

**CONDOM SOCIAL MARKETING ASSESSMENT  
IN GUYANA**

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## **Acronyms**

AIDS	acquired immune deficiency syndrome
GRPA	Guyana Responsible Parenthood Association
HIV	human immunodeficiency virus
STI	sexually transmitted infection
USAID	United States Agency for International Development

## EXECUTIVE SUMMARY

Guyana has the second highest HIV seroprevalence rate in Latin America and the Caribbean, at 5%–7.5% of the general population, although it is probably much higher, and increasing. Prevalence in urban areas may exceed 10% among the general population. With an adult population of 480,000 aged 15–64, this indicates that some 36,000 Guyanese are infected with HIV.

Sex with multiple partners is socially condoned, as it is in many other Eastern Caribbean countries, and risky sexual behavior is widespread, particularly among young people. Sexually transmitted infections are rife, there is undercover homosexuality, and considerable migration, both within and outside of Guyana. Conditions are such that, unless major interventions are undertaken, the epidemic will progress at an alarming rate, with societal and economic consequences.

Although 97% of women of reproductive age are aware of HIV/AIDS, only 24% of women surveyed could correctly identify three modes and three misconceptions of HIV transmission. A large proportion of the general population is unaware of the ways that HIV is transmitted.

The five-year, \$1.2 million USAID strategy for HIV/AIDS in Guyana has been in place since 1999. It has provided funding for eight local nongovernmental organizations to work at developing awareness, knowledge, and prevention strategies.

The government of Guyana has concentrated its efforts on providing care and support for patients with HIV/AIDS, rather than on prevention strategies. However, through the national AIDS program, the government delivers condoms free of charge in public places and to nongovernmental organizations.

The national AIDS strategic plan and several related studies have indicated that a social marketing intervention could help slow the transmission of HIV. The USAID Mission in Guyana commissioned this consultancy with the objective of examining the present system of condom distribution and to recommend the contribution that a condom social marketing initiative could make to an HIV prevention program. The consultancy was conducted in Guyana March 11–28, 2002, by Alan Handyside, an experienced, independent social marketing consultant.

Considerable stigma is attached to HIV/AIDS and, although nongovernmental organizations are doing good work in trying to overcome this, their scope is limited by their capacity to do so and their geographic coverage.

Effective mass media communication to the general population is virtually nonexistent. HIV prevention efforts to date have been done to raise awareness and promote education, rather than to encourage behavior change. Whereas care and support for people affected by HIV/AIDS is laudable and necessary, to ignore prevention activities will only allow the epidemic to spread.

Condoms are widely available in the public and private sectors. Estimates are that some 3 million condoms are issued or sold in Guyana each year, 1.7 million of which are available through 7000+ private outlets. Condoms are more widely available in urban and periurban areas.

Packaging for private sector commodities depict use of condoms for sex and pleasure, which is commensurate with the general public view of condoning high sexual activity.

Retail prices for condoms in the private sector are about G\$150–200 (about US\$1) for a packet of three. These prices are probably too high for regular use by young people, who are the primary target audience.

Although the brands and packaging of private sector condoms is overtly sexual, they are rarely visible in pharmacies, drug stores, and the nontraditional outlets that stock them because their display dispensers do not enhance the ordinariness of the product or encourage easy purchase.

Distribution of private sector brands is through Geddes-Grant and other importers. Rough Rider, the brand leader, can be found in 60%–70% of pharmacies, drug stores, mixture shops, and bars.

The public sector condom is distributed mainly by the National AIDS Program Secretariat, although the maternal and child health division of Ministry of Health and nongovernmental organizations also contribute to the high volume of condoms issued. The Ministry of Health appears to have little interest in recording how many condoms are distributed from the national stock; rather, its mentality is one of management and availability. This does not allow easy measurement of progress, and care needs to be taken not to double count the number of condoms issued by other government departments, because a considerable amount of stock moves between recording departments.

Religion plays a part in the lives of many Guyanese, and both Christian and Muslim communities are pragmatic about their approach to HIV/AIDS and condom use. They continue to promote the ideals of fidelity and abstinence, but they appear to be realistic about the spread of HIV/AIDS and its effects on their communities, and are doing what they can to promote safe sex. Although their efforts may not include positive promotion of condom usage, they are not prohibiting it.

Given the virtual absence of effective mass media communications to the general public, and the high level of risky behavior and misconceptions among the sexually active young target audience, the choice between a free public sector condom and the unpromoted, but relatively expensive brand name condoms, it appears that an effective condom social marketing intervention would make a valuable contribution to the HIV prevention effort.

An intervention would allow the promotion of condoms and generic messages via mass communications, raise the visibility of risky behavior and ways of reducing it, and help destigmatize HIV/AIDS. It would also enable good quality condoms to be made available to poorer people through commonplace, nontraditional outlets. This intervention should sit comfortably alongside the continuing distribution of public and private sector condoms, and would increase the capability and flexibility of nongovernmental organizations and others working in the field.

A good candidate to serve as the implementing agency in Guyana is Population Services International, which is in the process of developing a regional project that is likely to operate in Trinidad. Making Guyana a separately funded part of this project would be cost-effective.

An outline of such a program was devised during the consultancy. It calls for engaging the services of an existing local distributor that already sells and distributes food to many nontraditional outlets on a regular basis. Population Services International could set up an affiliate to its regional program and engage local sales promotion officers and support staff to work under an experienced local sales and marketing manager. Social marketing management oversight and technical support could be provided through the Population Services International offices in Trinidad and the United States.

Formative research is needed in Guyana to identify differences and similarities with other countries in the regional project, and to establish baselines for monitoring and evaluation purposes. Packaging, display, and communication materials generated at the regional level may have to be adapted for the unique Guyanese market.

It is estimated that the program could cost \$US375,000 in its first year, including \$80,000 for initial capital costs. The program could cost about \$280,000 per year on an ongoing basis. Heavy emphasis would be placed on marketing, communications, and research; and generic messages, which benefit all players in condom distribution, are also included in the outline.

Sales of a sensibly priced and well-supported socially marketed condom could reach 500,000 to a million units within the first two years.

Some parts of society require particular attention. Christian and Muslim groups will most likely support a condom social marketing program. The Hindu community may be more publicly resistant, but with careful cooperation among USAID, the implementing partner, and this important ethnic group, any major backlash can probably be avoided.

USAID may be unable to fund the project alone. Other donors such as Japan and the United Kingdom through their international development agencies have indicated that, within their own terms of reference, they may jointly support a condom social marketing project at a modest level.

It is recommended that USAID/Guyana fund a condom social marketing program in Guyana for at least three years and request that Population Services International develop a detailed proposal for the Guyanese market alongside its proposed East Caribbean project.

USAID/Guyana plans to support a logistics position within the Ministry of Health. This is commended and USAID should ensure that this addresses procurement and issues of stock, and that it puts in place efficient recording and monitoring mechanisms throughout the distribution channels for the public sector and nongovernmental organizations.

## **1. INTRODUCTION**

The objective of this condom social marketing assessment is to provide an analysis of objective, current information and the views of stakeholders on the viability of a condom social marketing program in Guyana. The report will be used primarily by the USAID/Guyana Mission to facilitate its FY2003 obligation for HIV/AIDS programming. The report may also be circulated to other interested parties, including the National AIDS Program Secretariat in the Ministry of Health, and to other donor agencies.

The consultancy was conducted in Guyana March 11–28, 2002 by Alan Handyside, an independent social marketing consultant.

The consultant met with USAID/Guyana officials and a variety of stakeholders and potential partners who were identified by USAID/Guyana and the consultant. They included officials in the Ministry of Health, the National AIDS Program Secretariat, the chief medical officer, and representatives of nongovernmental organizations and religious groups. Additional meetings were held with other donors, advertising agency representatives, and private sector distributors of condoms and other pharmaceutical and consumer goods. The consultant gathered information on condom procurement, distribution, and importation statistics from government and private sources. He also visited public sector condoms distribution sites and private sector wholesale trade and retail outlets that sell condoms in Georgetown and other semiurban areas.

The consultant met with USAID officials again on March 26th to relay his assessment, and delivered a draft report on March 28th.

## 2. BACKGROUND

After Haiti, Guyana has the second highest HIV seroprevalence rate in Latin America and the Caribbean. Structured sentinel surveillance has not been carried out in Guyana and prevalence rates are based on outdated and often small samples. HIV prevalence is estimated at 5%–7.5% of the general population, and 45% among Guyanese who practice high-risk behaviors, such as men who have sex with men, minibus drivers, and commercial sex workers. National authorities in Guyana have concluded that fewer than 20% of infected persons are aware of their infection. Therefore, it is likely that the HIV seroprevalence rate is underestimated and is growing rapidly.

Sex with multiple partners is socially condoned in Guyana, as it is in other Eastern Caribbean countries, particularly among the young. Sexually transmitted infections are common, an undercover culture of homosexuality exists, and considerable migration occurs, both within and outside Guyana. Unless major activities begin, the epidemic will progress at an alarming rate, with societal and economic consequences.

The government of Guyana has recognized this. A policy document on HIV/AIDS has been developed, and a national AIDS program strategic plan is in place for the years 1999–2001. Sadly, many of the recommendations in the strategic plan have not yet been implemented, and a new strategic plan for 2002 and onward is still in development.

Fortunately, much useful work is taking place among nongovernmental organizations and in some public sector facilities. USAID has funded projects for eight local organizations to develop awareness, knowledge, and prevention strategies. Peer educators have been trained and public activities such as street theater, music, and talk shows have been developed, with young people as the main target group. The current emphasis by the Ministry of Health is to concentrate on providing care, support, and treatment to those affected by AIDS. Several clinics in the public sector have trained staff who can counsel attendees on HIV/AIDS, and there is evidence of much dedicated work and care by those involved, within the context of limited resources.

Formal and organized sentinel surveillance has not take place; there is an absolute paucity of sound knowledge, attitudes, and practices data; there is hardly any mass media communication; and a condom social marketing program does not exist. The latter would increase ready access and availability of condoms, correct the considerable misinformation that exists about HIV/AIDS and sexually transmitted infections, and would reduce the stigma associated with HIV/AIDS.

The Synergy Project, which is implemented by TvT Associates, conducted an assessment of the need for HIV/AIDS assistance in 2000, the National AIDS Program Secretariat conducted a limited condom availability survey in 2000, and the JSI/DELIVER project conducted a condom logistics assessment in 2001. The National AIDS Program strategic plan called for a social marketing intervention, a feasibility study for using social marketing efforts to prevent and control HIV/AIDS in Guyana was carried out in 1999 by Population Services International, and a concept note for condom social marketing in Guyana was presented to USAID in 2001.

### 3. USAID ASSISTANCE

USAID has had a five-year, \$1.2 million HIV/AIDS strategy in place since 1999. The strategy aims to increase knowledge of HIV/AIDS and sexually transmitted infections among targeted groups, increase the number of people receiving quality services from nongovernmental organizations receiving USAID assistance, and increase condom use among the targeted groups. USAID has funded eight local organizations in 7 of the 10 regions in Guyana to develop awareness, knowledge, and prevention strategies. The target group is primarily young people, although this is now being extended to Amerindians, and to river and hinterland communities. The program works under the Guyana HIV/AIDS/STI Youth Project. Activities include campaigns to promote self-risk assessment, training for peer educators, and expansion of peer education networks. To date, 760 peer educators have been identified and trained. Nongovernmental organizations have used street theater, music, talk shows, and other methods to disseminate prevention messages, and some organizations have extended their activities to include voluntary counseling and testing, and some have developed and distributed print, radio, and television advertisements. Nongovernmental organizations are building their capacity and are effectively working with their communities.

In addition, initial investigations in logistics supply and management have taken place with the view of placing a condom logistics officer on the Guyana Pharmacy Board. Collaboration with the Ministry of Health will lead in 2002 to technical assistance being provided to an interministerial healthy youth initiative, and Peace Corps volunteers will work with active nongovernmental organizations. Collaboration has taken place with other donors; these include a \$45,000 Japanese Grass Roots grant to equip offices and an \$1,800 Kirby grant to support media coverage. The Joint United Nations Commission on AIDS contributed \$28,000 for expanded materials production and behavior change communications activities. A USAID Core Initiative grant of \$4,000 has assisted one nongovernmental organization to begin a program to support people living with and affected by HIV/AIDS.

Overall, the program appears to be working well and has been a major contributor to expanding the capacity of nongovernmental organizations and their activities in the communities they serve.

## **4. FINDINGS**

### **4.1 HIV/AIDS Prevalence**

The prevalence of HIV indicates that Guyana is confronting an epidemic among the general population. HIV prevalence rates among specific groups, which are not outdated, were the highest of all countries in the Caribbean Epidemiological Center (CAREC). For example, HIV prevalence was:

- 3.2% among blood donors in 1997;
- 7.1% among pregnant women in 1995;
- 21% among men seeking care for a sexually transmitted infection in 1992–1995; and
- 45% among commercial sex workers in 1997.

Currently, a formal sentinel surveillance program does not exist in Guyana, although one is planned for the near future in consultation with the U.S. Centers for Disease Control and Prevention.

As a start, however, in November 2001 the government of Guyana began a pilot scheme to monitor HIV rates among women attending antenatal clinics in public health centers. Details of this appear in Annex 3.

Nurses and other staff in six selected clinics were trained, and mothers were invited to participate in the study when they attended the clinics. They were advised of the consequences of HIV through mother-to-child transmission and were told that an initial test would be carried out to determine their HIV status. Participating mothers agreed to be informed of their status by the counseling nurses at the clinics. Otherwise, their status information remained anonymous.

Participation in the study was voluntary and, despite some misgivings, mainly related to the stigma associated with HIV/AIDS. Eighty percent of first-time mothers had agreed to be tested. By the end of January, 450 mothers had been tested, and the average HIV prevalence rate was 4.9%, with some variability by clinic. The David Rose and Camberville health centers showed rates of about 11% and 8%, respectively, and rates were clearly lower in sites away from Georgetown.

The early results from this study indicate an increasing urban prevalence among pregnant women, who serve as a proxy for the general population. Also emerging from the early experiences of this study is that much work needs to be done among the general population to destigmatize HIV/AIDS.

#### **4.1.1. AIDS Cases**

HIV and AIDS must be reported to the government (Table 1). The Ministry of Health believes that reports from the private sector are less than accurate, and therefore, data from the public sector are likely to understate the total number of cases in country.

**Table 1. AIDS Cases Reported to the Ministry of Health**

	1994	1995	1996	1997	1998	1999	2000
Men	56	110	77	70	124	201	523
Women	49	82	52	45	53	137	429
Total cases	105	192	129	115	177	338	952
WRA*	41	66	43	33	49	118	226
Children <5 years	2	5	7	1	2	10	10

\*women of reproductive age

Source: Ministry of Health, maternal and child health unit

The data in Table 1 are incomplete, but the Ministry of Health believes that more than 85% of the 295 health institutions in Guyana have reported AIDS cases. This figure does not include private sector health facilities other than private hospitals. Regardless of the reliability of these data, the rapid increase in reported AIDS cases has been evident in recent years. Also of note is that the number of cases among women is now on the increase, especially among the estimated 212,000 women of reproductive age (15–49 years).

Deaths from AIDS and AIDS-related illnesses are also increasing (Table 2).

**Table 2. Causes of Death**

	1997	1998	1999
Deaths from AIDS and AIDS-related complex	328	340	302
Proportion of deaths due to AIDS	6.4%	6.8%	7.2%

Source: Ministry of Health

In 1999, 7.2% of deaths were due to AIDS, which is now the third leading cause of death, after ischemic heart disease and cerebrovascular disease. It also may be that AIDS-related deaths are recorded as other things, which would also understate the rate at which the epidemic is pervading Guyanese society.

#### 4.1.2 HIV/AIDS Knowledge

One of the keystones of a strategy for reducing the rate of HIV/AIDS infections is the promotion of accurate knowledge of means of transmission and prevention. A household survey (the Multiple Indicator Cluster Survey) was conducted in Guyana August through October 2000 among 4801 women aged 15–49 years by the Bureau of Statistics under a grant from UNICEF. Among the questions associated with maternal and child health, some information was acquired regarding HIV/AIDS.

Awareness of AIDS is high, with 97% of the sample having heard of AIDS. Knowledge of means of prevention included the following:

- Having only one faithful, uninfected sex partner (74%),
- Using a condom every time (67%), and
- Abstaining from sex (58%).

Forty-three percent of respondents knew all three ways of preventing HIV, but noticeably, 17% did not know any way. Knowledge among people in the interior and the rural coastal areas was less than in urban areas and, predictably, knowledge was lower among less-educated people.

Seventy-four percent of women knew that AIDS could not be transmitted by supernatural means, 52% knew that it was not transmitted by mosquito bites, and 85% claimed that a healthy looking person can be infected. In total, 45% could name all three misconceptions and only 9% could not name any, whereas 84% of respondents knew that AIDS could be transmitted from mother to child.

Overall among those who responded to the Multiple Indicator Cluster Survey:

- 97% had heard of AIDS;
- 43% knew of three ways to prevent HIV transmission;
- 45% correctly identified three misconceptions about HIV transmission, but only 24% had sufficient knowledge about HIV and AIDS.

Thus, although some women of reproductive age have some HIV information, knowledge falls short of ideal among three-quarters of women in this sample.

When asked about AIDS testing, 69% of women, particularly those in coastal urban areas and who were better educated, knew where to get an AIDS test, only 16% had taken an AIDS test, and 88% knew their result.

Despite this apparent awareness and knowledge of HIV/AIDS, there is considerable discrimination. Thirty-nine percent of women interviewed agreed with at least one discriminatory statement in the interview, 37% believed that a teacher with HIV should not be allowed to work, and this view was prevalent in urban areas and among those who were more highly educated. Eleven percent said they would not buy food from a person with HIV/AIDS, however, this was obviously a difficult question for respondents to answer willingly as 61% responded with “neither agree nor disagree.”

## **4.2 Contraceptive Prevalence**

The Multiple Indicator Cluster Survey also inquired about contraceptive habits. Seventy percent of women in the survey were married or in a union. Of these, 37% of women of reproductive age were using contraception (any modern method). Of women who used a modern method, 31% used an oral contraceptive, 24% used condoms, 18% used an intrauterine device, 10% used injectable contraceptives, and 13% had been sterilized.

Although Guyana is a relatively poor country, contraception prevalence is quite high and condom use appears to be popular. Whether or not condoms are used for birth control or to prevent a sexually transmitted infection is not known, nor is it known whether they are used at all times or with other partners. Regardless, at least among married women or those in a union, reported condom use is quite high. This is especially true among urban women aged 15–24, in whom condom prevalence is twice as high as in those 25 years and older. Among women younger than 20, only 26% use a modern contraceptive method, but 66% of them use a condom. Contraception information is not available for women who are not in a union.

Given the free choice of contraceptive methods, their ready availability and access, and relatively low inhibitions about obtaining contraception, it appears that younger women use condoms more than other methods and, one surmises, because they may be concerned about contracting HIV or another sexually transmitted infection.

Data from the Multiple Indicator Cluster Survey shows that by age 24, most women of reproductive age had had at least one child. This rises to 4.2 children at age 49, and the mean number of children born per woman is 2.4. There is anecdotal information that if a woman wants to “keep her man,” one way to do so is to have a child. This implicitly involves having unprotected sex. However, this stratagem does not always work, because some 22% of children live with a single mother, whereas 65% live with both parents. Having children by multiple partners is commonplace among men and women, and without the normal means of support, single mothers often resort to commercial sex, whether it be for money or for favors.

Minibus drivers are reported to have several girlfriends, particularly schoolgirls or students. Girls offer or are persuaded to have sex with a minibus driver or conductor in exchange for free travel. In doing so, they can keep their snack money to spend on other items. Minibus drivers are reported to have several liaisons of this nature and many have unprotected sex. Some nongovernmental organizations are addressing this issue by working to raise awareness and educate minibus and taxi drivers, and to issue free condoms. However, these programs are local in nature and can reach only a small minority of the target population.

### **4.3 Condom Supply and Logistics**

#### **4.3.1 Public Sector**

The JSI/DELIVER assessment describes diverse routes of condom delivery. Procurement by the central warehouse is relatively straightforward. Condoms are obtained through the International Dispensary Association, in The Netherlands. The commodities are then held in bond under fairly good conditions and the stock decreases as the National AIDS Program Secretariat and other medical offices within the Ministry of Health draw on the national supply. In addition, the Guyana Responsible Parenthood Association (GRPA) obtains condoms from the United Nations Population Fund and other sources, and stores them until they are required for distribution to their own clinics, to nongovernmental organizations, and other outlets. Thus, maternal and child health outlets and nongovernmental organizations obtain condoms from the central warehouse, through the National AIDS Program Secretariat, and GRPA. Although the system was changed in 2001, and now condoms for distribution through maternal and child health clinics should be obtained solely from the central warehouse, some clinics still obtain them from GRPA. GRPA is charged with compiling and reporting condom apportionments by maternal and child health clinics on behalf of the government, even though they are not supposed to supply these outlets.

Data on condom distribution have been collected from several sources, including the central warehouse, GRPA, and the National AIDS Program Secretariat. This is not an easy task to perform because, other than GRPA, most government organizations do not maintain databases for this purpose. Rather, they examine their inventory and obtain further supplies when stocks run low or a heavy demand is predicted. To obtain data on the number of condoms that were issued during a particular period of time involves a manual exercise of deducing opening and

closing stock balances, and adding in the number of condoms received during the period. Thus, there appears to be a culture of giving out condoms with little regard for monitoring the progress of projects. Considerable benefits would be gained in monitoring how many condoms are issued as a means of measuring trends in condom use and for adapting programs accordingly.

Care must be taken in examining condom distribution data in order to avoid double counting. For example, in 1999, the central warehouse gave 1.6 million condoms to the National AIDS Program Secretariat. The secretariat claims to have issued 1.61 million condoms, but 1.1 million of these were donated to GRPA for onward dispensing to its organizations. Thus it is incorrect to simply add together the number of condoms that were issued from all sources. An attempt has been made to estimate the real number of condoms issued in the public sector (Table 3).

**Table 3. Condom Issues by Source (thousands)**

	CW/NAPS	CW/MCH	CW/NGO	GRPA/MCH	GRPA/NGO	GRPA/Others	Total
1999	496	51	0	443	0	193	1183
2000	193	199	0	426	352	346	1516
2001	477	667	81	33	2	324*	1584

CW, central warehouse; GRPA, Guyana Responsible Parenthood Association; MCH, maternal and child health clinics; NAPS, National AIDS Program Secretariat; NGO, nongovernmental organization.

Source: central warehouse stock movements, and NAPS and GRPA issues.

\*Supplied to some NGOs.

In total, about 1.5 million condoms are being supplied to the public sector, nongovernmental organizations, and others. In 2000, GRPA distributed 1.1 million of these, but this has fallen to 359,000 as the source was determined to be the central warehouse. The government now supplies about 1.2 million condoms, many of which go to maternal and child health outlets, including hospitals, clinics, and health centers.

According to GRPA data that monitors condom distribution to consumers at the health centers, in 2001, only some 75,000 condoms were passed on to consumers. Health clinics tend to provide women with 30 condoms at a time for family planning purposes, but these may be used for disease prevention. Given this degree of use by a relatively small number of clients, there is likely to be a considerable stockholding of condoms at individual public sector outlets.

At the end of February 2001, the central warehouse had 1.75 million condoms labeled with a recent manufacture date. An additional 700,000 condoms were recently discovered with an unknown manufacture date, and are likely nearing the end of their shelf life.

#### **4.3.2 Private Sector**

A considerable number of condoms are sold in the private sector, mainly through pharmacies, drug stores, some gas stations, and by an estimated 20% of bars and other general outlets. The main brand is Rough Rider, imported by Ansell. Several other ribbed and flavored “pleasure” brands exist. Geddes-Grant is the main importer of these, and other “suitcase” importers bring other brands into Guyana as well. Retailers obtain these brands from various wholesalers or through Geddes-Grant.

**Table 4. Imported Private Sector Brands**

	Agent	Manufacturer	Wholesale price (G\$)	Semi-wholesale price (G\$)	Retail price (G\$)
Rough & Rugged Rider	IPA	Hankook	70 for 3	100	150 for 3
Coronet Gold	IPA	Hankook	70 for 3	100	150 for 3
Siltex	IPA	Hankook	70 for 3	100	150 for 3
Gents	IPA	Hankook	70 for 3	100	150 for 3
Act Aroma	IPA	Vulkan	70 for 3	100	150 for 3
Erotim Long	IPA	Interlatex	100 for 3	120	160 for 3
Love					
Rough Rider	Bacchus	Ansell	110 for 3	120 for 3	150+ for 3
Bareback	Bacchus	Ansell	110 for 3	120 for 3	150+ for 3
Erotica	Bacchus	Ansell	110 for 3	120 for 3	150+ for 3
Wet & Wild	Bacchus	Ansell	110 for 3	120 for 3	150+ for 3
Casanova	Bacchus	N/A	45 for 3	60 for 3	60+ for 3

Retail prices are difficult to evaluate because price controls do not exist and prices vary from outlet to outlet and according to time of day.

Most condoms are packed in packages of 48, and although the outer packaging depicts the specific brand, the packages are rarely displayed. This is not so much due to inhibitions to selling condoms, than it is to the construction of the dispensers, which makes their display unsuitable.

Some 1.56 million brand name condoms are sold through the commercial sector each year. Yearly wholesale sales per brand are as follows:

- Rough Rider, 360,000;
- Casanova, 300,000;
- Erotim, 100,000;
- Coronet, Siltex, Gents, and Act Aroma, 150,000 each;
- Bareback, Erotica, and Wet & Wild, 50,000 each.

This volume is corroborated by a small-scale research study conducted by Geddes-Grant among 30 retailers in 2001. It indicates that Geddes-Grant brands share about 60% of the market, with the remainder shared by other imported products, mainly “suitcase” imports, with about 5%–10% leakage from Guyana government products and parallel imports. Using a sales of figure of 1 million Geddes products per year, this would put the total private sector sales at about 1.7 million units, including condoms that have found their way from the public sector to private markets. In addition, some cross-border exportation to Surinam has been reported.

Distribution in the private sector indicates that condoms can be found in about 7000 sales outlets, and the Rough Rider brand can be found in 60%–70% of them.

Thus, condom marketing in the private sector is fairly well developed. People of a wide range of ages purchase them, in particular, better-off youth, older men, and some women. There appears to be little inhibition in asking for condoms in the general trade, although some shy consumers use nicknames for them.

#### **4.4.1. Total Condom Market**

Currently, about 3 million condoms a year are available for distribution in Guyana. This can be verified by examining import data from the Bureau of Statistics. The estimate makes allowances for cross-border traffic, parallel imports, and the “leaking” of condoms meant for distribution through the public sector being sold in private sector outlets.

This translates into a condom per capita ratio of about 3.8 condoms, which by comparison with other countries, is fairly high. In other countries with a high incidence of HIV, condoms are available through a variety of routes, predominantly via government and social marketing programs. In comparison with other countries with high HIV prevalence, the private sector market for condoms in Guyana is well developed. Not all condoms issued in the public sector are free of charge; nevertheless, condom availability in Guyana is reasonable. It is likely that private sector condom sales reflect actual usage, but by a limited consumer base of those who can afford them.

#### **4.4. Communications**

Public information about HIV/AIDS and sexually transmitted infections are varied in their scope and effectiveness. Some international and local organizations have developed posters, and many are on display in public health facilities, but they have little visibility in common areas. Articles on HIV/AIDS appear in the press on a regular basis, and are usually informative and educational. Messages have aired on radio and TV, but the public sector does not use the mass media, and the quality and production values of the messages is not known. The distributors of Rough Rider considered advertising the product on TV, but management was reluctant to “risk an adverse knock-on effect” on its other products. World AIDS Day and other events are used mainly by nongovernmental organizations to bring further attention to HIV/AIDS.

Education efforts over the years have borne some fruit; awareness of HIV/AIDS is high and people recognize means of contraction and prevention. In the recent past, however, the government has focused its efforts on care and support activities rather than prevention. Many people know of government facilities that perform testing, and support facilities are promoted locally, which means that concerned people know where to go if they need help and counseling. But mainstream mass media is not addressing HIV prevention. There is little public communication of the need to adopt safe sex practices. General behavior change communication efforts are not in evidence, as opposed to the simpler approaches of displaying relatively simple information, education, and communications materials.

So few messages have been absorbed by the general public in such a meaningful way that people recognize their own behavior and risks. Much of the population still has misconceptions about HIV/AIDS. For example, some people believe that HIV can be transmitted through kissing, whereas some sexually active young men believe that it cannot be transmitted if a man withdraws before ejaculating.

Nongovernmental organizations are doing sterling work in distributing correct messages and information, but their operations are local, and relatively few people see the messages. Absent is

a mass media approach to behavior change, with high-quality messages that will attract the attention of the public, particularly young people.

On the one hand, sex is an important part of life in Guyana. Many people, especially young people, are very sexually active, and having multiple partners is condoned. Many pregnancies are out of union and a large number of children live with only one biological parent. A family may consist of a mother and several children, all of whom have different fathers, which seems to be acceptable by communities and by the present partner of the woman. Music, visual portrayal, and clothes all have an overt sexual overtone, and are usually evident in public.

On the other hand, religion plays a strong role in Guyana, and some people take a conservative view toward sexuality. Pregnancy is usually accepted and holds a lesser stigma than HIV infection, which is viewed as dirty, and the result of having illicit sex with an undesirable person.

Conservative views in some parts of Guyana may inhibit the promotion of meaningful anti-HIV messages. Politicians don't wish to appear by potential voters as condoning promiscuity. In reality, if HIV/AIDS and sexually transmitted infections were better described as diseases that can affect one's life, one's family, and one's community, then condom use would be accepted and destigmatized.

#### **4.5. Religious Influence**

##### **4.5.1 Christian Coalition**

The Christian Coalition of Churches is the coordinating body for 16 Christian sects, which constitute some 400 churches, each of which has approximately 500 active members; or about 200,000 active, church-goers. The coalition has important political influence, and it is likely that it will continue to take a pragmatic position on HIV/AIDS. Prevention rather than cure is a key part of the coalition message. Several individual organizations already provide a degree of care and counseling for individuals infected and affected by HIV/AIDS.

The coalition is about to develop a coordinated policy position that is likely to favor the promotion of fidelity and abstinence, and the use of condoms as a practical measure, especially among the youth. Some denominations are already providing care and support to people living with AIDS and they appear to be sympathetic to promoting condom use and favor publicity that encourages behavior change.

##### **4.5.2. Council of Islamic Organizations in Guyana**

The Islamic community comprises 10%–12% of the population, and some 7000 people attend 130 mosques on a regular basis, and many more Muslims attend events at special occasions. Islamic teachings incorporate the use of condoms to prevent HIV/AIDS to the extent that readers interpret it from the Koran. This involves condom use within marriage as well as abstinence and fidelity. Adultery and premarital sex is abhorred and care must be taken not to publicize condom use outside of marriage. For young people, if abstinence is not an option, then fasting is recommended. The approach is pragmatic within the teachings of Islam, but public announcements need to be managed with care.

The Islamic council has several programs that convey HIV/AIDS messages within the limits of the teachings of Islam, and it uses official statistics to reinforce its messages. Visual interpretation is extremely important; these can be used in sermons, TV programs, and in one-to-one sensitization sessions among separate groups of men and women.

#### **4.5.3. Hindus**

It was not possible to meet with representatives of the Hindu community. This group may be the most intransigent in accepting condom use because abstinence and fidelity are the cornerstones of traditional teachings. Hindu communities are the largest religious group in Guyana, and the activities of their young people are just as risky as those among other young people.

#### **4.6. Other Donors**

Population Services International is negotiating with the Canadian International Development Agency to begin an Eastern Caribbean HIV/AIDS project, which is to be based in Trinidad. The proposal does not include Guyana, although it would be possible to do so, and the work could be supervised by the project staff in Trinidad. Research on brands and the media is being planned, and marketing material will likely be obtained from Trinidad for the regional program.

Projects by funded by the U.K. Department for International Development (DFID) are primarily those for education, water, and other non-HIV/AIDS activities. DFID is now supporting HIV/AIDS activities as part of the CARICOM Regional Strategic Plan, and Guyana could be included in this, although DFID prefers to continue its current plan of helping develop expertise in Guyana. Skills development and research activities could be candidates for DFID funding within a social marketing program.

The Japanese International Cooperation Agency has shown interest in supporting elements of a social marketing program, particularly if the implementing agency were a nongovernmental organization. Assistance could be channeled through the Japanese Grass Roots program and could provide nonprogrammatic support in the form of hardware.

Guyana has recently requested funding from the Global Fund, although any funding accruing from this would likely pass through the Guyanese government and would not be earmarked for any one specific activity such as condom social marketing.

Funding from other donors, such as the World Bank, is unlikely to be directed to a condom social marketing program in Guyana.

## 5. Conclusions

HIV/AIDS prevalence is increasing and is probably understated by official statistics. Risky sexual behavior is rife, especially among younger people, and although awareness of HIV/AIDS is high, a large part of the population is still insufficiently aware or informed of the facts. Considerable stigma is attached to HIV/AIDS, and although nongovernmental organizations are doing good work, their scope is limited by their capacity and geographic coverage.

Little effective mass media communication exists to reach the population, and until now, activities were done to raise awareness of HIV, rather than encouraging behavior change. Efforts to provide care and support for people living with HIV/AIDS are laudable and necessary, but to ignore prevention activities will only allow the epidemic to spread.

Condoms are widely distributed in both the public and private sectors. People who are prepared to visit a Ministry of Health facility can obtain condoms, often free of charge, but their use is intended for family planning purposes, whereas the private sector caters to people who are slightly better off and who can afford to buy condoms. In the private sector, condoms are advertised to promote sex and pleasure, which is commensurate with the general public acceptance of high sexual activity. Although the packaging and brand names of condoms in the private sector are overtly sexual, they are rarely visible in pharmacies, drug stores, and other nontraditional outlets because display dispensers are not designed to promote the product and encourage their purchase.

Religion plays an important part in the social life of Guyana. Christian and Muslim communities are both pragmatic about their approach to HIV/AIDS and condom use. They continue to promote the ideals of fidelity and abstinence, but they appear to have a realistic view of the spread of HIV/AIDS and the impact it is having on their communities, and are doing their share to promote safe sex. Although their efforts may not include active promotion of condom usage, they are not actually prohibiting it.

An effective condom social marketing intervention could make a valuable contribution to slowing the spread of HIV in Guyana. Such a campaign would allow products to be promoted and generic messages to be distributed via mass communications. It would raise the visibility of risky behavior and ways of reducing it, and would help remove the stigma of HIV/AIDS. It may also enable poorer people to obtain access to good quality condoms by distributing the product in nontraditional outlets. This intervention should sit comfortably alongside the continuing distribution of public and private sector products, and would increase the capability and flexibility of organizations and individuals working in the field.

## 6. Options

Mass media communications is the key element in an HIV/AIDS program for Guyana. An implementing agency could be appointed to research, develop, and implement such a program independent of product promotion. Although a generic communications campaign has considerable value, promotion of condom use would help publicize the private sector and public sector brands alike. Although a mass media campaign could reach all sectors of Guyanese society, condoms may not necessarily become more accessible and affordable. If condom demand soared, the products would still be inaccessible because of distribution limitations, and believability of the message may suffer if free public sector condoms are perceived as inferior.

A second option is to work with nongovernmental organizations to distribute condoms through their sites and through an enhanced community-based distribution operation. Even in this scenario, however, the condoms most likely to be promoted would be those in the public sector. There are three problems with this approach. Many more community volunteers are needed in order to reach a large number of people. Second, who would manage and coordinate this force if the donor does not have the capacity or resources to do so? Third, if condoms to be advertised are those in the public sector, then the same concerns remain about perceived product quality, and distribution volunteers would have to be rewarded in ways other than from the sale of the product. Thus, the funding for such a scheme could well be expensive and its coverage limited.

The recommended route for an effective program to address the major gaps in the Guyanese HIV/AIDS strategy is a social marketing program. Futures Group International, Marie Stopes International, DKT International, and Population Services International all have experience with social marketing programs in other countries. Projects by all organizations other than Population Services International would need to stand alone, which would be more costly than present funding allows. Population Services International is developing an Eastern Caribbean regional project, and the recommendation is to include a condom social marketing project for Guyana within its proposed regional activity.

## **7. Recommendations**

1. USAID/Guyana should support funding for a social marketing program in Guyana, certainly for three years, and ideally, for five years.
2. Population Services International should be asked to develop a detailed proposal for a condom social marketing project in Guyana as part of its East Caribbean regional project.
3. If funds are available, USAID/Guyana should consider cooperating with other donors, particularly the international development agencies of Canada, Japan, and the United Kingdom, to properly fund a condom social marketing program in Guyana.
4. USAID/Guyana should support a logistics technician in the Ministry of Health to ensure that condom procurement and stock issues are addressed, and to institute mechanisms to record distribution through public nongovernmental organization distribution channels.
5. USAID/Guyana should encourage the Ministry of Health to clearly advise every organization that withdraws condoms through the public sector stock where the stock can be obtained, and to maintain detailed records of withdrawals. Condoms being issued should be monitored regularly to ensure a correct balance between procurement and distribution.
6. USAID/Guyana and its implementing agency should maintain close contact with the government of Guyana and religious bodies to ensure harmonious relations as mass media messages commence.

## **8. Proposed Program**

### **8.1. Outline Plan**

A condom social marketing program would address the need for behavior change communications by using mass media, and other supportive interventions can be incorporated in the program. Subsidized condoms would be marketed partly so that poorer people will have ready access to them, and to provide a vehicle for the marketing program.

Population Services International has considerable experience in effective condom social marketing in nearly 50 countries. Other organizations would need to start a project from scratch. In addition, Population Services International is working with the Canadian International Development Agency to begin a regional program in Trinidad, and a project in Guyana could easily become a part of this regional program.

Assuming that Population Services International is the implementing agency, and that its regional project begins, then a similar program could begin in Guyana, which with additional funding, could become part of the regional program. Guyana could engage the services of an existing, local distributor whose sales force can call on nontraditional outlets on a regular basis, and which would have an adequate storage and delivery system. The implementing agency could set up an affiliate to the regional program, possibly register it as a Guyanese nongovernmental organization, and staff it with a local manager who has sound sales and marketing experience and three or four sales promotion officers. Sales officers would require an office and support staff, and one assumes that imported condoms would be stored in an adequate environment by the distributor. Vehicles and equipment would be required, as well as commodity provision and marketing costs as outlined in section 8.4.

### **8.2. Regional Constraints**

By combining Guyana with the Population Services International regional project, special care must be taken to promote suitable brands, and to promote proper communications. Although regional projects can be an effective way of managing a variety of projects in neighboring countries with small populations, each country has its own peculiar mores and cultural sensitivities. Guyanese people need to own their products and activities, rather than merely being part of a larger Caribbean initiative. Also, the ethnic mix in Guyana is different from nearby countries, and products and communication need careful handling.

Brands, packaging, and research need to ensure compatibility with a regional product. If a separate brand is required in Guyana, then a predicted demand for 500,000–1,000,000 condoms a year could enable separate production runs of an overbranded product at little extra cost. Unique external packaging for condoms and dispensers in Guyana could be produced at a sensible cost.

Communications and products need local research to ensure they are appropriate for Guyana. Visual materials need to be filmed in Guyana, mixed with additional footage, and carefully edited. Advertisements can be dubbed with voice-overs to provide unique advertisements for Guyana. Recording facilities in Guyana could be used, although creative input is weak, but this problem can be overcome with guidance from a regional marketing team. A generic communication scheme for Guyana could be developed regionally once the strategic

communication approach is agreed to, or materials specific for the Guyanese market could be developed at little additional cost.

Product pricing needs to be addressed. With the highly developed state of the private sector market in Guyana and the high volume of condoms available, there is little need to greatly subsidize a particular brand. On the other hand, an affordable condom would encourage use by poorer people who do not now have easy access to them. In addition, the price of condoms in Guyana must be similar to the wholesale price elsewhere in the region. If prices vary too much, then cross-border sales traffic could occur in either direction. Research could indicate an acceptable price for a Guyanese condom, but because retail prices are presently uncontrolled, it may be better to take a pragmatic view of the wholesale price, taking into account factors noted above.

### **8.3. Pricing Structure**

A nominal retail price of G\$50–70 (US\$0.30) for a pack of three condoms is appropriate. Trade margins for wholesalers and retailers of other relevant consumer goods are about 25%–30% of national recommended retail prices. Discounts of up to 5% are given to larger retailers who purchase in volume. Therefore, a retail price of G\$50 is feasible, given likely procurement costs. A slightly higher price would interest more traders, and may lead to cost recovery. A higher price would add value to the commodity, compared with the free condoms issued through government outlets, and would still be affordable by most sectors of the community, other than the very poor. In addition, there would likely be little down-trading by people who currently purchase the private sector condoms.

### **8.4. Budget**

Estimates of the costs in setting up a social marketing program are based on local salaries, costs of accommodation, current media rates, costs for imported vehicles with duty free status, and commodity and packaging costs. Allowances have been made for knowledge, attitudes, and practices research, and for research and implementation of packaging and communications materials from the regional work.

The table on the next page proposes a first-year budget. It includes capital costs, and set up and operating costs. Local costs have been converted at \$US 1.00 = G\$190.00.

The total first year requirement amounts to \$375,000, including \$80,000 for capital costs. In the second year, the heavy research investment will decline, as will some expenditures for communications. However, commodity costs will increase as demand increases and as normal inflation is considered. If program staff and marketing expenditures remain the same, then second year running cost would be about \$280,000.

<b>OUTLINE BUDGET</b>	<b><u>\$US</u></b>
Office rent	12,000
Office costs	8,000
Sales manager	12,000
Four sales promotion officers	12,000
Public relations/media manager	10,000
Staff fringe benefits	10,000
Travel and expenses	10,000
Secretarial/security (3 people)	9,000
Insurance, accounts, and sundries	<u>7,000</u>
Subtotal	90,000
<b>Marketing</b>	
Television (500 30-second spots @ G\$2000)	6,000
Radio (3000 45-second spots @ G\$1000)	16,000
Press (50 one-half-page insertions @ G\$30,000)	8,000
Generic advertising	20,000
Modifications to regional material	8,000
Events	20,000
Promotional items	7,000
Sundry marketing costs	10,000
Knowledge, attitudes, and practices research	30,000
Pack/pricing/communications research	<u>10,000</u>
Subtotal	135,000
<b>Commodities</b>	
500,000 condoms, packed	15,000
Distributor allowances	<u>5,000</u>
Subtotal	20,000
Regional assistance	7,500
Headquarters technical assistance and support	17,500
International travel and per diem	10,000
External consultant	<u>6,000</u>
<b>Subtotal</b>	<b><u>41,000</u></b>
<b>First Year Running Costs</b>	<b>286,000</b>
<b>Initial Capital Costs</b>	
Vehicles (2)/motorbikes (4)	70,000
Computers (3)	6,000
Furniture, etc.	<u>4,000</u>
Subtotal	80,000
<b>First Year Subtotal</b>	<b>366,000</b>
Contingency	9,000
<b>TOTAL</b>	<b><u>375,000</u></b>

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## **ANNEX 2 CONTACTS**

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### **Ministry of Health**

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Mr. Ali, Program Manager, GUM  
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Rudolph Cummings, Chief Medical Officer  
Lennox Benjamin, Chief Statistician, Bureau of Statistics  
Ian Cox, Statistician Information Systems, Bureau of Statistics  
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### **Canadian International Development Agency**

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Violette Pedneault, Health and Population Advisor

### **CARICOM**

Aoki Shigemaro, Project Identification Expert, Regional Development Planning

### **Guyana Revenue Authority**

Khurshid Sattaur, Commissioner, Internal Revenue

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Rev. Roy Thakurdal, Second Vice Chair  
Rev. Barrington Litchmore, Treasurer  
Rev. Nigel Hazel, Secretary

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Karen Persaud, Media Manager

**Kings Advertising**

David King, Managing Director

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Simone Sills, Program Manager

**Linden Care Foundation**

Hazel Chichester, Chair

Hyacinth Sandiford, Counsellor

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Deryck Coleman, Pharmacist

### **ANNEX 3**

#### **PILOT SURVEILLANCE STUDY**

A pilot study began in November 2001 in public health centers by the government of Guyana in an effort to obtain some indication of HIV prevalence among pregnant women. The study involved nurses and other staff in six clinics who were being trained in pretest and post-test counseling. Mothers who attended the clinics were invited to participate in the study and were advised of the consequences of mother-to-child transmission of HIV. They were advised that they should have their baby in Georgetown General Hospital and, at the time of birth, both mother and child would be administered appropriate drugs to minimize HIV transmission. In addition, an initial test would be carried out to determine their HIV status. Results of this would be communicated to the mother by trained counselors in the clinics, but otherwise, results would remain confidential.

Initially, group information sessions were held, and mothers were invited to volunteer for counseling and to participate in the study. At first, some women were reluctant to participate but 43% eventually volunteered by the end of January.<sup>1</sup> Since then, a majority of other mothers who had initially declined subsequently agreed to take part in the study, and participation is now running about 80% for first appointment mothers. Test information is given to the National AIDS Programme Secretariat, but test results are not formally documented. By the end of January, 450 mothers had been tested and the average HIV prevalence rate was 4.9%. Prevalence varies according to the clinic; the David Rose and Camberville health centers have prevalence rates of 11% and 8%, respectively, with lower rates reported in clinics outside Georgetown.

Participation in the pilot study was voluntary. Considerable stigma is associated with HIV and AIDS, not so much from a fear of death from AIDS, because death can result from many causes. Rather, a social stigma surrounds HIV/AIDS. If a mother thinks she may be infected with HIV because of her past or present sexual behavior, then she may decline to participate in the study, and equally, other mothers have said they and their husbands are faithful to each other, which means there is no need to be tested. Whether or not this is the case or if this is an indication of not wishing to know one's HIV status is not known. It does, however, show that considerable work needs to be done to deliver correct information about HIV/AIDS and to better assess self-risk. Much also needs to be done among the general population to destigmatize HIV/AIDS.

Early results from the study indicate an increasing urban prevalence among pregnant women, who serve as a proxy for the general population.

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<sup>1</sup> These data are being re-examined by the National AIDS Programme Secretariat because second-time visits were included in the count from some clinics.

## **ANNEX 4 SCOPE OF WORK**

### **Guyana Condom Social Marketing Assessment**

#### **Statement of Work**

The consultant will conduct a condom social marketing assessment in Guyana that conforms with the Synergy programming framework—assessment module. The objective of the assessment is to provide expert analysis of objective, current information, and stakeholder views on the viability of condom social marketing in Guyana. The assessment and subsequent report will be used to facilitate the Guyana Mission’s obligation of Fiscal Year 2003 funds for HIV/AIDS programming.

The consultant will follow the Synergy’s best practices—assessment module process and address the following points.

#### **Preparation**

The consultant will review current and available literature on condom social marketing specific to the Guyana assessment, particularly the study by Population Services International.

#### **Identify Key Stakeholders/Assemble Information and Knowledge**

Upon arrival, the consultant will identify and meet with the following key stakeholders in the various governmental, commercial, and religious sectors to assess roles and to aid in the development of the condom social marketing strategy and implementation of a future program:

- ❖ Government
  - Minister of Health
  - National AIDS Program Manager
  - Chief Medical Officer
  - National Surveillance Manager
- ❖ Nongovernmental Organizations
- ❖ Commercial Sector
- ❖ Religious Sector: Muslim, Hindu, and Christian

The consultant will conduct site visits and assess conventional and atypical condom distribution sites in both urban and rural settings.

The consultant will discuss and obtain Mission approval of a proposed outline of the condom social marketing assessment report prior to commencing writing.

#### **Analyze Data/Present findings to Client**

The consultant will analyze and write a report to address the following issues:

- ❖ Various mechanisms for condom distribution (fee-based for the different target populations);
- ❖ Acceptability of condom social marketing by the government, social, and religious community;
- ❖ Necessary demographic and geographic provisions in condom social marketing program;

- ❖ Key factors for a successful social marketing program, including the required magnitude to have a significant impact on the HIV/AIDS epidemic (number of condoms sold and price per condom);
- ❖ Strategy for market segmentation that will include the following points:
  - What level will the market support?
  - Who is willing to pay for the condoms?
  - Are the markets for condom promotion the same or different for HIV/AIDS prevention and family planning?
  - What is an affordable price for the different target groups?
  - Who can supply condoms for the different target groups?
- ❖ Specific strategy to target individuals that can not afford the price of condoms and avoid leakage to individuals that can afford to pay for condoms;
- ❖ Key markers or indicators of success; and
- ❖ Feasibility of expanding the Jamaica social marketing program (providing cultural, religious, and government acceptability).

The consultant will also recommend alternative strategies, if it is determined at a later date that a condom social marketing program is not feasible. The alternative strategies will address the following issues (but not limited to them):

- ❖ Feasibility of community based delivery system—commission sales by NGOs and/or other health workers; and
- ❖ Alternative market strategy for currently distributed condoms.

The final report will provide options for several strategies, including estimated costs, and will address all of the above-mentioned points. The report will also contain recommendations for an appropriate cooperating agency or a firm to implement the condom social marketing program in Guyana.

## **Report**

The contractor will submit a Condom Social Marketing Assessment Report in accordance with the requirements specified below. Three days before departure from Guyana the consultant will submit a draft report to the Guyana Mission and the Synergy Project for review (see schedule below). The consultant will ensure that input from Mission debrief and comments to the draft report from both the Guyana Mission and Synergy will be incorporated in the final (unedited) Guyana CSM Assessment. Furthermore, the consultant will ensure that the final (unedited) Guyana CSM Assessment will be delivered to the Guyana Mission and the Synergy Project, prior to departure from Guyana.

The Synergy Project will provide an edited/printed Guyana Condom Social Marketing Assessment to the Guyana Mission within two weeks upon receipt of a final (unedited) report from the consultant.

The format for the Condom Social Marketing Assessment Report is as follows:

- ❖ **Executive Summary** – concisely state the most salient findings and recommendations;
- ❖ **Introduction** – purpose, audience, and synopsis of task;
- ❖ **Background** – brief overview of HIV in Guyana;

- ❖ **USAID's Assistance Approach** – describe the USAID program strategy and activities implemented;
- ❖ **Findings/Conclusions/Recommendations** – for each SOW area;
- ❖ **Lessons Learned;**
- ❖ **Issues** – provide a list of key technical and/or administrative if any;
- ❖ **Future Directions;**
- ❖ **Annexes** – useful for covering assessment methods, schedules, interview lists, and tables; they should be succinct, pertinent, and readable.

The report should be submitted to USAID/Guyana in hard copy and also provided on a 3½-inch diskette. The report should be compatible on Microsoft products only. The report format is in 12-point font size with 1-inch margins (top and bottom, left and right).

The report should contain the following information on the title page:

- 1) Title
- 2) Author Name
- 3) Project Activity Number
- 4) Contract Award Number
- 5) Sponsoring USAID Office
- 6) Contractor/Grantee Name
- 7) Date

### **Deliverables**

The following deliverables are required:

- ❖ Final (unedited) report prior to departure (hard and electronic copies) to the Guyana Mission and the Synergy Project
- ❖ Technical debriefing to key staff at the Guyana Mission

### **Relationship and Responsibilities**

The consultant will work under the direction of Barbara de Zalduondo, The Synergy Project.

### **Performance Period**

The expected period of performance in Guyana will be from March 11 to March 28, 2002.