AIDS advisor. A senior foreign service national will be requested in the new Strategic Plan or earlier, but that position has not yet been approved.

Given the lean staffing situation, the current robust portfolio of approximately \$800,000/yr. is managed with a high degree of technical expertise and competence. The HIV-AIDS advisor and program enjoy full support from USAID Mission Director, Dr. Mike Sarhan, and both are indirectly complemented by Mission Strategic Objectives in Democracy and Governance and Economic Policy.

## **B. Recommendations**

At the beginning of this consultancy on October 7, 2002, William Slater shared his draft "Concept Paper for an HIV-AIDS Strategy 2004-2008." This strategy was due in USAID/Washington within a week's time and during the first week of consultation, the paper was slightly modified and refined after key meetings with the minister of health, the NAPS director, the chief medical officer, the UNAIDS advisor, Caribbean Epidemiological Center staff, and numerous donor representatives. On October 15, USAID Director Sarhan approved the concept paper and forwarded it to USAID/Washington. A copy of the HIV/AIDS section of the concept paper can be obtained from the appropriate office in the Latin America Caribbean (LAC) Bureau.

The concept paper satisfies the key Statement of Work requirement of this consultancy to "recommend programs for expansion," and I am in full agreement with its substance and program proposals.

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<sup>6</sup>Personal communication, Theresa D. Rubin, CDC, and William Slater, USAID, October 2002

Program interventions and recommendations related to them follow:

## **C. Current Activities**

### **1. Guyana HIV/AIDS/STI Youth Project**

Continue to support and expand this vital nongovernmental organization (NGO) project; encourage a shift to an "output orientation," meaning an increase in coverage, scaling up interventions, greater focus on reducing HIV transmission through voluntary counseling and testing (VCT), condom marketing, behavior change communications, and, whenever possible, advance sexually transmitted infection (STI) diagnosis and treatment.

### **2. Commodity Logistics Improvement**

The John Snow, Inc. "Deliver Project" currently provides technical support. A limited and superficial examination of the essential drug situation indicated that while supplies, seem adequate, numerous bottlenecks pervade the distribution system. Improving the distributive efficiency for condoms, STI and antiretroviral (when it becomes available) drugs are fundamental to a functioning HIV-AIDS prevention effort.

Health Minister, Dr. Leslie Ramsammy, emphasized the need for this assistance during a meeting to discuss future USAID support. The Minister indicated commodities currently are responsible for one third or more of the overall health budget and improving the management of drug logistics will continue to be an area that needs USAID support.

## **D. New Activities**

### **1. National Condom Social Marketing Project**

This project will be launched early in 2003 as planned with implementing partner Population Services International. In addition to expanding condom distribution nationwide, the accompanying national behavior change communications program on a national scale will fill an important void in information, education, and communication (IEC) coverage.<sup>7</sup>

### **2. Expanded Business and Labor Response**

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<sup>7</sup>Condom Social Marketing Assessment in Guyana, Alan Handyside, The Synergy Project, TvT Associates Inc., Washington, D.C., March 2002

Engaging the organized business and labor sectors to be involved with their own members and as advocates for an expanded and sustained national effort makes good sense. Many firms provide some level of health care or service to their employees, and all are in a position to promote information campaigns about the disease and develop a work environment that supports HIV-positive people in the workforce. Trade union involvement would add an important voice to the advocacy effort aimed at making the government more responsive to preventive and care and support needs. To expand the response of business and labor, technical assistance will be necessary.

### **3. Voluntary Counseling and Testing**

Although a part of several ongoing projects (i.e., the Guyana Youth NGO Project), voluntary counseling and testing efforts need an infusion of technical expertise and assistance. USAID intends to engage the Johns Hopkins Program for International Education in Gynecology and Obstetrics (JHPIEGO) to examine ways to expand voluntary counseling and testing services using the best approaches available worldwide.

### **4. New and Emerging Issues**

Establish a modest fund (e.g., \$100,000/yr. or alternatively, 10 percent of the annual budget) for rapid response to new proposals and opportunities. For example, the concept of mobile voluntary counseling and testing clinics merits early operations research to test its feasibility. Similarly, testing the prevention of mother-to-child transmission at birthing sites would be timely—in advance of anticipated central funding—since 80 percent of all births reportedly are taking place at Georgetown hospital.<sup>8</sup>

With prospects for a significant increase in donor funding (e.g., the World Bank's \$6.0 million anticipated in late 2003), having ready resources available for feasibility studies and start-up actions makes good sense and would contribute to accelerating program coverage.

### **5. Working Relationship with the Centers for Disease Control**

The Centers for Disease Control, as of September 2002, has a resident technical presence and is rapidly developing an ambitious work plan for the fiscal years 2003 and 2004. Although the CDC will bring funding from its Global AIDS Program (GAP), collaboration between USAID and the CDC is imperative. Both agencies are willing to collaborate, but it promises to be fairly labor intensive and it will require a significant allotment of the HIV-AIDS advisor's time.

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<sup>8</sup>Personal communication, Cliff Cortez, Senior Policy Technical Advisor, USAID's Office of HIV/AIDS, October 2002

## **E. Conclusion**

Within the above programs voluntary counseling and testing, behavior change, condom marketing, and logistics management will be emphasized. The Youth NGO effort is on target and growing more dynamic and effective by the month. The addition of CDC's activities and contributions by other donors mean that nearly all interventions should be receive support in FY03.

Given USAID's staffing constraint and the possibility of budget increases in FY 2003, the challenge for USAID will be to continue to focus on the current portfolio and the additions outlined above. Unless there is a dramatic increase in staffing and funding, the Mission and the HIV-AIDS advisor should resist inevitable exhortations to expand the workload.

## **II. INTRODUCTION**

**Purpose:** Assess existing USAID- and non-USAID supported HIV/AIDS and HIV/AIDS-related activities in Guyana and recommend ways to expand programming. Also, assist USAID Guyana and the HIV/AIDS advisor in developing a new five-year strategic plan for 2004–2008.

**Audience:** The primary client or audience is the Director of the USAID Mission in Guyana and the HIV/AIDS advisor. Other audience members are the staff of USAID's Bureau for Latin America and Caribbean and the Office of AIDS Prevention in the Global Bureau.

**Synopsis of Task:** Become knowledgeable of existing documentation, including previous assessments and evaluations, Government of Guyana strategic plans, and work plans of cooperating agencies, contractors, and NGOs. Conduct interviews with principals in the Ministry of Health, the National AIDS Programme Secretariat, the Office of the Chief Medical Officer; UNAIDS representative; technical staff of the Caribbean Epidemiological Center (CAREC); and donor representatives. Undertake field travel as time permits. Receive guidance from and maintain close interaction with the USAID/Guyana HIV/AIDS advisor, William K. Slater.

## **III. BACKGROUND: OVERVIEW OF THE HIV/AIDS EPIDEMIC, KEY POLICIES, AND CURRENT SITUATION**

Guyana is one of five countries in the Latin America/Caribbean region where the HIV/AIDS epidemic has spread beyond specific high-risk groups into the general population. With an estimated 3.5–5.5 percent of adults infected, Guyana has the second highest HIV/AIDS prevalence in the region after Haiti

Approximately 80 percent of HIV transmission is heterosexual, 18 percent is attributed to men having sex with men, and 2 percent is due to intravenous needle use. Seventy-five percent of infections are attributed to persons 19–35-years old. By the end of 1999, according to UNAIDS, 15,000 adults were living with HIV/AIDS and 1,100 children under the age of 15 had lost their mother or both parents since the beginning of the epidemic. There were 900 AIDS deaths in 1999 alone. An estimated 45 percent of commercial sex workers (CSWs) were infected as of 1997, representing a "time bomb" that has already exploded?<sup>9</sup>

The country's HIV/AIDS prevention policy endorses the "ABC" strategy emphasizing abstinence, be faithful, and condom promotion. The government also is committed to reducing mother-to-child transmission and universal access to treatment.

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<sup>9</sup>Guyana HIV/AIDS Assessment and Recommendations, U.S. Centers for Disease Control and Prevention, Global AIDS Program, July 9-16, 2001

The National Strategy Plan for HIV/AIDS 2002-2006 is thoughtful, comprehensive, and ambitious. Shortcomings are not in the policy arena, but they may be evident in the implementation capacity and effectiveness.

Interventions undertaken by the government and for which external donor assistance has either been requested or already is underway include development of HIV surveillance systems, voluntary counseling and testing), training for health professionals, capacity building of the health infrastructure, and availability of antiretroviral medicines.

In addition, the Minister of Health has requested USAID to provide assistance in logistics management of essential drugs and launch a condom social marketing project and a nationwide behavior change campaign.

#### **IV. USAID ASSISTANCE**

In FY 2001, USAID allocated \$800,000 to Guyana's HIV/AIDS prevention efforts. The centerpiece of the USAID-supported program is the Guyana HIV/AIDS/STI Youth Project, now in its third year, which involves eight NGOs and technical assistance by Family Health International (FHI).

Due to minimal staff (a Johns Hopkins Fellow as HIV/AIDS advisor), USAID supports interventions that (1) are directly targeted to the prevention program, (2) are where USAID and its contractors have a comparative advantage or competence, and (3) respond to high priority needs of the Government of Guyana. In addition to the youth program, the Mission supports improvement of essential drug logistics management. John Snow, Inc. provides technical assistance to this program.

Proposed for FY 2003 are (1) a national condom social marketing program with Population Services International; (2) upgrading voluntary counseling and testing with technical assistance from Johns Hopkins University; (3) support to the organized business and trade union sectors, and (4) a special fund for operations research and new and emerging issues.

In addition, USAID envisions extensive collaboration with Centers for Disease Control, which recently established resident presence in Guyana and is gearing up to become operational.

## **V. FINDINGS, CONCLUSIONS, RECOMMENDATIONS<sup>10</sup>**

### **A. Information, Education, and Communication**

Past assessment teams and most recently Alan Handyside, have noted, "Effective mass media communication to the general population is virtually nonexistent." Moreover, Handyside says, "HIV prevention efforts to date have been done to raise awareness and promote education, rather than to encourage behavior change."<sup>11</sup>

Most donor-funded projects include some provision for information, education, and communication, but the coverage remains sporadic and incomplete. USAID will make a major contribution in this area when Population Services International begins operations in January 2003. The Population Services International program will include a robust information, education, and communication campaign directed at behavior change, particularly among young people aged 15–24 years, who are at greatest risk. The project will be national in scope, a dimension missing until now.

The Population Services International project represents a significant infusion of resources into information, education, and communication and fully meshes with Guyana's need and USAID's capability.

### **B. Communicable Diseases and STI Diagnosis and Treatment**

The Canadian International Development Agency has assumed the lead in supporting an upgrade of the Ministry of Health's infectious disease capacity, although discussions still are underway to finalize plans. USAID, through the Guyana HIV/AIDS/STI Youth Project, plays a major supporting and complementary role by addressing sexually transmitted infections. This dimension of the project, however, remains underdeveloped and it will require sustained attention in the future.

Providing national coverage for sexually transmitted infection diagnoses and treatment is beyond the capacity of USAID's staff and funding. Consequently, it remains an area in which collaboration with the Ministry of Health and other donors will continue to be essential if sexually transmitted infection co-factors for HIV transmission are to be diagnosed, treated and reduced. When fully developed and operational, the CDC program is expected to contribute to this effort.

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<sup>10</sup>This section addresses specific points on page 5 of the statement of work. Incorporated within are lessons learned, a discussion of issues, and recommendations for future directions. This collapsing of the assessment outline was done with the concurrence of the USAID HIV/AIDS advisor in the interest of eliminating repetition and enhancing readability.)

<sup>11</sup>Condom Social Marketing Assessment in Guyana, Alan Handyside, The Synergy Project, TvT Associates Inc., Washington, D.C. March, 2002

Other donors, notably the Canadian International Development Agency and Pan American Health Organization, are committed to addressing the increase in tuberculosis (estimated to be increasing 10–20 percent annually).<sup>12</sup> The Ministry of Health also has applied to the UNAIDS Global Fund for support to increase tuberculosis activities. Given USAID's staffing and budgetary constraints, however, no additional role in the communicable disease arena is recommended.

### **C. Youth Initiatives**

The Guyana HIV/AIDS/STI Youth Project is the centerpiece for the Mission's intervention in the epidemic. USAID's previous director, Dr. Carol Becker, the USAID Latin America Caribbean Bureau, and Family Health International (FHI) are to be applauded for launching this project more than two years ago. It meets an urgent need and remains central to reversing the course of the HIV epidemic in Guyana.

The leaders of eight NGOs participating in the Youth project assembled for an all-day meeting at USAID that, in addition to giving an update on their activities, signaled the inauguration of their new web site, [www.guyanayouth.com](http://www.guyanayouth.com). The web site offers a menu of information on sexually transmitted infections, counseling approaches, data on the epidemic's course, reproductive health, safe sex, and other health tips.

In contrast to encounters and meetings earlier in the week with government officials, the energy, openness, creativity, willingness to collaborate and learn from each other, and general high spirit among NGO leaders were impressive.

It is evident that the Mission's HIV/AIDS Advisor, Bill Slater, has done an outstanding job guiding and supporting this group of NGO's, which uniformly expressed their appreciation for USAID's role.

Much, of course, remains to be done, but in a rapidly evolving program, this is expected. Two areas need sustained attention:

**(1) Output orientation/expanded coverage:** Now that these NGOs are established and functioning, the next task is to steer them toward expanding their coverage to increase impact. Whether this expansion includes counseling sessions, referrals to voluntary counseling and testing, condom distribution, or community education events, the idea is to increase coverage to involve as much of the target audience in their respective catchment areas as possible. A series of training sessions is recommended to elaborate on the implications of output orientation and to modify work plans accordingly.

**(2) Voluntary Counseling and Testing:** More than half of the NGOs either offer or plan to add voluntary counseling and testing to their portfolios. A few NGOs have complete

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<sup>12</sup>Country Assistance Plan for Guyana, FY03–04, Draft, Theresa D. Rubin, deputy director, CDC-GAP, Guyana, October 1, 2002

pre- and posttesting counseling and blood-drawing capabilities, and some are interested in rapid assessment kits. Other NGOs perform the counseling and refer clients to a clinic or hospital for drawing blood and analysis.

Volume has been small or modest (as indeed it is in the government's VCT program where, for example, regions 5 and 6 had only 100 clients in an eight-month period as reported in the VCT review meeting, October 10).

The rationale for voluntary counseling and testing is straightforward, but VCT is still not widely accepted or acted upon. People must learn their HIV status so that those who are negative have an incentive to remain that way. For those that are positive, counseling is offered to help them live positively; avoid infecting others; and seek medical attention to ward off opportunistic infections, such as tuberculosis, that attack a weakened immune system. It is estimated less than 20 percent of infected persons today are aware of their infection; the other 80 percent continue with their relationships, passing the virus to unsuspecting partners.

Much remains to be done to increase the volume of VCT referrals, but much of the service delivery architecture is in place and ready to be energized. A missing piece, however, is the absence of a government-approved rapid test kit and its dissemination to VCT sites. This latter issue merits early advocacy vis-à-vis the MOH by both CDC and the Mission.

#### **D. Preventing Mother-To-Child-Transmission**

This initiative, announced by President Bush last year, has not been funded with any Congressional appropriation, although both CDC and USAID have authorized preparations and preliminary work. CDC will have the "lead role." The Caribbean Epidemiological Center also is gearing up to be a major player and will work closely with the National AIDS Programme Secretariat (NAPS).

When and if funding materializes, USAID is prepared to play a facilitative role. The bulk of the technical and administrative effort will rest, however, with CDC, a division of labor that is entirely appropriate.

#### **E. Special Populations**

**(1) Uniformed Services—The Military and Police:** HIV/AIDS prevention programs worldwide have neglected working with the police and military. For inexplicable reasons, they fail to appear on civilian bureaucracy radar screens.

Soldiers in particular merit special attention. Young men in uniform are away from home and removed from traditional social restraints. Believing they are impervious to harm, they typically indulge in a freewheeling sex life, possibly contracting HIV and passing it on to wives and girl friends.

The U.S. Department of Defense provides support to its counterpart military establishment in Guyana. Through the International Military Education Training Program, a woman Guyanese army major attended a two-week AIDS policy planning course at the Naval Postgraduate School in Monterrey, CA. The Southern Command also sponsored two public health nurses from the U.S. Army Center for Preventive Health Promotion and Wellness in April 2002. During a three-day stay in Guyana, the nurses (a) gave general information classes on STIs, HIV and how to prevent contracting them to more than 400 Guyanese soldiers; (b) conducted a seminar for military medics on infection control; and (c) briefed Guyana Defense Force officers on elements of HIV/AIDS prevention policy. The U. S. Department of Defense sent two Guyana Defense Force physicians to a Baltimore conference on public health policy for seven days. The conference included one day on HIV/AIDS counseling.<sup>13</sup>

The opportunity exists for one or several NGOs to work with the Guyana Defense Force, which consists of 2,500 personnel. The USAID should encourage such collaboration. Similarly, the CDC may want to explore collaborative possibilities with the local military medical establishment, although the "military-to-military" connection might prove more fruitful.

**(2) Miners:** Bauxite and gold mining are major extractive industries located in the remote hinterland and not readily accessible. The concept of "mobile VCT" operations offers a possible approach to reaching the population groups associated with these industries (including the CSWs who serve them). Several youth program NGOs have expressed intentions to operate mobile VCT clinics in the near future. Some miner populations have HIV prevalence rates of 6 percent. The proposed Business and Labor Response would also provide a vehicle for reaching these hard-to-reach populations.

**(3) Amerindians:** Amerindians comprise about 7 percent of the population and inhabit the most remote parts of the country. They are more vulnerable to disease and least likely to have access to preventive and curative health services. It is recommended that the Youth Project explore adding an NGO to begin targeting this population.

## **F. Geographical Coverage**

Approximately 30 percent of Guyana's population lives in urban areas and 70 percent lives in rural areas, of which 61 percent is located in the rural coastal areas of the country.<sup>14</sup>

Given the relatively early stage of USAID's program and the constraints of limited staff and funds, skewing the allocation of resources and program effort toward areas of higher

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<sup>13</sup>Personal communication, Major Tyler Fitzgerald, U.S. military liaison officer to Guyana, U.S. Embassy, Georgetown, October 17, 2002

<sup>14</sup>Health Systems & Services Profile, PAHO, 2nd Edition, December 2001

population densities is indicated. NGOs will operate some youth programs (as well as the condom marketing program when it becomes operational in 2003) in some rural areas.

### **G. Care and Support and Orphans and Vulnerable Children**

The magnitude of AIDS cases, AIDS deaths, and orphans due to AIDS mortality remains relatively small in Guyana compared with the magnitude in many larger countries, particularly in Africa. For those who are affected, the needs are equally real, but from a programming perspective, the demand for large-scale resources, including USAID resources, to meet these needs has yet to arise.

On a field trip, October 15, to the city of Linden (population 60,000), some 75 miles from Georgetown, we were advised that in the area were 71 AIDS orphans, including 8 who were infected with HIV. Assuming about three children per family, that sum reflects approximately 24 adult deaths. This suggests that the orphan issue bears careful monitoring since the numbers can quickly escalate.<sup>15</sup>

Nevertheless, it is recommended that USAID let the government and other donors provide support in this sector. As in other interventions, some USAID-funded NGOs will undoubtedly work in the care and support of orphans and vulnerable children as a secondary or related activity to their main mission.

### **H. Faith-Based Organizations**

Faith-based organizations have offered relatively little support, which perhaps, reflects an attitude of denial and a reluctance to be associated with certain aspects of the epidemic, such as multiple partner sexual relations, homosexual transmission, and commercial sex workers.

At the NGO Youth Program review on October 10, 2002, several spokespersons reported the involvement of faith-based organization. Notable was the Volunteer Youth Corps' work with "Youth on a Mission," a church-based organization. Greater open support and advocacy for an expanded program effort by faith-based organization would be welcomed. Faith-based organizations are a "target of opportunity," and USAID should carefully monitor their developments.

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<sup>15</sup>Personal communication, Hazel Benn, public health nurse and director of Linden Care Foundation, Linden City, October 15, 2002

## **I. People Living With HIV/AIDS**

Engaging and involving people living with HIV/AIDS can be a powerful component in an AIDS prevention effort, and their involvement should be seized upon whenever possible. A major achievement of the Youth Project is the addition of the Guyanese Network of HIV Positive People, "G +." Because of stigma and perceived social disapproval, however, few instances have occurred in which people living with HIV/AIDS have been willing to openly associate themselves with information, education, and prevention programs.

Two consequences of the stigma issue are that people delay testing for HIV (with the average period between diagnosis and death only 4.5 months)<sup>16</sup> and they are reluctant to report AIDS cases despite legislation requiring it. These two consequences could be traced to a perceived lack of confidentiality within the Ministry of Health reporting system, where breaches of patient records have occurred.

The youth program review, reported some signs of change regarding stigma against people living with HIV/AIDS. NGO leaders are cognizant of this change and they will continue to monitor its progress whenever possible. When the voluntary counseling and testing program begins to handle a volume case load, it is possible that those who are tested may be empowered and encouraged to speak out, but who until now, they remain unaware of their HIV status.

## **J. Commercial Sex Workers**

Survey data in 1997 indicated 45 percent of commercial sex workers were HIV positive, an increase from 25 percent in 1989. The HIV rate today is unknown because sample surveys have not been taken in the past 5 years.<sup>17</sup>

Despite widespread acknowledgment infected sex workers' role in spreading the virus, remarkably few preventive programs address this issue. The public health establishment must reorient itself to work where the virus lives and is transmitted and not restrict its operations to what is conventional and socially acceptable between the hours of nine and five.

Specifically, it should be recognized that the virus typically is transmitted at night during unprotected sexual intercourse, frequently after the intake of considerable alcohol and often between partners who are only casually acquainted. This means that outreach prevention programs must focus on bars, brothels, truck stops, military hangouts, nightclubs, and hotels where casual sexual encounters occur. It also means that peer education and condom distribution activities must be organized and mobilized.

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<sup>16</sup>Guyana: National Strategic Plan for HIV/AIDS 2002–2006, July 2002

<sup>17</sup>Guyana: National Strategic Plan for HIV/AIDS 2002–2006, July 2002

Regardless of this lackluster program history, there may be reason to expect change. On October 7-8, 2002, the National AIDS Program Secretariat (NAPS) convened a planning workshop to chart a reinvigorated approach to commercial sex workers and their HIV status. Attending were representatives of the MOH, CAREC, UNAIDS, CDC, USAID, CIDA and GTZ. Details of this workshop will be reported separately, but the general expectation is that a more energetic and comprehensive approach of working with commercial sex workers will be launched in the next few months.

### **K. Men Who Have Sex With Men**

Whereas an estimated 80 percent of HIV transmission is heterosexual, roughly 18 percent represents homosexual or bisexual transmission. These proportionate data are probably more reliable than the number of cases in each category, which are greatly underreported.

There is minimal official acknowledgment in Guyanese society that male-to-male transmission occurs and virtually no organized effort to deal with it. The most promising intervention on the horizon is Population Services International's national condom marketing program, which includes a behavior change communications component, to be launched early in 2003. It is expected, too, that focused marketing will be directed at men, although at this time, specific details have not been developed.

### **L. Voluntary Counseling and Testing**

Voluntary counseling and testing should be central to any HIV-AIDS prevention program (see rationale in no. 3 above). With the support of the Caribbean Epidemiological Center, six pilot voluntary counseling and testing sites are operational. But a review conducted October 10 in the office of the Chief Medical Officer, Dr. R. Cummings, revealed more problems than successes. Shortcomings included:

- The voluntary counseling and testing initiative has been without a coordinator since 2001.
- There is no information, education, and communication campaign associated with the voluntary counseling and testing service; counselors are forced to rely on word-of-mouth communications.
- The government hospital in Linden was reported as "having problems" and although additional personnel had been trained in May, they have not yet started to work.
- A Ministry of Health policy paper on voluntary counseling and testing exists, but has yet to be approved per Dr. Wagner of GTZ and Caribbean

Epidemiological Center. Despite its draft status, the policy paper serves as guidance for voluntary counseling and testing activity, he said.<sup>18</sup>

- Services are not "user friendly." Some hospitals offer voluntary counseling and testing daily; others, one day per week. Voluntary counseling and testing is not available in the evenings or on weekends.
- Rapid tests reportedly are available at some sites, but a Ministry of Health policy on their use does not exist. Dr. Morris Edwards, the NAPS Programme Director, expressed concern that rapid tests were "being abused," inferring that patient blood samples are being analyzed without their consent, which constitutes a violation of patient human rights.)
- The volume of service is low, and reporting is incomplete. Regions 5 and 6 reportedly conducted only 100 tests in the past year, or about 4 per site per month. Region 3 reportedly performs presurgical testing and counseling, but fails to report on activity. No one at this meeting was able to report on overall volume of services.
- Due to the confusion on use of rapid test kits, most sites send blood samples to Georgetown Hospital each Friday, which delays reporting the results to clients at least a week or more (assuming that in fact they return for their results which many do not).

The voluntary counseling and testing program is progressing poorly and contributing little to curbing the HIV epidemic. USAID and CDC representatives are cognizant of this situation and are committed to pressing for urgently needed improvements. Technical assistance from the Johns Hopkins Program for International Education in Gynecology and Obstetrics is expected to contribute to upgrading the voluntary counseling and testing program early this fiscal year.

Of the entire essential actions needed to strengthen the AIDS prevention program, upgrading voluntary counseling and testing should be first priority.

### **M. Multisectoral Responses**

Sectoral involvement in the Guyana AIDS prevention program should not be a priority focus for USAID. For the time being, it would be wiser for USAID to concentrate on those institutions and interventions that should be the primary frontline actors, e.g., the public health infrastructure including all hospitals and clinics, the voluntary counseling and testing program, drug and condom logistics improvement, and youth program NGOs.

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<sup>18</sup>Personal communication, Dr. Uli Wagner, GTZ/Caribbean Epidemiological Center, October 10, 2002

Top-level political support from the Office of the President and political establishment would be welcomed.

USAID's move to engage the organized business and labor sectors fits into the multisectoral category. The Mission's Strategic Objectives for Democracy and Governance and Economic Development also will complement the AIDS prevention program. At the moment, however, the USAID program is full with little room to add more workload.

## **N. Surveillance, Monitoring, and Evaluation**

The needs in this category admittedly are extensive. Until now, the HIV/AIDS prevention effort has been hampered by a lack of credible data and, particularly, by a lack of recent data. As pointed out in the National Strategic Plan (NSP, June 2002), "Unfortunately the true extent of the problem is unknown since AIDS data are incomplete and seroprevalence data outdated."<sup>19</sup>

If acknowledgement of the problem is the first step toward its resolution, then that first step has been taken. The Strategic Plan goes on to state that: "Good surveillance is, therefore, going to be the cornerstone of the execution and monitoring of the National Strategic Plan for HIV/AIDS."

The list of activities in the plan is comprehensive and will not be repeated herein; however, several key actions are presented for illustrative purposes:

- Laboratory capability is essential to good surveillance.... therefore, increase the capacity and capability of laboratories to handle the volume of work expected to be generated because of increased demand for diagnosis and monitoring.
- All designated sites in the public sector (will be) reporting monthly on the number of new STIs, tuberculosis, HIV and AIDS cases, and opportunistic infections by the end of 2002.
- Seroprevalence surveys (will be) carried out biennially among target groups starting in 2002.
- Surveys (will be) carried out biennially among youths 15–24 years of age to provide information on age at first sexual contact, condom use at last sexual encounter, and drug use, starting mid 2003.
- Carry out seroprevalence surveys among antenatal women, commercial sex workers, and men who have sex with men.

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<sup>19</sup>Guyana: National Strategic Plan for HIV/AIDS 2002–2006, July 2002

With the arrival of CDC staff member, Theresa Rubin, in Guyana in September 2000, additional funding and technical resources have become available to the entire monitoring, surveillance, and evaluation sector. CDC's work plan calls for surveillance activities to be a "primary focus for year one" so that data can be developed to guide program activities in the future. The CDC chief of party is Dr. Okey Nwanyanwu, an epidemiologist with extensive international experience and who will be on site in January 2003.

Details of CDC plans in surveillance and related areas are found in "Guyana HIV/AIDS Assessment and Recommendations," July 9–16, 2001, an expansive and generally all-encompassing report. See also the "Country Assistance Plan for Guyana, Plan Period FY03-FY04," October 1, 2002, by Theresa D. Rubin, which remains in early draft status.

In addition to CDC, CAREC with GTZ support continues to provide some funding and technical assistance for surveillance. This long-standing relationship is expected to continue.

To the extent that these useful but ambitious activities are actually carried out, the program will move up to a much more solid operational footing. The blueprint is there; implementation remains the challenge.

## **O. External Donor Activities**

Until now, a good share of Guyana's HIV/AIDS prevention effort has been externally funded. Support from the Government of Guyana also has been substantial in terms of staff and facilities, which constitute the core of the activity. At this time, the AIDS program appears to be on the verge of a major boost in external assistance, which should give the program a quantum increase in both coverage and effectiveness. The table below matches donors with areas of assistance.<sup>20</sup>

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<sup>20</sup>R 4" Results, Review and Resource Request, p. 18USAID, 2002–2003 and Country Assistance Plan for Guyana, Plan Period: FY03-FY04, Draft by Theresa D. Rubin, October 2002.

<b>DONOR</b>	<b>MAJOR AREAS OF ASSISTANCE</b>
Pan American Health Organization	HIV/AIDS prevention; tuberculosis; malaria control; strengthening national capacity in Ministry of Health
UNAIDS	Coordinate HIV/AIDS activities of UN Group (but with little or no program funding available)
UNICEF	Prevention of mother-to-child-transmission; youth programs; HIV/AIDS prevention; malaria
UNDP	Socioeconomic impact of HIV/AIDS
USAID	Youth NGO programs; condom social marketing; behavior change communications; logistics improvement; voluntary counseling and testing; labor and business communities
GTZ, with Caribbean Epidemiological Center	Technical support for voluntary counseling and testing surveillance; HIV/AIDS and sexually transmitted infections; HIV among commercial sex workers
Canadian International Development Agency	HIV/AIDS prevention; communicable disease control; pilot health management information system
European Union	Strengthen national capacity to respond to epidemic
Japan International Cooperation Agency	Small grants
World Bank	Preliminary discussions on \$6.0 million grant for HIV/AIDS program

With so many donors involved in the country's HIV/AIDS program, the potential for overlap, duplication, and confusion is increasing. To facilitate coordination, the donor community should meet monthly to exchange pertinent information and plans. Donors must exercise care and tact, of course, so that the Government of Guyana does not regard the meetings as some kind of donor conspiracy. (Note: At the final mission debriefing, the HIV/AIDS advisor indicated he would take the lead on this.)

It would also be useful to complete a compilation of donors and their areas of support and funding levels. . The National AIDS Programme Director attempted this recently, but only CIDA and USAID responded. A local-hire contractor possibly could be engaged to compile this information.

#### **P. Concluding Observation**

Guyana can still be regarded as having a relatively low HIV infection rate. This would be true even if subsequent surveys showed a 6 or 7 percent prevalence rate, which is slightly greater than earlier estimates of 3.5 to 5.5 percent. Implementation of an aggressive prevention program will likely keep the HIV prevalence level low. Knowing what to do is not the main issue; determining how to do it is the challenge.

## **ANNEX A: CONSULTATIONS AND PERSONS INTERVIEWED**

Dr. Mike Sarhan, USAID/Guyana Mission Director  
Mr. William Slater, USAID/Guyana HIV/AIDS Advisor  
Dr. Leslie Ramsammy, Minister of Health  
Dr. Rudolph Cummings, Chief Medical Officer, Ministry of Health  
Dr. Morris Edwards, Director, National AIDS Program, Ministry of Health  
Dr. Janice Woolford, Director, Maternal and Child Health Division, Ministry of Health  
Major Tyler Fitzgerald, U. S. Military Liaison Officer  
Ms. Theresa D. Rubin, U. S. Centers for Disease Control and Prevention, Global AIDS Program  
Mr. Godfrey Frank, UNAIDS Country Program Advisor  
Dr. Uli Wagner, GTZ/Caribbean Epidemiological Center  
Mr. Salim Habayeb, World Bank  
Ms. Shiela Samiel, Caribbean Epidemiological Center  
Mrs. Williams Mitchell, Caribbean Epidemiological Center  
Mr. Paul Nary, Family Health International  
Mr. Kenroy Roach, Chairman, Volunteer Youth Corps  
Mrs. Hazel Benn, Director, Linden Care Foundation  
Mr. Basil Benn, Region 10 Executive Administrator, Region 10  
Ms. Gillian Butts, Guyana Responsible Parenthood Association  
Mr. Ivor Melville, Hope Foundation, Bartica  
Mrs. Shawndella Charles, Comforting Hearts, New Amsterdam  
Ms. Simone Sills, Youth Challenge Guyana  
Mr. Stephen Sandiford, Canadian International Development Agency  
Mr. Jimmy Bhojedat, Lifeline  
Mr. Dexter Rowe, Artistes in Direct Support

### **USAID/Washington DEBRIEFING, Monday, October 21, 2002**

Dr. Paul DeLay, Director, Office of HIV/AIDS  
Mr. Clifton Cortez, Senior Policy Technical Advisor, Office of HIV/AIDS  
Ms. Sonja Heller, Desk Officer, Latin America Caribbean Bureau/Guyana  
Ms. Shanti Conley, Technical Advisor, Office of HIV/AIDS  
Ms. Diana Prieto, Caribbean Coordinator, Office of HIV/AIDS  
Ms. Logan Brenzel, Senior Health Economist, Latin America/Caribbean Bureau

### **TvT Associates, Synergy Project Staff, October 21, 2002**

Dr. Barbara O. de Zalduondo, Director  
Ms. Monica Larrieu, Senior Program Manager  
Ms. Shirl Smith, Training Specialist  
Dr. Saha Amara Singham, Monitoring and Evaluation Specialist  
Dr. Ruth Hope, Senior Technical Specialist

## **ANNEX B: REFERENCE MATERIALS**

### **THE SYNERGY PROJECT**

1. Agenda
2. Scope of Work

### **USAID**

3. "R 4" Results, Review and Resource Request, 2002–2003
4. Guidance on the New Monitoring and Evaluation Reporting System Requirements for HIV/AIDS Programs
5. R4 Documentation and FY 2003 Indicator Data for Guyana
6. HIV/AIDS in Guyana and USAID Involvement
7. HIV/AIDS Youth Program for Guyana: A Report on the Assessment of Eight Guyanese NGOs (Family Health International)
8. Condom Social Marketing Assessment in Guyana (The Synergy Project)
9. Guyana HIV/AIDS Assessment: The Need of HIV/AIDS Assistance in a Country Without a USAID Health Program
10. Special Objective Results Framework
11. Ready Body Monthly Monitoring Tool

### **Pan American Health Organization**

12. Health Systems and Services Profile of Guyana, 2nd edition, December 14, 2002
13. Country Health Profile 2001: Guyana

### **Centers for Disease Control and Prevention**

14. Guyana HIV/AIDS Assessment and Recommendations, July, 2001
15. Country Assistance Plan for Guyana, Plan Period: FY03-FY04, Draft by Theresa D. Rubin, October 1, 2002

### **Inter-American Development Bank**

16. Basic Nutrition Program: Sector Facility Profile, Guyana, April 23, 2002

### **Guyana Ministry of Health**

17. Health Sector Reform 1999–2004

### **General**

18. Report on Peer Education Reinforcement: Guyana STI/HIV/AIDS Youth Project, September 12, 2002
19. Guyana: National Strategic Plan for HIV/AIDS 2002–2006, July 2002