

National Strategic Plan For HIV/AIDS 2002-2006

INTRODUCTION

This document is the result of a review of the degree of implementation of the National AIDS Programme Strategic Plan 1999-2001, together with the input of a wide cross section of Government Ministry Officials, NGOs, legal profession, representatives of PLWHAs, religious organizations and UN and other international and bilateral agencies. The 1999-2001 strategic plan was comprehensive but suffered from an insufficiency of resources, human, technological and financial for its execution. Additionally, the structure and position of the NAPS within the Ministry of Health, and its preoccupation with implementation rather than management and coordination has contributed to the slow implementation of this previous plan. Also, the multi-sector response was less than anticipated with the public sector response being mainly from the Ministry of Health with some involvement of the Ministry of Labour. However there was encouraging response from NGOs and some of the larger private enterprises.

Voluntary counseling and testing is now more readily available with more counselors having been trained in every region over the past three years. However, treatment, care and support have remained limited, with ARV therapy being available in the public sector, only in Georgetown, since April 2002. Unfortunately there is still a lot of stigma attached to being HIV positive and this is most likely responsible for the late testing of persons diagnosed with AIDS, the mean age of survival between diagnosis and death being four and a half months.

This present plan, covering the period 2002-2006, has taken into consideration the constraints of the previous implementation process and the strengths and potential strengths of various partners within the public and private sectors and the international community. It has been made within the context of recommendations made for a revision of the national policy on AIDS, a rethinking of the composition of the NAC and RACs, and a restructuring and repositioning of the NAPS.

HIV/AIDS SITUATION

AIDS was first diagnosed in Guyana in 1987 in a homosexual male. There has been a progressive increase in reported AIDS cases since that time with a significant increase between 1997 and 1998 and a further sharp increase in 2001 over 2000. The sharp increases may in part be due to improved surveillance or a reflection of the infections contracted 7-10 years ago, which had not had benefit of treatment. The epidemic has become generalized among the population and by the end of 2001, 2,185 cases had been reported.

The rate of increase of AIDS cases is faster in females than males, with an accelerated rate beginning in 1993. Females now make up 38% of all AIDS cases but outstrip the men in the 15-24 age group. In general the largest number of cases occur among persons 20-49 years of age, peaking in the 30-34 age group. The numbers of HIV positives within these age groups are not currently available.

Data coming out of the PMTCT programme reveal that by the end of the first seven months of the programme 54.35 % of pregnant women attending the eight pilot sites, had accepted testing. Of the

1,232 women tested 58 (4.7%) tested positive. This however is a self-selected group and may well represent those who thought that they were at higher risk of being infected. The positive rates differ widely between clinics with an average of 1.3% in Region 6 and a range of 3.6%-8.0% in the Clinics in Georgetown.

Most recent data indicate HIV prevalence rates of:

- 1.0% among blood donors (2001) (down from 3.2% in 1997)
- 7.1% among pregnant women (1995) (up from 3.7% 1993)
- 13.2% males (1992) 6.5% females (1993) STD clinic patients; and
- 45% among female commercial sex workers (1997) (up from 25% 1989)
- No data are available for prevalence rates among men who have sex with men.
- According to data from 2000, approximately 80% of HIV/AIDS cases come from Region 4, (at a rate of 144.8 per 10, 000 population), about 6% each from Regions 6 (25.9 per 10,000 pop.) and 10 (86.6 per 10,000 pop.). Region 3 has a rate per 10,000 population of 33.8 while the other Regions have rates ranging from 6.2 to 28.6.

HIV/AIDS is thus a national problem of growing concern in Guyana. With the opening up of Guyana's hinterland for development, the proposed Guyana/Brazil road, and the subsequent increase in the transient population, a further drastic increase in the prevalence of HIV/AIDS is anticipated. Because of the difficulty of access to some of the interior areas, the response has so far has been concentrated primarily in Georgetown, with some activity in Regions 6 and 10.

HISTORY OF THE RESPONSE TO THE EPIDEMIC

At the time of the diagnosis of the first case of AIDS there were no facilities, nor the expertise in Guyana to deal with the situation, samples from suspected cases having to be sent to CAREC for testing. In response to increasing numbers and with collaboration between CAREC and the Ministry of Health, a national programme began to emerge. In 1989 with the collaboration of CAREC, the European Commission, PAHO/WHO and the Global Programme on AIDS, the Ministry of Health established the Genito-Urinary Medicine (GUM) Clinic, the National Infectious Disease Laboratory (NIDL) and the National Blood Transfusion Service (NBTS).

The GUM clinic was given the responsibility for the diagnosis and management of all sexually transmitted infections, including HIV. In the public sector, all HIV testing was carried out by the NIDL with confirmatory testing being carried out by CAREC initially until the NIDL acquired the capability. CAREC maintains quality control.

In 1989, the National AIDS Programme (NAP) was initiated under the Ministry of Health and the National AIDS Committee (NAC) was constituted. In 1992 the National AIDS Programme Secretariat (NAPS) was established. Up until 1998, the NAPS was working under its Medium Term Plan (MTP) for 1992-1997. In that year, following work carried out by the Legal and Ethical Committee of the National AIDS Committee (NAC) and a review of the HIV/AIDS/STD surveillance systems, an HIV/AIDS Policy document was developed in 1998 and presented to Cabinet for consideration. This is yet to be tabled in Parliament and this should be treated as a matter of urgency to facilitate the

implementation of the updated plan.

The NAPS, in collaboration with CAREC-GTZ, has developed a programme to increase access to voluntary counseling and testing (VCT) services as a key element in the national AIDS strategy. In addition an educational programme has been formulated for youth, most notably the “Ready Body” project funded by USAID (Family Health International) and in which eight youth oriented NGOs are participating.

In recent times HIV/AIDS has become a significant area for NGO involvement. NGOs working in this area are active in 6 Regions (3, 4, 5, 6,7 and 10). They fall into two main categories, Information and Education and Care and Support. Some organizations provide both.

Another positive area of support has been in the workplace. Considerable work has been done, both through the IEC programme of the NAPS and the Occupational Safety and Health Department of the Ministry of Labour. Occupational Safety and Health officers from public and private enterprises were sensitized to HIV/AIDS issues in 2000 and they began the process of sensitizing employees at their work sites. In January of 2001 a number of these from the Ministry of Labour, Barama, Linmine, GUYSUCO, M&CC, GS&WC, GNIC, Banks DIH Ltd, and GNSC were trained to conduct HIV/AIDS awareness workshops at their respective workplaces. Over 600 workplaces had awareness and education sessions reaching nearly 14,000 employees.

Over the past three years, there has been a considerable amount of public and targeted education but the emphasis has been on awareness raising and providing information on the cause, spread and prevention of the disease. Sensitization of the general public, health care providers, youths and employers/employees, entertainers and female CSWs was also carried out. A media initiative for responsible journalism and strong networking with the NAP has also been undertaken and has borne good fruit. It has resulted in more information in the print and non-print media about HIV/AIDS and its effects on Guyana, with less sensationalism.

Progress has also been shown in the initiation of a pilot project for the prevention of mother to child transmission (PMTCT) at eight pilot sites (November 2001), the production of ARVs at the New Guyana Pharmaceutical Corporation and the initiation of a treatment programme with ARVs at the GUM clinic in early April 2002.

CONTEXT OF THE 2002-2006 STRATEGIC PLAN

The aims and objectives of the NAP as set out in 1992 are still relevant today and are consistent with the Global Strategy Framework. These are to:

- Reduce the risk and vulnerability to infection through prevention and control of the transmission of STIs and HIV, and promoting sexual health
- Saving/ prolonging and improving quality of life, of persons with STIs/HIV/AIDS
- Reduce the social and economic impact on individuals and communities.

In fact #3 can be considered the overall goal of the Strategic Plan because if #1 and #2 are achieved #3 will result.

The guiding principles of the strategic framework for the 1999-2001 plan are also still relevant:

- The use of a coordinated multi/inter-sector approach
- Upholding the rights and responsibilities of persons affected, and striving for active/greater involvement of PLWHAs in planning and implementation of the response
- Providing information and a supportive environment to empower persons to prevent further HIV transmission
- Guaranteeing voluntary counseling and testing and confidentiality
- Integration of care and support of PLWHAs into existing health and social services and
- Minimizing and eliminating where possible any inequities between the Regions in the response to the HIV/AIDS epidemic.

There are several opportunities:

- We know the virus that causes the syndrome and how it is spread, and from collective experience we know that it is technically feasible to reduce the spread and impact of the epidemic.
- We have the means of ensuring the safety of the blood supply, of providing a physical barrier to the sexual spread of infection through the use of condoms, and spread in other settings through the use of universal precautions.
- We have the means of reducing infectivity by lowering viral load through treatment with ARVs.

The first is clearly a service issue. The second and third have implications for both service delivery and behaviour change on the part of the population. People need to recognize the value of consistent condom use in situations that put them at risk, and the services have to ensure an adequate supply and non-discriminatory and non-judgmental access to those condoms. Services have to provide universal access to care and a supportive environment that will create early care seeking behaviour on the part of the population. This requires political and financial commitment.

Based on the allocation for the HIV/AIDS programme in the 2002 budget, which has been substantially increased, it can be assumed that the financial commitment to the programme is there; never the less funding is never infinite and realism had to be weighed against idealism and what is feasible in the preparation of the plan.

Up until now the main responsibility for responding to the epidemic has been with the Ministry of Health, although recognition has been given to the need for involvement of other stakeholders including other government Ministries/Agencies. One way of showing commitment to the process would be by inclusion of HIV/AIDS related activities in the annual programme and budget of those Ministries/Agencies.

Partnerships with key social groups, NGOs, CBOs, and religious organizations, and greater involvement of PLWHAs, have also been shown to contribute tremendously to successful strategies addressing HIV/AIDS. The NGO community and some of the international Agencies have played an important part in the response to date. This needs to continue and be strengthened and better coordinated.

But a truly expanded response requires not only greater involvement of all sectors of the society but a recognition of the interrelationship between reducing risk, vulnerability and impact and the need to act on all three simultaneously. The most effective responses to the epidemic have integrated education, prevention and care and support strategies.

PLANNING PROCESS

The framework of the plan was developed at a workshop held at the Tower Hotel from 18-20 June 2002. Representatives came from a number of Government Ministries and Agencies, NGOs, PLWHAs, UN and other international and bilateral agencies, the legal profession, business community and religious organizations.

Presentations were made on the HIV/AIDS situation and a review of the implementation of the 1999-2001 Strategic plan to provide an insight to the conditions under which the plan was to be developed. Following the pattern of the previous plan, four components were identified and these components discussed by four different groups. At the end of the two and a half days, the participants had identified issues to be considered, priorities for action, the purpose of each component and some activities to be undertaken. A smaller subsection of each group met subsequently to finalize each component.

PROGRAMME DESCRIPTION

The ultimate goal of the Plan is to: Reduce the social and economic impact of HIV and AIDS on individuals and communities and ultimately the development of the country.

The overall goal is to reduce the rate of increase in the incidence of HIV infection and the development of AIDS.

For convenience *the plan has been divided into four components* dealing with different aspects of the strategy.

- Surveillance will provide the information on the extent of the epidemic, the population groups most affected and the behaviours driving the epidemic
- Care, Treatment and Support will contribute to the reduction in spread of the disease and improve and prolong the useful life of those infected
- Risk Reduction is self evident; and
- Management, Coordination and Policy Formulation is the engine that will drive the other three components.

It must be understood however that this is one plan and that it is essential for the components to come together as an integrated whole since the various components are interlinked; surveillance and risk reduction, surveillance and monitoring and evaluation, care and treatment and risk reduction.

PROGRAMME COMPONENTS

I. Surveillance

AIDS is playing an increasingly important role as a cause of death in Guyana; currently the second commonest cause of death. In 2000 it accounted for 14,154 years of potential life lost (YPLL), more than that of acute respiratory infection (ARI), ischaemic heart disease (IHD) and cardiovascular (CVD) combined.

Unfortunately, the true extent of the problem is unknown since AIDS data are incomplete and seroprevalence data outdated. A serious situation of underreporting exists, estimated at approximately 60%. Additionally the dynamics of transmission have not been fully explored.

Information is essential to rational planning and decision-making. Good surveillance is, therefore, going to be the cornerstone of the execution and monitoring of the National Strategic Plan for HIV/AIDS. Good surveillance, however, calls for developing a culture of information gathering, analysis and utilization for decision-making. Data collection has to be active and provide both quantitative and qualitative information. Quantitative to define the extent of the problem and the population groups to which qualitative surveillance must be directed, and qualitative to gain a better understanding of what is fueling the epidemic, to help guide the type of intervention needed and determine what works and what doesn't and why. Currently most of the quantitative data originates in the public system and qualitative surveillance has not yet been institutionalized.

Laboratory capability is essential to good surveillance. There is therefore need to plan for increasing the capacity and capability of laboratories to handle the volume of work that is expected to be generated with the increased demand for diagnosis and monitoring if the strategic plan is successful. This will include plant, equipment, (this will be based on the criteria to be used for starting treatment and monitoring parameters), testing supplies and human resources.

This component will address these issues.

Purpose: To strengthen the surveillance system to produce information that will be most useful in designing interventions for reducing the spread of HIV/AIDS and in planning care for those affected.

Indicators:

1. All designated sites in the public sector reporting on the number of new STIs, Tb, HIV and AIDS cases and Opportunistic Infections (OIs) on a monthly basis by the end of 2002.
2. At least 50% of sentinel surveillance private physicians and laboratories reporting on the number of new STIs, Tb, HIV and AIDS cases and OIs on a monthly basis by the end of 2003 and at least 80% reporting by the end of 2005.
3. Regions 3 and 4 providing quarterly reports on HIV/AIDS situation in their respective Regions, according to an agreed upon format, by the end of 2002 and Regions 5 and 6 by the end of 2003, other

		documents to be used in both public and private sectors]	
ER.2 Data produced to provide information on prevalence and a better understanding of the dynamics of the epidemic.	<p>1.Seroprevalence surveys carried out among target groups biennially starting 2002</p> <p>2.Surveys carried out biennially among youths 15-24 years of age to provide information on at least age at first sexual contact, condom use at last sexual contact, and drug use, starting mid 2003.</p> <p>3.Surveys carried out biennially among MSM to provide information on at least condom use and rate of partner change starting 2003.</p> <p>4.Surveys carried out biennially among HIV positive persons on at least access to care, compliance with treatment regimen and support mechanisms starting 2002.</p> <p>5.Surveys carried out biennially among CSW to provide information on at least number of clients during past week, condom use with clients and with regular partner</p> <p>6.Surveys carried out biennially among the sexually active general population to provide information on at least number of non-regular sex partners in past 3 and 12 month period, % of persons in a mutually monogamous relationship and % condom use at last sexual contact and risk perception, starting 2002.</p>	<p>2.2Conduct five BSS in specified population groups, and repeat biennially.</p> <p>2.2. Conduct well designed research studies to answer specific questions arising from results of surveillance</p> <p>2.3 Carry out seroprevalence surveys among antenatal women, CSWs, and MSMs</p> <p>[Assumption That information gathered will be used in designing appropriate behaviour change interventions]</p>	<p>\$120,000,000</p> <p>\$40,000,000</p> <p>\$40,000,000</p>
ER 3 QA system institutionalized in all laboratories carrying out HIV/AIDS/STIs - related testing	<p>1.All laboratories participating in proficiency testing by the end of 2003.</p> <p>2.All laboratories achieving 99% accuracy in testing as determined by external valuation by the end of 2003.</p> <p>3.All laboratories participating in 6 monthly internal QA</p>	<p>3.1Conduct annual refresher training of staff in conducting commonly used tests STIs and HIV to maintain accuracy.</p> <p>3.2 Develop forms and format for reporting at all levels</p> <p>3.3. Train staff in the use of standardized forms</p>	<p>\$140,032,000</p> <p>\$24,000</p> <p>\$1,076,000</p>

	<p>evaluations starting 2003</p> <p>4.All private laboratories using standardized format for reporting.</p> <p>5.All laboratories accredited by the end of 2006.</p>	<p>3.4 Conduct annual training for staff in private and public sector in QA and bio-safety</p> <p>3.5. Develop core standards for the accreditation of laboratories</p> <p>3.6. Train assessors for evaluation of laboratories for accreditation.</p> <p>3.7. Plan and conduct a series of meetings to identify issues to be considered in the development of legislation to govern the operation of laboratories.</p> <p>Assumption: (i) That the private laboratories will agree to become integrated into the system (ii) That the Bureau of Standards have in place the mechanism for utilization of the assessors.</p>	<p>\$14,032,000</p> <p>\$48,000</p> <p>\$38,000,000</p> <p>\$96,000</p>
<p>ER4 Increased laboratory capacity to diagnose indicator diseases.</p>	<p>4.1.By end of 2003 culture and sensitivity of Tb mycobacterium and GC being carried out in at least one laboratory.</p> <p>4.2.By end of 2004 at least one laboratory doing testing for toxoplasmosis and at least one other OI as indicated by clinical findings.</p>	<p>4.1. Procure and install equipment and reagents for testing for specified OIs.</p> <p>4.2.Train technologists in performing GC and TB culture and sensitivity testing</p> <p>4.3.Conduct annual training and refresher courses in VDRL, HIV testing and TB, GC cultures (combine with 3.1)</p> <p>4.4.Train staff in routine maintenance (daily and preventive)</p> <p>4.5.Conduct training of laboratory technologists in use of standard operating procedures (SOP)</p> <p>Assumptions (i) That purchase agreement will include a maintenance contract that will include maintenance of the equipment by the supplier/producer and training of users in preventive maintenance. (ii)That persons trained in the use of the equipment will be retained in that department for at least two years, and that succession planning will be put in place (iii) That the Public Health Laboratory will be established within the next year (iv) That an appropriate mechanism will be in place to ensure a timely and constant supply of reagents and testing kits to maintain proper</p>	<p>\$420,000,000</p> <p>\$3,544,000</p> <p>No Cost</p> <p>No Cost</p> <p>\$320,000</p> <p>\$70,000,000</p>

		laboratory capacity.	
Total Cost			\$773,204,000

II. Care, Treatment and Support

Treatment is essential to reducing risk of viral transmission, prolonging useful life and improving quality of life. Currently treatment for STIs and opportunistic infections is available in both the public and private sector. National guidelines for the syndromic management of STIs exist and training of health personnel in the public sector in most of the Regions has been carried out in using the approach.

Only the GUM clinic is presently routinely treating patients with ARVs. Decision to treat is currently based on clinical criteria. This means that persons already have AIDS at the time they start treatment and are starting later than is optimal. Unfortunately this situation is all that is possible at this time given that there is no testing currently being offered locally for CD 4 count or viral load, two of the parameters used in deciding when to start treatment. This situation has to be changed pretty quickly since treating persons when they have already started to show signs of disease, although it may improve the quality of life, will not reduce the number of new cases of AIDS.

Prevention of mother to child transmission has been shown to be technically and administratively feasible in many countries. Currently this intervention is being offered on a pilot basis at eight sites, five in Georgetown and three in Region 6. The aim is to offer this as an integral part of the regular antenatal services.

Offering antiretroviral triple therapy is not sufficient to ensure a successful treatment programme. Having systems in place for ensuring compliance, and quality laboratories for monitoring response to treatment and viral sensitivity, are essential. Medical care also needs to be supported by counseling, home care, empowerment of PLWHAs in providing self-care, social welfare and nutrition services.

Centralization of services has the disadvantage of diminishing access to care of persons living outside the city and putting treatment compliance in jeopardy. At the current estimated cost of between US \$ 450 and \$ 575 per capita per annum for ARV therapy it will not be feasible to treat everyone needing to be treated, especially since the number of such persons will increase each year. Extension of the treatment services outside of Georgetown, inclusion of the private sector in provision of treatment and prioritization of population groups for receiving free/subsidized care have to be taken into consideration.

Purpose: To improve the quality and length of life of persons infected and affected by HIV/AIDS, in a supportive environment, so they could achieve their maximum potential.

Indicators:

1. Mean survival time between diagnosis of AIDS and death increased to at least 3 years by end of 2006.
2. Prophylaxis and treatment of opportunistic infections (OI) and other co-infections available as part of a minimum care package by the end of 2003.
3. At least 80% of mothers in the ANCs accept HIV testing by the end of 2006.

4. ARV therapy provided through the public health services, free of charge to all those who cannot afford it by end 2004.
5. Psychosocial, adherence and risk reduction counseling services available to all HIV positive services in all Regions by the end of 2004.
6. Anti discrimination legislation in place by mid 2004
7. Social support services available to all PLWHAs and their dependants by the end of 2005

[Assumption: That education and promotion programmes, and availability of VCT will result in persons presenting earlier for testing, and if positive remain in a care and treatment programme]

Expected Results: 2. Care, Treatment and Support

Expected Results	Indicators	Activities/Tasks	Costs
ER 1: Capability and capacity of designated laboratories strengthened to perform diagnostic testing for HIV, CD4 count and other tests for monitoring response to treatment	1. At least the Central Laboratory equipped to do CD4 count by mid 2003	1.1. Carry out needs assessment of all regional hospital laboratories.	\$1,472,000
	2. At least 3 persons trained to perform CD 4 count by mid 2003.	1.2. Procure and install CD4 counter in central laboratory and obtain reagents.	\$54,000,000
	3. At least one person from each Regional Hospital laboratory trained in routine monitoring tests by the end of 2003, and proficiency in HIV, VDRL and other testing is maintained.	1.3. Train technologists to perform CD 4 counts	\$1,890,000
	4. At least one laboratory each in Regions 4, 6 and 10 have the capability of performing culture and sensitivity for gonococcus.	1.4. Train technologists in routine maintenance of CD4 counter.	No Cost
	5. At least one laboratory has the capability of diagnosing herpes by the end of 2004.	1.5. Conduct training for technologists at regional laboratories in performing routine tests used in monitoring progress of HIV infection and treatment of AIDS.	\$2,804,000
		1.6. Procure equipment, reagents for conducting GC culture and sensitivity and install in Laboratories in Regions 6 and 10	\$400,000,000
		1.7. Conduct base line survey on GC sensitivity.	\$2,646,000
	Assumptions: (i) That the necessary space for accommodating the CD4 counter and the equipment for GC culture will be made available. (ii) That proper maintenance		

		<p>contracts will be negotiated with the purchase of equipment including at least the commitment to train technologists in routine day-to-day and preventive maintenance.</p> <p>(iii) That persons trained will remain in the area for at least 2 years and succession planning will be put in place.</p> <p>(iv) That there will be a constant supply of reagents to carry out testing.</p>	\$400,000,000
ER 2 More treatment sites (public and private) and treatment options available for the management of HIV/AIDS	<p>1. ARV treatment available at least at every Regional Hospital, and the basic minimum package of care at sites outside the hospital setting, by the end of 2003.</p> <p>2. Each treatment site staffed by health care workers who have been trained in the recognition of STIs, AIDS defining illnesses, in the use of appropriate treatment and other management parameters, by the end of 2003</p> <p>3. At least 5 non-public sector treatment sites available in Regions 2,3, 4,6, and 10 by the end of 2003</p> <p>4. At least 7 ARVs (1 additional NNRTI and 1 additional PI) available for treatment by the end of 2003</p> <p>5. Pediatric preparations of ARVs available by the end of 2003</p>	<p>2.1. Assess potential treatment sites to determine their suitability as a treatment center either as a special center or as part of integrated services.</p> <p>2.2. Review and revise the minimum package of care</p> <p>2.3. Develop/ review and revise management protocols for STIs, OIs, HIV/AIDS and PEP for both adult and pediatric cases</p> <p>2.4 Develop a training manual for the management of STIs, OIs, HIV/AIDS and PEP</p> <p>2.5. Conduct training on the use of the protocols with annual updates.</p> <p>2.6. Conduct series of meetings with the Medical Association to encourage more doctors to become trained in the management of HIV/AIDS</p> <p>2.7. Carry out an assessment of the efficacy of the current treatment with ARVs.</p> <p>2.8. Conduct discussions with local manufacturers re feasibility of manufacturing additional ARVs</p> <p>2.9. Advocate for additional budgetary allocation to meet the needs for ARVs and other pharmaceuticals for the</p>	<p>\$1,600,000</p> <p>No cost</p> <p>\$48,000</p> <p>\$120,000</p> <p>\$2,350,000</p> <p>\$2,520,000</p> <p>\$17,010,000</p> <p>No Cost</p> <p>No Cost</p>

		<p>treatment of AIDS.</p> <p>2.10. Purchase ARVs for treatment of PLWHA</p> <p>Assumptions: (i) That Government will provide for any structural upgrading required to prepare a treatment site in the public sector. (ii) That private practitioners will be willing to become involved in the HIV/AIDS management]</p>	\$2,000,000,000
ER 3 PLWHAs and families empowered to provide mutually supportive care	<p>1. At least one support group formed in conjunction with each treatment site within one year of the establishment of the treatment site.</p> <p>2. PLWHAs attending support groups and their families trained in self care within 6 months of the formation of the group.</p>	<p>3.1. Develop information and education programme aimed at encouraging PLWHAs to participate in support groups.</p> <p>3.2. Review available self-care manuals and adapt to suit the local situation.</p> <p>3.3. Develop standardized training programme for PLWHAs and their families in the use of the self-care manuals.</p> <p>3.4. Conduct initial training and annual refreshers in self care</p> <p>Assumption: That PLWHAs will have the courage to disclose their status to members of the family and that families have the required love and understanding to want to support the PLWHA.</p>	<p>\$9,428,400</p> <p>\$2,044,000</p> <p>\$840,000</p> <p>\$5,880,000</p>
ER 4. Support services established to complement care and treatment of PLWHAs	<p>1. Mechanism in place linking each treatment site with the relevant support services by the end of 2003</p> <p>2. By 2005 at least 50% of PLWHAs who cannot provide for themselves and families receiving social assistance.</p> <p>3. Service providers sensitized and trained in dealing with PLWHAs by the end of 2003</p> <p>4. A system of home care for shut-ins established by the end of 2006.</p>	<p>4.1 Carry out an analysis of the situation to project the number of persons (including orphans) who are likely to require support, the type of support, and availability.</p> <p>4.2 Conduct workshop with service providers, (including nutrition/dietetic services) to develop a plan of action for the establishment of support services, and the mechanism for accessing services.</p> <p>4.3. Train service providers in the approach to interacting with PLWHAs</p> <p>4.4. Develop materials for</p>	<p>\$800,000</p> <p>\$620,000</p> <p>\$2,338,000</p> <p>\$13,470,000</p>

		<p>patient education and information about availability of services</p> <p>4.5 Conduct series of meetings with religious organizations and NGO to determine interest in participating in home care support to PLWHAs</p> <p>4.6. Review existing manuals of home care of PLWHAs and adapt to local conditions</p> <p>4.7. Conduct training for care providers in psychosocial, adherence and risk reduction counseling.</p> <p>Assumptions: That other Ministries state enterprises, NGOs and religious groups will accept responsibility for providing the needed services.</p>	<p>\$1,267,200</p> <p>No cost</p> <p>\$2,704,800</p>
<p>ER 5 The general public has increased access to VCT services</p>	<p>1. VCT services available at all Health Centers and selected private sector sites, including NGOs by mid 2003</p> <p>2. At least one youth friendly VCT site each available in Regions 2,3,4,5,6,7 and 10 by the end of 2005 and in regions 1, 8 and 9 by the end of 2006</p>	<p>5.1. Conduct assessment of the available and potential VCT sites.</p> <p>5.2. Procure Laboratory supplies for conducting rapid test.</p> <p>5.3. Train personnel in the use of HIV rapid testing</p> <p>5.4. Review and revise guidelines for pre and post test counseling and referral for testing</p> <p>5.5. Train counselors in the use of the guideline</p> <p>5.6. Develop a promotional campaign to promote the sites and encourage early testing.</p> <p>Assumption: (I) That both public and private sector authorities will make the necessary adjustments/structural changes for providing the necessary privacy for counseling</p> <p>(ii) That promotional campaigns will be successful in encouraging at risk persons to be</p>	<p>\$1,160,000</p> <p>\$795,300,000</p> <p>\$1,276,000</p> <p>\$24,000</p> <p>\$2,704,800</p> <p>\$9,450,000</p>

		tested.	
ER 6 Women of child bearing age and their partners have increased access to PMTCT services	1.PMTCT services available at all public and 50% of private ANCs by the end of 2004 and at all ANCs by the end of 2006	6.1. Conduct a needs assessment of all ANCs in all region 6.2. Develop a time frame for phasing in services in the public sector. 6.3. Advocate to bring private practitioners on board 6.4. Update PMTCT management protocol 6.5. Train care providers in the use of the protocols 6.6 Develop and conduct promotional campaign to encourage testing during pregnancy Assumption: (i) Relevant infrastructure and staffing will be available at public sector settings (ii) That private practitioners will consider PMTCT an essential part of their practice.	\$5,244,000 No cost No cost \$64,000 \$7,560,000 \$9,450,000
Total Cost			\$3.658,140,400

III. Risk Reduction

HIV infection is associated with specific risks, including behaviours such as unprotected sexual intercourse, and situations where there is risk of infection such as blood transfusions and in the health care setting. The focus in this component is therefore on changing risk-taking behaviours and reducing the occurrence of risk situations.

There has been a progressive increase in reported AIDS cases since 1987 with a significant increase between 1997 and 1998 and an even sharper increase between 2000 and 2001. The rate of increase of AIDS cases is faster in females than males, with an accelerated rate beginning in 1993. Females now make up 38% of all AIDS cases but outstrip the men in the 15-24 age group.

In general the majority of cases occur among persons 20-49 years of age (our workforce), with the largest number in the 30-34 age group. Considering that it takes from 7-10 years after infection for AIDS to develop it is clear that persons in their teens and early twenties are at highest risk, especially teenage females. Given the above it would appear that the two areas for special attention are youths and persons in the workplace.

Providing information and educating the general public and groups that are particularly vulnerable, and promoting supportive values and attitudes are an integral part of risk reduction. In setting out its

HIV/AIDS policy the Ministry of Health gave recognition to and endorsed the promotion of abstinence, fidelity, marriage and strengthening and positive reinforcement of the family structure and family values as effective lifestyle patterns against the spread of HIV.

In the past the IEC emphasis has been on awareness raising, sensitization of the public and health care providers and information on the cause, spread and prevention of the disease. Focus group discussions with young people have revealed that they are well acquainted with the syndrome, know how it is spread and how to prevent it.

It is also known that persons are seeking medical attention late in the disease process. Most current data (2001) indicate that the mean survival time between diagnosis of AIDS and death is four and a half (4 1/2) months. Starting treatment so late in the process is counter productive.

These findings seem to suggest that there is need for a shift in the focus of the educational effort from information about what the disease is, how it is spread and how to prevent it, to emphasizing what constitutes risky behaviour and encouraging persons who have been indulging in these behaviours to seek testing. If HIV positive they must also be encouraged to use the health care services to monitor the progress of their disease so as to start treatment as early as indicated, taught how to take care of themselves, and also how to prevent transmission to someone else. If virus free they must be taught how to, and encouraged to maintain that status.

We know that condom use is a technically sound method of reducing spread of infection through sexual intercourse. However with the continued high infection rate one has to assume that there is need for promoting the increased use of condoms in high-risk situations.

Purpose: To reduce the risk and vulnerability to infection with HIV

Indicators:

1. At least 60% of persons having sex with a non-regular partner, using a condom by the end of 2002
2. The average age at first consensual sex increased to at least 16 years by end of 2006
3. Teenage pregnancies reduced by x% by the end of 2006
4. At least 75% of persons reporting sexual risk behaviour have an appropriate perception of their own risk.

Expected Results: III. Reducing Risks

Expected Results	Indicators	Activities/tasks	Costs
ER 1 Targeted communications encouraging change in risky behaviour designed and implemented.	1. Communications strategy encouraging condom use among the sexually active, designed and messages being delivered through several media by mid 2003.	1.1.Design pretest and produce materials for communications campaign, using survey results to encourage consistent and correct condom use.	\$9,450,000
	2. Campaign to encourage abstinence before marriage	1.2. Conduct meeting with religious organizations to discuss approach to abstinence campaign	\$241,000

	and faithfulness launched by end 2002	<p>1.3.Conduct series of meetings with different denominations to develop campaign and assist in designing materials for campaign</p> <p>1.4. Facilitate organizations in launching campaign</p> <p>Assumptions: That the religious organizations can be convinced to commit to joining the fight against AIDS.</p>	<p>\$1,687,000</p> <p>\$5,670,000</p>
ER 2 Condoms more easily accessible in all Regions.	<p>1. Policy in place to ensure anonymous access to condoms at public health facilities by end of 2002</p> <p>2. Workplaces providing condoms have a system of anonymous access in place by the end of 2003</p> <p>3. At least one youth friendly multi-purpose service available in at least Regions 2,3,4,5,6,7, and 10 by the end of 2006</p> <p>4. The cost of at least one brand of condom on the commercial market reduced to \$50 or less per strip of three by the end of 2003.</p>	<p>2.1. Access government institutions where condoms are distributed, and alternative sites for distribution and utilize information to develop policy re distribution</p> <p>2.2. Ministry of Labour advocate with business community to put in place systems of distribution of condoms that allows for privacy</p> <p>2.3. Meet with youth oriented NGOs and CBOs/community groups, to determine interest in providing multi-purpose services</p> <p>2.4. Design services, on a regional basis, with input from youth.</p> <p>2.5. Mobilize resources to inaugurate services in various region</p> <p>2.6. Train staff to operate the service</p> <p>2.7. Advocate with Government to remove duty from condoms</p> <p>2.8. Conduct social marketing programme for condom use.</p> <p>Assumptions: (i) That a sufficient quantity of condoms will be available for free distribution (ii) That Government will remove the duty on condoms; and (iii) That commercial enterprises will agree to keep down the level of markup on condoms</p>	<p>\$9,450,000</p> <p>No cost</p> <p>\$7,560,000</p> <p>\$14,974,000</p> <p>\$30,024,000</p> <p>\$7,560,000</p> <p>No cost</p> <p>\$9,450,000</p>
ER 3 Young women provided	1. At least 50 young women trained yearly as educators	3.1. Conduct annual training for young women in schools and	\$3,164,000

<p>with the tools to negotiate delayed and safe sex</p>	<p>to provide negotiating skills that will allow their peers to determine when and how they participate in sexual encounters, starting 2003</p> <p>2. At least one training programme conducted yearly for trainers in condom use negotiations, among female CSWs starting 2002</p>	<p>youth groups as trainers in negotiating skills</p> <p>3.2. Conduct training programmes for parents and teachers of the young women in supporting the young women in utilizing these skills</p> <p>3.3. Conduct trainer of trainers programmes for female CSWs in negotiating condom use</p> <p>Assumptions: (i) That PTAs will be interested in participating in the programmes (ii) That the CSW community is well enough organized to come together for training</p>	<p>\$7,560,000</p> <p>\$3,780,000</p>
<p>ER 4 Targeted behaviour intervention for vulnerable groups designed and implemented</p>	<p>1. Special programmes aimed at encouraging safe sexual behaviour among MSMs, and men who have sex with CSWs, designed and operational by the end of 2004</p> <p>2. AIDS in the workplace programmes institutionalized in the major work sites by the end of 2004</p> <p>3. Education campaign aimed at persons who perceive themselves to be at risk, encouraging early HIV testing, instituted by end of March 2003</p> <p>4. Public education programme aimed at reducing stigma and discrimination in place by mid 2003</p> <p>5. Information on availability and access to hot lines, VCT, PMTCT, social welfare and youth friendly services being provided through, electronic and print media by mid 2003</p>	<p>4.1. Conduct a survey among MSMs, in different regions to gain information on extent of practice of multiple partners and sharing of partners, condom use and access to care and treatment</p> <p>4.2. Design interventions based on result of surveys</p> <p>4.3. Conduct survey and design education programme aimed at men who have sex with CSW, encouraging condom use</p> <p>4.4. Conduct meeting with the OSH Committee to determine the approach to AIDS education in the workplace</p> <p>4.5. Facilitate OSH worksite committees in initiating implementation of education programmes</p> <p>4.6. Design campaign to encourage use of VCT sites and early HIV testing by persons considering themselves to be at risk</p> <p>4.7. Design campaign aimed at reducing stigma and discrimination</p> <p>4.8. Design messages and materials providing information on types of services and where available, and</p>	<p>\$5,670,000</p> <p>\$3,780,000</p> <p>\$9,470,000</p> <p>\$490,000</p> <p>\$1,890,000</p> <p>\$9,450,000</p> <p>\$9,450,000</p> <p>\$23,780,000</p>

		strategy for the dissemination of information Assumptions: That it would be possible to obtain a large enough sample of MSMs and men who have sex with CSWs	
ER 5 HIV/AIDS education targeting young people, developed and implemented	1.HFLE programme implemented (on a pilot basis) in secondary schools by September 2002, and in all secondary schools by Sept 2003, and in post primary and primary schools by September 2004 2.Ministry of Culture, Youth and Sport have in place a policy addressing HIV/AIDS education in youth activities by end of 2003 3.HIV/AIDS included in the curriculum of training programmes for out-of-school youth (15-25) by end of 2004	5.1. Facilitate training of teachers in the delivery of the HFLE curriculum and in the use of the HIV/AIDS peer education manual 5.2. Hold discussions with the policy makers of the Ministries of Education and Culture, Youth and Sport and provide guidance in the development of the HIV/AIDS education policy 5.3. Train peer educators in secondary and special schools in the use of peer education manual Assumption: (i) That the HFLE programme will be introduced according to schedule (ii)That the Ministry of Culture, Youth and Sport will agree to the use of the manual in the programmes and schools under their control]	\$5,670,000 \$378,000 \$4,000,000
Total Cost			\$175362000

IV. Management, Coordination and Policy Formulation

The management of this expanded response will be one of the most important factors determining the success of the Plan. The type of structure, which needs to be in place to ensure a truly intersectoral response, is therefore very important. This was recognized in the 1999-2001 plan and a review of the structure of the Secretariat was carried out. However it remained solely health oriented. The scope of the secretariat needs to be broadened to provide a wider range of skills, and its position within the governmental structure needs to be reconsidered, to make it truly intersectoral and to raise its profile.

A review of the 1999-2001 Plan revealed that the prime responsibility for carrying out most of the activities in the plan was placed on the NAPS. Thus a considerable amount of time was devoted to implementing activities leaving little time for management and coordinating functions. The budget also largely came from the Ministry of Health. This needs to change in the 2002-2006 plan. A true national commitment to deal with the problem of HIV/AIDS will be demonstrated when at least the Ministries of Labour, Education, Culture, Youth and Sport and Human Services and Social Security have financing in their annual budgets for HIV/AIDS.

Monitoring and evaluation is an integral part of management, and the role of the Secretariat should be to coordinate activities where indicated and to ensure that those agencies charged with the responsibility of implementing each component carry these out. Since a strategic plan is dynamic, strategies that do not work must be revised or changed. Continuous evaluation is therefore important. The indicators agreed upon in the other components will be used in monitoring and evaluation of the plan.

The ultimate goal of the Plan is to reduce the social and economic impact of HIV and AIDS on individuals and communities and ultimately on the development of the country. This can be achieved by prolonging the productive lives of individuals infected with HIV, thus allowing them to contribute to the well being of their families and reducing the burden on the welfare system. The key to achieving this is to encourage persons at risk to seek early testing and treatment, make treatment easily available and create the supportive environment that will encourage persons to seek early testing and treatment. One of the functions of management is to ensure that supportive environment.

Purpose: National Strategic Plan for HIV/AIDS being managed in a well coordinated and transparent manner, with a multi-sector approach within a supportive environment

Indicators

1. The NAC and RACs restructured according to the stipulations of the policy, and the NAPS according to the recommendation coming out of the June 18-20 consultation, by December 2003.
2. At least 7 Regions have RACs in place with an action plan, within the context of the NSP, covering the period 2003-2006, by October 2002, and annual work plans with budgets, by August each succeeding year starting 2003.
3. NAC and RACs meeting monthly to monitor and evaluate the progress of the NAP and their annual plans respectively by January 2003 and, NAC and RACs meeting jointly at least quarterly starting March 2003.
4. At least 5 subject Ministries have provision for HIV/AIDS programme(s) identified in their 2003 budget, and the others by 2004 budget
5. Public Health laws as they relate to communicable diseases reformed and enacted by the end of 2003 and the accompanying regulations in place by June 2004.
6. Relevant legislation on non-discrimination against persons living with HIV/AIDS enacted by December 2003.
7. Policies addressing HIV/AIDS in the workplace developed and institutionalized within the public sector and larger private enterprises by the end of 2003.

Assumptions:

- (i) That Government accepts the recommendations about the composition of the NAC, RAC and restructuring and repositioning of the NAPS.
- (ii) That PLWHAs will be empowered enough to come forward to participate in the programme at all levels.
- (iii) That legislation having been drafted and policies developed will be enacted/endorsed.

Expected Results: IV. Management, Coordination and Policy Formulation

Expected Results	Indicators	Activities/Task	Cost
ER 1 Mechanisms developed and implemented for the management and coordination of the NAP	1.Existing policy on HIV/AIDS revised to reflect wider participation on the NAC, an a-political composition and a transparent method of selection of the membership, by October 2002, and endorsed by June 2003.	1.1. Review and revise the policy document and resubmit to Cabinet	No Cost
		1.2.Conduct a series of meetings with the REOs and the RACs to introduce the strategic plan and conduct training for members of the RACs in planning, programming and evaluation	\$5,023,000
	2.Document available indicating working and reporting relationships between the NAC, RACs and the NAPS, and NAPS and other stakeholders/partners, and reporting formats and schedule of reporting, by December 2002, and system institutionalized by June 2003	1.3.Conduct training in the subject ministries in planning, programming and evaluation of HIV/AIDS programmes.	\$1,504,000
		1.4.Conduct a series of meetings with partners to develop reporting formats and schedules for various agencies	\$186,000
	3.Management information system designed and institutionalized by March 2003.	1.5. Train RACs and other partners in the use of the reporting formats	\$376,000
		1.6. Design a management information system for the NAPS	\$3,780,000
		1.7.Develop a mechanism for ensuring a constant supply of ARVs and test kits for HIV. Assumption: (i) That enough interest resides in the Regions to ensure participation in and sustainability of the RACs (ii) That all HIV/AIDS related projects being supported by national partners and donor Agencies will be planned and executed within the framework of the national plan (iii) That Government will accept the strategic plan	No cost
ER 2: Relevant legislation and policies drafted	1.Legislation dealing with non-discrimination against PLWHAs and including all areas identified in the policy document, drafted by June 2003	2.1.Contract a consultant to review existing anti-discrimination laws, and draft legislation relevant to Guyana, for submission to AG'S office.	\$3,780,000
		2.2. Contract consultant to draft	\$3,780,000

	<p>2.Reformed public health laws drafted by June 2003</p> <p>3.AIDS in the workplace policies addressing ethical issues, drafted by June 2003</p> <p>4.Policy on distribution, access and advertisement of condoms developed by September 2002</p> <p>5.Policy on access, distribution and cost of ARVs developed by December 2002</p> <p>6.Draft legislation for accreditation of laboratories ready by mid 2004</p>	<p>new public health legislation as it relates to communicable diseases, for submission to the Attorney General's office</p> <p>2.3. Contract consultant to prepare draft legislation for accreditation of laboratories.</p> <p>2.4.Conduct a series of tri-partite meetings (Min. of Labour, Unions and Employers' Association(s)) to review existing policies and the ILO convention to develop HIV/AIDS workplace policies relevant to Guyana.</p> <p>2.5.Hold a series of meetings with workers to introduce ILO code of practice ON HIV in the world of work and the national policy</p> <p>2.6.Conduct a series of meetings with policy makers, religious organizations and the Ministries of Health, Education and Culture, Youth and Sport to agree on a policy of condom distribution, access and advertisement.</p> <p>Assumptions: That once the drafting has been completed the process would be fast-forwarded to ensure early enactment.</p>	<p>\$3,780,000</p> <p>\$1,016,000</p> <p>\$1,890,000</p> <p>\$1,704,000</p>
<p>ER 3 Number of partners in the response increased</p>	<p>1.At least 10 private sector businesses in Regions 3, 4, 6, and 9, and 5 in Regions 2, 7, and 10, and 2 in other Regions have in-house programmes or are supporting Regional activities by December 2004</p> <p>2.At least the three main religions (Christian, Hindu and Moslem) have at least one programme aimed at HIV prevention and /or care and support in each of the coastal regions by Dec 2004</p>	<p>3.1. Carry out study on economic and social impact of HIV/AIDS.</p> <p>3.2. Utilize results of socio-economic impact study in sensitization meetings with Cabinet, Parliament and the judiciary to emphasize the importance of HIV/AIDS to the development of the country</p> <p>3.3. Conduct advocacy sessions with Government Ministers to support call for HIV/AIDS Programmes within Ministries</p> <p>3.4.Conduct advocacy meetings</p>	<p>\$11,340,000</p> <p>No cost</p> <p>No cost</p> <p>\$8,160,000</p>

		with the private sector and religious organizations to encourage participation in the expanded response	
Total Costs			\$46315000

Recommendation for Management of the NAP

It is recommended that direction and coordination be exercised at two levels, policy and advisory by the National AIDS Committee (NAC) and operational by the National AIDS Programme Secretariat (NAPS).

The NAC should comprise representatives from various sectors of civil society. The recommendations in the policy document are appropriate with a few additions, as recommended by the group, which discussed management, coordination and policy formulation. It must, however, be apolitical and non-partisan and therefore should have no representation from political parties.

With respect that the choice of representatives should be the prerogative of the relevant organizations and that the Chairperson should be chosen by the representatives of the NAC. The manager/director of the NAP should be an ex-officio member of the NAC and provide the link between the NAC and the NAPS. The NAC will not be required to implement any activities.

The Regional AIDS Committees will support the NAC and will be similarly constituted. It is recommended that the REO and the RHO be ex-officio members. Unlike the NAC, the RACs will be expected to do some programme implementation.

The NAPS should comprise a Director whose area of expertise must be management, with experience in programming and planning. He/she will be supported by technical and administrative staff:

- A physician with expertise in the management of STIs and HIV/AIDS
- A Laboratory specialist with experience in epidemiological surveillance
- A communications specialist with a social science background
- An administrator with strong accounting skills
- Experienced social worker.

The latter may not be needed immediately but certainly when the problem of orphans and persons severely affected by AIDS escalates. The laboratory specialist may also become redundant when the laboratory and surveillance systems have been strengthened enough to stand on their own. As the programme progresses other skills may need to be brought on board.

The NAPS must be supported by and maintain close liaison with an inter ministry committee of key Ministries such as Health, Education, Culture, Youth and Sport, Labour, Finance, Local Government, Human Services and Social Security, Home Affairs, AG's office and Tourism. Consideration should be given to inclusion of Agriculture. Representation should be at the level of at least PS or Chief Technical Officer and the Finance Officer.

This is expected to engender a better understanding of the issues related to the problem of HIV/AIDS and its impact and result in provision for programmes within each ministry.

The NAPS will be the hub or 'engine room' of the monitoring and coordinating process. It will not be expected to implement programmes. Apart from the inter-ministry liaison the NAPS will liaise/interact with NGOs, Religious Organizations, in the areas of care and support and behaviour change education; with the private health sector in the areas of care and treatment and surveillance; with the Ministry of Labour in relation to AIDS in the workplace. The staffs of this Ministry have the relevant skills to manage that aspect of the programme. The Ministry of Labour will in their turn liaise with the non-health private sector, and the Unions.

In due course as the Ministries of Education and Culture, Youth and Sport develop their skills they will be expected to manage the programmes in their constituents. In general it is being recommended that programme implementation be carried out by the units with relevant expertise rather than the NAPS.

In relation to the positioning of the NAPS within the government structure it is recommended that it be brought out from under the Public Service. The NAP is currently a sub-programme of a Programme of the Ministry of Health, giving credence to the perception that HIV/AIDS is a health problem. Its profile needs to be raised. Coming out from within the Public Service will pave the way for offering employment packages that would attract and retain the skills required.

Budget Calculations NSP 2002-2006

Surveillance

ER1. 1.1. Review /update/design surveillance forms, formats and guidelines. (MOH surveillance Unit. Include some physicians and private labs): 7-10 persons. \$5,000/day x 2 days (meals) and \$12,000/day for out of towners (accommodation) + \$4,000 travel

Workshop for MOH surveillance team 20 persons. Use same rates for accommodation for out-of-town participants and travel. Include cost of venue, snacks and meals.

GUM clinic staff - 4 afternoons. Provide snacks. Provide for printing forms and guidelines for training, training manuals (10), flow charts (24) and supply of forms for 5 years.

Annual training of interns 12-15.

- 1.2.** Private labs about 24 persons. 2-day workshop. Same calculation as above.
Private physicians. 2 CME sessions, one in GT one in NA. Approx. 50 persons/sees. Evening sessions. Provide a substantial snack
For NA session 4 persons to travel to NA from GT. Calculate for travel and overnight accommodation.

ER 2. 2.1. 4 BSS surveys specified groups x US \$ 25, 000 each + generalized population by US\$ 50,000. For 2 years

2.2 4 studies coming out of 2.1. at US\$ 25, 000 each

2.3 Seroprevalence study among CSWs and MSMs. US\$25,000 each. (seroprevalence among ante natal women will be done as part of PMTCT programme)

ER. 3 3.1. Workshops each years x 5 years , x 2 sessions /year x 40 persons. Calculate about 20 from out of town.

- 3.2.** One day working lunch for 12 persons
3.3. 1 one-day workshop 40 persons. About 20 Out of town
3.4. Same as 3.1.
3.5. Two day meeting- working lunch 12 persons
3.6. Call CAREC
3.7. 4 meetings, working lunches x 12 persons

ER 4. 4.1. Equipment and reagents for 5 years) check with lab. Director

4.2. 4 annual sessions starting 2003 x 25 persons

4.3. No cost. Should be part of cot of equipment

Care and Treatment

- ER1. 1.1.** 2 persons doing the assessment, 2 days in each Region, per diem + travel.
- 1.2.** Cost of CD counter approx. US\$ 35,000+ 10% shipping and handling + cost of reagents for 5 years + per diem for installation
- 1.3.** & **1.4.** Training 1 week (approx. US\$5,000)
- 1.5.No cost.** Will be done at same time as lab. Training under Surveillance
- 1.6.** Cost of incubators, safety cabinet, and reagents for 5 years. Microscopes, slides, cover slips etc.
- 1.7.** Base line survey GC sensitivity approx. US\$ 7,000

ER 2. 2.1. Same as for **1.1.**

- 2.2.** And **2.3.** 12 persons 2 day working lunches each
- 2.4.**Cost of production of 100 training manuals
- 2.5.** 4 day consultancy-per diem + US\$150 per day (first year training only). Add cost of venue x 2 days x 30 persons (public sector) per day (snacks and meals). Add 2 day weekend session for about 50 practitioners each in NA and GT. Annual refreshers for trainers x 10. Annual Regional updates by national trainers in Regions, 2, (3&4), (5&6), and 10.
- 2.6.** 2 2-day sessions one in Berbice and one in GT for about 50 physicians each
- 2.7.** Calculate 100 persons on treatment, pre treatment + 6 months later (CD4 and viral load).
- 2.8.** & **2.9 No cost**

ER 3. 3.1. Focus group discussions 12 persons, (approx US\$ 1,000 per session) in Rs. 1,2,3,6, 7, and 10. + transportation and accommodation and meals for 2 persons. Snacks for group sessions. Conduct sessions over a 3-year period.

- 3.2.** 2-day workshop x 30 persons – 2 each from smaller Regions and 3 from larger Regions. Include PLWHA from Regions 2, 6,7 and 10. Add transportation and per diem to cover cost of accommodation and meals.
- 3.3.** Cost of bringing 2 persons from Trinidad 3 days + 2 day working lunches.
- 3.4.** First year 50 persons total, about 30 from 6 Regions. Annual update x 3

ER-4. 4.1. & 4.2. One consultancy – 3 weeks (social sciences background)

4.3.3-day workshop x 30 persons. Venue snacks and lunch. (All participants based in Georgetown)

- 4.4.** 6 Regions x 1-day workshops. Approx 30 persons. Travel, and per diem for 2 persons to conduct workshops.
- 4.5.** Printing of posters, pamphlets, and other IEC materials.
- 4.6.** 6 main Regions, 1-day sessions. Provide for snacks and lunch. Approx 12 persons.
- 4.7.** No cost. To be done in conjunction with 3.2.
- 4.8.** To be carried out in 6 Regions x 4 days x 20 persons.

ER 5. 5.1. 1 month contract, 3 days per Region. Travel and per diem (accom. and meals)

- 5.2.** (75 sites). Approx 20,000 tests per year x 5 years, + 4,100 for blood bank + 10% ELISAs.
- 5.3.** Train trainers (2) from each Region. 2-day workshop.

- 5.4. 1 day x 12 persons working lunch
- 5.5. Same as for 4.8.
- 5.6. Approx US \$ 25,000

ER 6. 6.1. Contract one person per Region to document ANC services and their needs. 2 weeks. Hold 2 one-day workshops for training in use of assessment tool and for presentation of report.

6.2 and 6.3. No cost

- 6.4. 1-day meeting 30 persons. Working lunch
- 6.5. 2 sessions per year x 30 persons x 5 years
- 6.6. Campaign US\$ 25,000

Risk Reduction

ER 1. 1.1. & 1.2. US\$ 25,000

- 1.3. 1-day meeting about 30 persons (reps. from each denomination)
- 1.4. 7 one-day meetings, 30 persons each (different denominations)
- 1.5. US\$ 15,000

ER 2. 2.1. Contract for 1 month. US\$ 25,000. Includes cost of travel to Regions.

- 2.2. No cost
- 2.3. US\$ 20, 000. Includes travel to Regions.
- 2.4. 7 Regional 2-day meetings, about 10 persons. Plus 3-day visits for 7 persons to Trinidad, Bahamas and Jamaica to see successful programmes in action
- 2.5. US\$ 80,000 (inauguration of services)
- 2.6. Staff training US\$ 20,000
- 2.7. No cost
- 2.8. US\$ 25,000

ER3. 3.1. 2-day workshops in Regions 2,(3&4), (5&6), 7& 10 x 25 participants each

- 3.2. US\$ 20,000
- 3.3. Approx. 30 persons. US\$ 10,000

ER 4. 4.1. US\$ 25,000

- 4.2. Contract US\$10,000
- 4.3. Survey and design - US\$ 25,000
- 4.4. 1-day meeting – 25 persons
- 4.5. US\$ 5,000
- 4.6. US\$25,000
- 4.7. US\$25,000
- 4.8. US\$10,000

ER 5. 5.1. & 5.3. US\$15,000

- 5.2. US\$ 1,000

Management

ER 1. 1.1. No cost

1.2. & 1.3. 7 sessions in Regions 2,3,4,5,6,7 & 10,- 3 days each. Travel, lunch and accommodation for 2 persons to conduct training in the Regions + workshop costs.

1.6. 7 Ministries (Health, Education, Culture, Youth and Sport, Labour, Home Affairs, Local Government, Human Services and Social Security), 3 days each, approx 10 persons – snacks and lunch.

1.7. US\$ 500

1.8. US\$1,000

1.9. Contract (1 month-6 weeks) US\$ 10,000

1.10. No cost

ER 2. 2.1. 2.2 and 2.3. One month consultancy each (or one 3-month)

2.4. 2-day meetings in Regions 2,4, and 6. 20 persons.

2.5. ILO code of practice. US \$ 5,000

2.6. 2-day meeting about 50 persons

ER 3. 3.1. Socio-economic impact study US\$ 30,000

3.2. & 3.3. No cost

3.4. Eight breakfast sessions, approx 25 persons per session. Travel for 2 persons to Regions 2,3,6,7 & 10 and if necessary over night accommodation in Regions 6 and 7. (?? Lunch meeting for Region 10) May need 3 sessions in Region 4. Cater for these meetings annually for reporting.

Summary of Budget Estimate

Component	Subtotal	Component Total
Surveillance		
ER 1	\$56032000	
ER 2	\$80120000	
ER 3	\$193306000	
ER 4	\$493864000	\$823322000
Care and Treatment		
ER 1	\$862812000	
ER 2	\$2023646000	
ER 3	\$18192400	
ER 4	\$21200000	
ER 5	\$809914800	
ER 6	\$22318000	\$3758085200
Risk Reduction		
ER 1	\$17048000	
ER 2	\$79018000	
ER 3	\$14504000	
ER 4	\$63980000	
ER 5	\$10046000	\$184596000
Management		
ER 1	\$1086500	
ER 2	\$15950000	
ER 3	\$19500000	\$36536500
Grand total		\$4802535700