Ministry of Health

HIV/AIDS Behaviour Change Communication
Strategy for Guyana 2006-2010

Family Health International
USAID
From the American People
# Table of Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acknowledgements</td>
<td>3</td>
</tr>
<tr>
<td>Acronyms</td>
<td>4</td>
</tr>
<tr>
<td>Introduction</td>
<td>5</td>
</tr>
<tr>
<td>Executive Summary</td>
<td>6 - 13</td>
</tr>
<tr>
<td>Section One: Behavior Change Communication: Definition and Role</td>
<td>14</td>
</tr>
<tr>
<td>Section Two: Background</td>
<td>15 -19</td>
</tr>
<tr>
<td>Section Three: Prioritized Populations</td>
<td>20 - 26</td>
</tr>
<tr>
<td>Section Four: Behavior Change and Behavior Change Communication: Theory, Guiding Principles and Steps for Strategy Development</td>
<td>27 - 35</td>
</tr>
<tr>
<td>Section Five: Gaps for Future Programming</td>
<td>36 - 38</td>
</tr>
<tr>
<td>Section Six: Partnerships for a Comprehensive Response</td>
<td>39 - 40</td>
</tr>
<tr>
<td>Section Seven: Monitoring and Evaluation</td>
<td>41</td>
</tr>
<tr>
<td>Section Eight: The Strategy Development Process and Next Steps</td>
<td>42 - 44</td>
</tr>
<tr>
<td>Contacts</td>
<td>45 -46</td>
</tr>
</tbody>
</table>

**Appendices**

- **Appendix A** – Suggested Objectives, Indicators, Program Areas and Activities per Priority Target Population
- **Appendix B** -- The media landscape in Guyana (TV, radio, print )
- **Appendix C** – Analysis of Specific Past BCC Interventions/Campaigns
- **Appendix D** – Advantages and Disadvantages of Different Types of Communication Channels and Activities
- **Appendix E** – MOH Surveys and Studies
- **Appendix F** – Timeline
- **Appendix G** – Tips for Developing Mass Media Campaigns
- **Appendix H** – Summaries of Organizations Working in the field of HIV/AIDS in Guyana
## Acknowledgements


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<table>
<thead>
<tr>
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### Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tr>
<td>AIDS</td>
<td>Acquired Immunodeficiency Syndrome</td>
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<tr>
<td>AIS</td>
<td>AIDS Indicator Survey</td>
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<tr>
<td>ANC</td>
<td>Antenatal Care</td>
</tr>
<tr>
<td>ART</td>
<td>Antiretroviral Therapy</td>
</tr>
<tr>
<td>ARV</td>
<td>Antiretroviral</td>
</tr>
<tr>
<td>BCC</td>
<td>Behavior Change Communication</td>
</tr>
<tr>
<td>BCI</td>
<td>Behavior Change Interventions</td>
</tr>
<tr>
<td>CAREC</td>
<td>Caribbean Epidemiology Centre</td>
</tr>
<tr>
<td>CARICOM</td>
<td>Caribbean Community</td>
</tr>
<tr>
<td>CRN+</td>
<td>The Caribbean Regional Network of People Living with HIV/AIDS</td>
</tr>
<tr>
<td>CRS</td>
<td>Catholic Relief Services</td>
</tr>
<tr>
<td>DFID</td>
<td>The Department for International Development</td>
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<tr>
<td>EU</td>
<td>European Union</td>
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<tr>
<td>GOG</td>
<td>Government of Guyana</td>
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<tr>
<td>GRPA</td>
<td>Guyana Responsible Parenthood Association</td>
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<tr>
<td>HSDU</td>
<td>Health Sector Development Unit</td>
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<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<tr>
<td>ILO</td>
<td>International Labour Organisation</td>
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<tr>
<td>MOH</td>
<td>Ministry of Health</td>
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<tr>
<td>MOL</td>
<td>Ministry of Labour</td>
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<tr>
<td>MTCT</td>
<td>Mother-to-Child Transmission of HIV</td>
</tr>
<tr>
<td>NAPS</td>
<td>National AIDS Programme Secretariat</td>
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<tr>
<td>NGO</td>
<td>Non-Governmental Organization</td>
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<tr>
<td>OVC</td>
<td>Orphans and Other Vulnerable Children</td>
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<tr>
<td>PANCAP</td>
<td>The Pan Caribbean Partnership Against HIV/AIDS</td>
</tr>
<tr>
<td>PAHO</td>
<td>Pan American Health Organisation</td>
</tr>
<tr>
<td>PLHA</td>
<td>Persons Living with HIV/AIDS</td>
</tr>
<tr>
<td>PMTCT</td>
<td>Prevention of Mother-to-Child Transmission</td>
</tr>
<tr>
<td>STD</td>
<td>Sexually Transmitted Disease</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually Transmitted Infection</td>
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<tr>
<td>VCT</td>
<td>Voluntary Counseling and Testing</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
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<tr>
<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
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<td>USAID</td>
<td>United States Agency for International Development</td>
</tr>
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Introduction

This National BCC Strategy for HIV/AIDS for Guyana has been developed at the request of the Ministry of Health (MOH) of the Government of Guyana (GOG,) with support from the United States Agency for International Development (USAID) through its implementing partner, the Guyana HIV/AIDS Reduction and Prevention Project.

This strategy supports the goals and objectives of the Government of Guyana’s 2006-2010 National HIV/AIDS Strategy, which include:

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

Other priorities of the GOG addressed by this Strategy include:

- To promote behavior change and maintenance of positive behaviors to reduce risk and the spread of HIV
- To build a comprehensive response to HIV/AIDS, addressing prevention, care, support and treatment
- To follow the “3 ones” principles established by the international community:
  - One coordinating mechanism
  - One strategic plan
  - One monitoring and evaluation system
- To provide scientifically sound data to support and guide the response
- To strengthen surveillance, monitoring and evaluation of HIV/AIDS program components, including BCC interventions

This document was developed through a consultative process involving governmental and non-governmental partners, donors and consultants in Guyana from June to August 2005.
Executive Summary

This strategy is intended to serve as a practical tool for an effective response to HIV/AIDS in Guyana. In particular, the document provides:

1. **A National BCC strategic framework** – The framework (below) illustrates the broad programmatic areas that should be integrated for a comprehensive response to HIV/AIDS in Guyana
2. **Overarching strategic elements including prioritization of target populations** that are at highest risk and most vulnerable to the impact of HIV/AIDS. Also, specific strategic elements that should be included in any specific population focused BCC strategy
3. **Summaries of organizations** funding and/or implementing HIV/AIDS programs in Guyana
4. **Analysis of previous experience in BCC** in Guyana in the area of behavior change communication (BCC) – successes, challenges and lessons learned to date
5. **Theory, guiding principles and steps for strategy development** for the development of BCC strategies that support a comprehensive response to HIV/AIDS in the areas of prevention, care, support and treatment
6. **Gaps and next steps** – programmatic gaps, next steps and timeline for addressing these

In effect, this strategy serves as a “roadmap” for an effective response, to guide the GOG, donors and other stakeholders in a transparent process of planning appropriate and timely BCC interventions in a coordinated way. The goal is to improve coordination of BCC interventions, reduce duplication and maximize resources brought to bear.

This strategy does not suggest specific themes or messages. These would require specific processes based on formative assessments and development of creative concepts on a population-by-population basis. (See page 31 for discussion of theme and message development.)

**Behavior Change Communication Defined** -- Behavior Change Communication (BCC) is an interactive process with communities, integrated into overall programs, to develop tailored messages and approaches using a variety of communication channels and activities, to develop and sustain positive behaviors and to promote and sustain behavior change. BCC functions on at least three major levels: 1) Interpersonal communication/counseling; 2) traditional and small media, advocacy, community/social mobilization, social marketing; and 3) mass media.

**National BCC Strategic Framework** -- The framework below illustrates the areas that should be integrated for a comprehensive response to HIV/AIDS in Guyana:

Contribute to Goals and Objectives of the GOG National Strategic Plan

The main components of each program area include:

- **Prevention/Risk Reduction** – “ABCD” (Abstinence, Be Faithful, Condoms and (avoiding) Drug abuse) prevention programming; promotion, (including social marketing,) of counseling and testing and prevention of mother-to-child transmission (PMTCT) services; interpersonal communication/counseling (IPC/C), workplace prevention programs, links with private sector initiatives. Stigma and discrimination reduction should be integrated into all prevention/risk reduction programming

- **Care, Support and Treatment** – Counseling and testing; prevention of mother-to-child transmission, anti-retroviral therapies; home-based care/palliative care; treatment of opportunistic infections, including tuberculosis; PLHA support/empowerment; IPC/C at facilities; reduction of stigma and discrimination in all Interventions

- **Community Response/Impact Mitigation** – Community mobilization, PLHA support and empowerment; programs for orphans and other vulnerable children; home-based care/palliative care; IPC/C; reduction of stigma and discrimination

- **Creation of an Enabling Environment** – NGO/FBO/CBO programs; reduction of stigma and discrimination; policy-related advocacy; workplace/private sector programs; links to economic/social programs

Mass media, Interpersonal Communication/Counseling, Traditional/Small Media, Community/Mobilization, Advocacy
**Overarching Strategic Elements**

The strategic elements below are intended to offer broad parameters for all BCC interventions undertaken in Guyana:

**Goal of the strategy** – The goal of the National BCC Strategy for Guyana is to support the goals of the National Strategic Plan for 2006-2010:

- 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;
- To reduce the social and economic impact on individuals and communities.

In addition, the National BCC Strategy aims to include well-designed BCC interventions wherever possible to support these goals, particularly among the populations prioritized and described herein. Please note that a revised National HIV/AIDS Strategy for 2006-2010 is under development by the MOH, but is not yet available. As a result, there may be some minor inconsistencies in this draft National BCC Strategy.

**Priority target populations.** An effective strategy should address the populations that are most active in transmitting HIV or most vulnerable to infection. Stakeholders and programmers should consider the following prioritization in deciding on which target population(s) to address. The rationale for prioritization below is based on available data concerning rates of prevalence, behaviors or potential for being involved in risk activities, on the role of some groups as “bridge” populations to other groups, and on vulnerability to HIV/AIDS.

**NOTE:** Please See Section Three for further rationale/details.
In order of urgency, these populations are:

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<thead>
<tr>
<th>Population</th>
<th>Rationale for Prioritization</th>
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<tr>
<td>1. Female commercial sex workers (FSWs)</td>
<td>26*-45% prevalence; 28%* positive marker for syphilis; Only 54% ever tested for HIV</td>
</tr>
<tr>
<td>-Clients of FSWs</td>
<td>Bridge population to general population</td>
</tr>
<tr>
<td>-Regular/intimate partners of FSWs</td>
<td>Low condom use (46%)* among non-paying partners of FSWs</td>
</tr>
<tr>
<td>2. Men who have sex with men</td>
<td>21%* seroprevalence; low rates of self risk assessment (63%); high rates of commercial sex (60%* in last 6 months.) Only 70%* rates of condom use at last sex with regular partner</td>
</tr>
<tr>
<td>Female partners of MSM</td>
<td>Vulnerable to undisclosed MSM activities of partners.</td>
</tr>
<tr>
<td>3. People living with HIV/AIDS (PLHA) and those affected by HIV/AIDS</td>
<td>Approx. 20,000 in country. Lack support/access to services. High rates of stigma/discrimination keep them in shadows. Estimate: 80% of PLHA do not know they are PLHA.</td>
</tr>
<tr>
<td>(PLHA)</td>
<td></td>
</tr>
<tr>
<td>4. Orphans and other vulnerable children (OVC, including street children)</td>
<td>Widely underserved population</td>
</tr>
<tr>
<td>5. STI patients/clients</td>
<td>Male – 15.1%; female – 12%. National Strategic Plan 2002-2006</td>
</tr>
<tr>
<td>6. Health care workers</td>
<td>Believed high stigma/discrimination; fail to provide confidentiality; lack commodities for universal precautions</td>
</tr>
<tr>
<td>7. Policy makers</td>
<td>Need to have insight of the rights of PLHA/OVC and HIV/AIDS overall.</td>
</tr>
<tr>
<td>9. Mobile populations (miners, loggers, construction workers)</td>
<td>Believed high contact with CSWs and interior populations; low health-care seeking; 3.9% seroprevalence among miners (unpublished data 2004, MOH)</td>
</tr>
<tr>
<td>10. In-School youth</td>
<td>63%* sexually active. Transactional sex motivated by material need</td>
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*Note: Data cited are based on a recent presentation of preliminary BSS data and are subject to change

Additional populations include the **General Population**, among whom prevalence is between 2.5% and 5.5%. Primary mode of transmission is heterosexual, but there is anecdotal evidence of undisclosed bisexuality among men. Two population groups require further study to confirm anecdotal risk behaviors and vulnerability. **Interior populations** including Amerindians are an underserved group who lack access to services and appear to have significant transactional sexual contact with mobile populations. **Prisoners:** although there are only about 3000 prisoners in
Guyana, they are believed to have high rates of alcohol/drug abuse and possible MSM activity. A fourth group, should also be considered: members of the uniformed services. They are believed to have high rates of CSW contact, alcohol abuse, multiple partners, STDs and possibly MSM activity.

**Objectives** – Specific objectives and indicators per priority population will vary. Each BCC strategy per specific population should include analysis of current behaviors/desired behaviors based on formative research and a range of other parameters. (See population summaries on Chart Section Three, page 22 for further details.) **Illustrative behavioral objectives, indicators, to guide BCC strategies in Guyana are included in Appendix A.**

**Specific Population-Based Strategic Elements** -- Each BCC strategy developed for specific populations should include certain specific elements that depend on analysis of that population. These include behavioral determinants (barriers and motivating factors), key benefit statements, themes, messages, selected channels and activities. Channels and activities may include mass media, interpersonal communication/counseling, small/traditional media, Community Mobilization, Advocacy, Social Mobilization and Social Marketing. **Illustrative program areas and activities to guide BCC strategies in Guyana are included in Appendix A.** Appendix D offers a summary analysis of the benefits and challenges of using particular channels/activities.


**Analysis of Previous Experience in BCC** – Overall, BCC for HIV/AIDS programs has had some notable successes in Guyana. Particular interventions have been developed in a participatory fashion, involving target populations, community stakeholders and to some extent, PLHA. Some BCC to date has been based on formative assessments and has been well targeted to specific populations. Interventions have succeeded in raising awareness, stimulating community discussion and in some cases, leading to behavior change. However, communication activities have been generally ad hoc in nature, consisting of various discreet, uncoordinated, and in some cases duplicative interventions, usually limited in scope and time, and thus having limited impact.

This National BCC Strategy presents information and analysis to guide and coordinate BCC efforts supported by the various donors that have been active in Guyana in recent years.

**Theory, guiding principles and steps for strategy development** -- This Strategy also offers analysis of behavior change theories that should be applied when developing BCC strategies. The document recommends a mixture of individually-focused and contextually focused theories, the application of which will vary depending on the specific population targeted.
Gaps for The Future Response to HIV/AIDS -- Based on stakeholder feedback, this strategy assesses programming gaps to guide future decision making. In particular, research gaps are assessed since further data is needed to inform well-targeted population approaches. Gaps identified to guide future BCC include:

- **Lack of adequate data** – The main challenge to HIV/AIDS Programs in Guyana (See “Research Gaps, below)
- **Orphans and Other Vulnerable Children** -- Lack access to food, education, medical and emotional care. High stigma/discrimination, especially among those infected/affected.
- **Anti-Retroviral Therapies** – BCC needs to support this growing program area with comprehensive strategy, support materials, creation of enabling environment for ART
- **Home-Based Care/Palliative Care** – Need comprehensive approach, support materials, creation of enabling environment.
- **Ongoing Reduction of Stigma and Discrimination** – Needed as part of enabling environment for ALL components of HIV/AIDS programs. Briefly, these interventions to reduce stigma and discrimination can include:
  a. Information dissemination
  b. Coping skills acquisition/”imaging” peer education exercises
  c. Counseling approaches/support groups
  d. Contact with PLHA
  e. Monitoring and addressing human rights violations
  f. Training and sensitization of providers, staff, media
  g. Building service delivery capacity
  h. Monitoring, evaluating, documenting and reporting on all the above

(See page 37 for a discussion about the relevance of and more on suggested approaches for reducing stigma and discrimination in the context of HIV/AIDS programs in Guyana.)

- **Addressing the “D” (Drugs/Alcohol Abuse)** – High rates of alcohol/drug abuse accompany high-risk sexual activities
- **Sexual abuse/gender issues** – Poorly understood but believed deeply engrained and widely practiced sexual abuse and inequalities enable early first sex, transactional sex, HIV/STD transmission
- **Links to economic opportunity/income** – lie at the basis for transactional sex, vulnerability of children/women to HIV/STD transmission

The Role of Non-governmental Organizations – Non-governmental organizations (NGOs), faith-based organizations (FBOs), and other community-based organizations (CBOs) have played and continue to play a vital role in the response to HIV and AIDS in Guyana. An effective response to HIV/AIDS must continue to involve them. The best approach will include collaboration between the GOG and the NGO/FBO/CBO community.
This strategy does not intend to describe the specific ways NGOs and other CBOs should respond to HIV/AIDS in Guyana, nor is it designed to prescribe the kinds of collaborations or partnerships that should continue to grow between NGOs/FBOs/CBOs and the GOG, donors and other stakeholders. Rather, NGOs/FBOs and CBOs should use this strategy as a way to understand the populations and program areas where their important work can continue to make a difference. The exact role of NGOs/FBOs/CBOs will continue to be determined based on various factors including community needs, the evolving role of faith-based organizations, the strength of NGO/FBO/CBO relationships with the GOG and the support and direction of outside donor funding.

Some key areas of BCC where NGOs/FBOs/CBOs can be especially effective include:

- Community-based interventions including peer education and outreach, community theater, town hall meetings, participation in “Mashramani” “Diwali” and other traditional celebrations, rituals and events, theater, drama and music events
- Providing referrals to community members seeking HIV testing, treatment, prevention, care and support services
- Implementing support groups, counseling and other support services for HIV negative and HIV positive people
- Advocacy at local level to engage community political, religious and other leaders in HIV/AIDS programs and interventions
- Providing support to orphans and other vulnerable children (OVC)
- Providing support and outreach to PLHA and those affected
- Developing local media programs and promoting local events through local media
- Reaching vulnerable populations such as MSM, CSWs and others through community networking and providing tailored services to these and other hard-to-reach populations

Research Gaps -- Research Gaps include:

1. **Men Who Have Sex With Men (MSM)** – Poorly understood; Seroprevalence above 21% (Source: presentation of preliminary BSS data)
2. **Economic Impact Study** – A valuable advocacy tool for reaching policy makers and employers
3. **PLHA Health Services, Care and Support Assessment; Policymakers (attitudes, etc.)** – High levels of stigma, discrimination and lack of confidentiality believed at facility level. These hinder uptake, behavior change, adherence
4. **Ethnic factors** – Includes Indo-Guyanese culture, other cultures’ attitudes, practices, etc. Separate study or integrate into various others
5. **Clients of CSWs** – Important bridge populations to the general population. Hard to reach and poorly understood.
7. **Interior populations, including Amerindians and People of Mixed Race** – Anecdotal evidence of high-risk behaviors. These populations are vulnerable due to lack of access to health care and other services.

8. **Prisoners** – May be involved in high rates of MSM activity, drug and alcohol abuse and sexual violence.

9. **Media Landscape plus advertising; PR; printing companies’ capacity** – Reach of mass media cannot be measured and planned in cost-effective ways.

10. **Physical and sexual abuse** – Violence against children/women, incest, rape and abuse fuel HIV transmission and vulnerability. Anecdotal evidence suggest that these practices are widespread, but further study is needed.

**Next Steps Recommended** -- Next steps include:

1. **Proposed National BCC Advisory Committee** -- This document proposes that a National BCC Advisory Committee be formed by the Government of Guyana to report to the Presidential Commission on AIDS to provide ongoing oversight, coordinate BCC, ensure standards and principles are applied across all BCC interventions in Guyana and support flexible programming in accordance with changing needs. See Section page 39 for Proposed Terms of Reference.

2. **Follow-up Meeting Proposed** – A meeting of stakeholders to review the latest draft of the National BCC Strategy has been proposed for Thursday, August 11th, 2005
Section One

Behavior Change Communication: Definition and Role

Behavior Change Communication is an interactive process with communities, integrated into overall programs, to develop tailored messages and approaches using a variety of communication channels and activities, to develop and sustain positive behaviors and to promote and sustain behavior change. BCC functions on at least three major levels: 1) Interpersonal communication/counseling; 2) traditional and small media, advocacy, community/social mobilization, social marketing; and 3) mass media.

The Role of BCC – BCC should be designed and implemented to:

- Support the entire continuum HIV/AIDS prevention, care, treatment and support interventions (see Appendix E)
- Deliver consistent messages through multiple interventions, channels and activities for maximum effectiveness
- Promote behavior change and maintenance of positive behaviors in conjunction with services and commodities
- Advocate for improved legislation, policies and protocols to support PLHA and HIV/AIDS programs
- Mobilize and engage communities in support of HIV/AIDS program goals and objectives
- Promote commodities and services
- Stimulate dialogue at interpersonal, community and national levels
- Increase knowledge, concern and motivation to change behavior and/or maintain positive behaviors
- Promote reduction of stigma, fear, and discrimination

BCC is strategic, which means it is most effective when it:

- Integrates within a comprehensive program
- Links program elements
- Includes effectively designed messages, materials, activities for specific target populations
- Utilizes the right combination of channels and activities
- Is developed and implemented using certain essential steps (See page 30.)
Section Two

Background

HIV/AIDS history in Guyana

The first case of HIV/AIDS in Guyana was detected in 1987. At the time, there were few resources in country to deal with HIV/AIDS. There were few cases through 1991 and little attention paid to the disease through that time.

The period following 1991 saw a steady increase in incidence, with a greater number of cases among men then women. Small studies by local agencies, combined with estimates by UNAIDS, estimated that 75% of cumulative cases of HIV/AIDS between 1989 and 2000 were among Guyanese between ages 20 and 44.

By 2001, Guyana was generally regarded as ranking second in the Caribbean Region in HIV/AIDS prevalence. Prevalence among commercial sex worker respondents in small studies was as high as 45%. UNAIDS estimated that 75% of those infected were between 15 and 35. In addition, it was estimated that 80% of those infected in Guyana did not know that they were infected with HIV.

During the period 2001-2005, UNAIDS estimated that the epidemic had become more generalized, roughly 2.5% at the end of 2004 (UNAIDS).

GOG data from the 2002-2004 National Strategic Plan put the AIDS cases in the 15-19 age group of females at 60% and has confirmed continued 45% HIV seroprevalence among CSW. In addition, unpublished data, MOH, 2004 preliminary BSS data show 15% HIV seroprevalence among patients with STIs; 3.9% HIV seroprevalence among miners.

HIV transmission appears to be predominantly heterosexual. However, there is anecdotal evidence of widespread & undisclosed bisexuality.

The Response Overall

In 1989, the National AIDS Programme Secretariat (NAPS) was initiated under the Ministry of Health and the National AIDS Committee (NAC) 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.

Recent activities have been developed and implemented by the Health Sector Development Unit (HSDU) of the MOH, and the NAPS – generally educational messages and ad hoc activities promoting condom use and prevention. Activities were generally
intended for the general population, although some were intended for youth. There was little monitoring and evaluation of these early responses.

At the non-governmental level a small group of “activists” lead the community-based response throughout the 1990’s. The first non-governmental organizations committed to HIV/AIDS prevention began their programs from the mid-nineties onward.

The situation for people living with HIV/AIDS has been difficult and remains a challenge for Guyana. Stigma and discrimination against PLHA is considerable. At the policy level, a 1934 ordinance that gives neighbors the right to have a diseased person removed from their neighborhood remains on the books.

Particular areas of concern include confidentiality at service-delivery, employment and educational levels, anti-discrimination policies, and guarantees of quality services at all levels for PLHA. There are many disheartening anecdotes, but no formal studies/assessments have been done. This is a research gap identified by this strategy to be filled.

Services for testing and treatment have until recently been confined to the Genito- Urinary Medical clinic (GUM). However uptake at the clinic may have been limited owing to stigma, since patients attending the clinic were associated with HIV/AIDS. Until recently, ART was not available to PLHA. However, in 2002, the GOG began making anti-retroviral drugs, making them available to PLHA who presented with at least two symptoms/opportunistic infections.

The BCC Response

Over the last 6 years, several “turning points” stand out that have strengthened and/or can continue to strengthen Guyana’s capacity to respond to HIV/AIDS and to develop effective BCC interventions. These include:


The Guyana HIV/AIDS/STI Youth Project (1999-2004) -- Successes include its Steering Committee (has met monthly for over 5 years); well targeted messages, strong, locally developed peer education, and popular mass media campaigns: “Ready Body is it Really Ready” (2001-2003) and “Words Have Power” (2004) which featured well targeted “ABCD” prevention messages and messages promoting reduction of stigma and discrimination. Target populations included out-of-school youth in organized settings, “limers” and mini-bus drivers and conductors, ages 8 to 24. The project steering committee has evolved
into the NGO Coordinating Committee. The project was also guided by a five-year BCC strategy.

The Government of Guyana PMTCT program (2002-2003). The program established PMTCT services for women in 8 clinics, offering the anti-retroviral drug “nevirapine” for the first time in Guyana. The program laid the groundwork for the current expanded PMTCT program.

The USAID/PEPFAR 1.5 PMTCT Initiative (Began in 2003) -- The program expanded PMTCT services to 37 clinics in 6 regions of Guyana. A key success has been increased acceptance of testing among attending ANC women from 67% to 80%. On the BCC front, an innovative package of client-provider BCC materials “PMTCT Is Everybody’s Business” is a first of its kind and has received recognition at the global level.

Anti-Retroviral Drugs First Offered by GOG -- The GOG began manufacturing anti-retroviral drugs locally in 2002.

“Me To You-Reach One, Save One” -- The GOG/Health Promotion Unit (HPU) prevention campaign promoting the “ABCs” of prevention “Me to You-Reach One, Save One” was launched in 2004. The campaign included mass media and the formation of health clubs in schools to provide HIV/AIDS-related information. By December, 2004, the campaign had reached 55% of its target of 100,000 pledges to “take immediate action to prevent the spread of HIV and to respect persons living with HIV and AIDS.”

USAID/Population Services International (PSI) -- From January 2003-December 2004, PSI implemented social marketing for STI/HIV/AIDS prevention in Guyana among groups practicing high-risk behavior through promoting the “ABCs” of prevention, increased self-risk perception and risk management, and socially marketing VCT services and condoms. The project established a network of VCT services including four franchise sites, one stand-alone site, and a mobile unit under the “New Start” brand. The project provided training to MOH and NGOs to enhance VCT services; launched the “Vive” brand condoms nationally, and established BCC campaigns focusing on the ABC approach. The project also provided technical support to the MOH “Me To You – Reach One, Save One” campaign.

USAID-GHARP -- The Guyana HIV/AIDS Reduction Project (GHARP) began in 2004, including 34 million for the period 2004-2009. Includes multiple BCC approaches for prevention, care, support and treatment interventions

UNFPA HIV/AIDS project -- The campaign was launched in 2004. Included TV and radio spots promoting safe sexual practices as a means of good reproductive health. Need more on this.
BCC Successes and Challenges Overall

Following are summaries of the successes, challenges and lessons learned through BCC interventions carried out in recent years in Guyana. More specific analysis of interventions can be found in Appendix E.

Successes of BCC in Guyana

Overall, the BCC response in support of HIV/AIDS programming in Guyana has had some notable successes, much of it has been developed in a participatory fashion at the community and mass media levels. Interventions, messages and materials have to a certain extent been well targeted to specific, well-defined populations. Interventions have been good at raising awareness and stimulating community discussion. Some have lead to behavior change. Specifically:

- BCC has been developed with the inclusion of target populations, PLHA and other stakeholders
- Some specific interventions have been well targeted (Ready Body; Words Have Power; PMTCT Is Everybody’s Business)
- BCC has been especially effective in reaching and engaging populations at the community level
- BCC has been particularly effective on the interpersonal level, guided by strong peer education training, supported by strong peer education guides (Bodywork I and II), effective blending of peer education with theater/drama
- BCC under the Guyana HIV/AIDS/STI Youth Project has been coordinated through a Steering Committee which has met monthly over 5 years and which has evolved into the NGO Coordinating Committee.
- The Guyana HIV/AIDS/STI Youth Project was guided by a written, 5-year BCC strategy
- The Youth Project was guided by a small study assessing knowledge, attitudes and practices (KAP) of a limited number of Youth

Challenges to BCC in Guyana

However, BCC has also been generally ad hoc in nature, consisting of often discreet, uncoordinated, and in some cases duplicative interventions. Interventions have tended to be limited in scope and time, and thus impact.

- There has been no national BCC strategy in Guyana to coordinate BCC efforts
- BCC interventions in Guyana have thus generally consisted of various discreet, uncoordinated, and often duplicative programs and activities
- BCC interventions over the years in Guyana have achieved high awareness, but have generally failed to achieve significant behavior change
- Some interventions have not been based on formative research
- Quantitative data have been lacking in Guyana until recently
- Due to the small media context of Guyana, targeting specific groups can have a significant spill-over effect. This means that large numbers of unintended populations, not targeted by mass media, will receive and potentially misinterpret BCC messages not intended for them
There has been a lack of monitoring and evaluation of BCC interventions

Rural populations have been under-reached. These include Indo-Guyanese populations and Amerindians

Most agencies implementing BCC have had no written HIV/AIDS communication strategy or plan, thus no BCC strategic plan

Many agencies have produced generic interventions, messages and materials
Section Three

Prioritized populations

Certain key populations are understood to play important roles in the transmission of HIV in Guyana. Any effective strategy must include targeted efforts to address these. In most cases, they have high rates of HIV among them, but they also serve as “bridge” populations to other groups. The following offers brief assessments of primary modes of transmission, related behaviors, contextual factors, etc. based on available data and anecdotal information. It is hoped that the information below, will lead to improved prioritization by programs, particularly BCC interventions.

1a. Commercial Sex Workers (CSWs) -- FSWs are a top priority for the GOG for several reasons: 
   A) A presentation of preliminary BSS data found prevalence among Female Sex Workers to be at 26%. The same data found 28% of FSW respondents had a positive marker for syphilis. Syphilis and other STDs are known to facilitate HIV transmission; 
   B) Clients of sex workers are at considerable risk for HIV transmission. They serve as a bridge group to the general population. Reaching them can be done in the most targeted, effective manner through the CSWs themselves. 
   C) According to a presentation of preliminary BSS data, while condom use with last paying partner was almost 90%, condom use at last sex with non-paying partners was just 46%.

Although FSWs show high knowledge of condoms and high risk assessment, consistent use of condoms with paying clients is only 74%. Condom use is likely dependant to a certain extent on a FSW’s economic situations at a given moment. “Dying tomorrow of AIDS is better than dying today or hunger.” Small studies and anecdotal reports suggest that most FSWs are in their profession based on economic need, are likely to have self esteem issues and are negatively impacted by stigma and discrimination. They therefore are reluctant to seek health care and/or discuss their problems, including HIV/STIs, with others. A presentation of preliminary BSS data showed that only 54% of FSWs surveyed had ever had an HIV test. Some qualitative assessments suggest that FSWs value stability, family, and the future of their children. These factors should be considered when developing BCC interventions intended for them.

Although 76% of FSWs said they know someone who is HIV+, over 30% said they thought mosquitos transmit HIV.

There are no data available on male sex workers. However MSWs should be considered a top priority for additional research (see data gaps,) especially in light of what it thought to be considerable MSM activity.

1b. Clients of FSWs -- As noted above, clients of FSWs are a primary bridge population to their wives and other partners, and thus, the general population. Although more research is needed among them, they are thought to have low rates of condom use, and high rates of alcohol and drug use prior to commercial sex. Clients are probably
experimental with sex, meaning that some are probably MSM, who are thus themselves possible transmitters of HIV to FSWs.

1c. **Regular/Intimate Partners of FSWs** -- The data above citing condom use by FSWs with last non-paying partner at just 46% suggest that consistent condom use by FSWs with their regular or intimate partners is low. FSW-regular partner relationships are likely to be based on a false sense of emotional security as well as a dependency on FSWs for financial support.

2a. **Men Who Have Sex with Men (MSM)** -- Although a recent presentation of preliminary BSS data offers the most compelling view to date regarding men who have sex with men (MSM), there is generally a lack of data, particularly qualitative data, regarding MSM in Guyana. (See Research Gaps page 33.)

MSM and in particular, male sex workers are a significant population for future research. Preliminary presentation of BSS data found that 60% of MSM had paid a commercial partner for sex in the last six months.

A presentation of preliminary BSS data found 21% of MSM respondents were HIV positive. These data also showed that most MSM engage in high rates of risky behavior, including having multiple partners, high rates of partner change, oral sex, group sex and sex for gain (monetary or material.) Anecdotal evidence points to widespread & undisclosed bisexuality. Yet their self risk assessment appears to be low. According to the same data (above), just 63% of MSM believed that they were at risk for HIV infection. They are often involved in drug use and abuse alcohol. 53% said they used marijuana daily and almost 44% said they used cocaine on a daily basis.

Although their knowledge about condoms and basic HIV/AIDS facts is fairly high only 70% reported that they had used a condom a last sex with a regular partner. Condom use at last oral sex was just 54%. MSM show high rates of incorrect condom use and use of unsafe lubricants. Rates of STIs are high among them: 10% reported that they had ever tested positive for syphilis, while 19% said they had genital discharge syndrome in the last year.

Owing to stigma and discrimination in Guyana, most are unwilling to “come out” about their sexuality. This leads to low rates of health care seeking behavior, including testing for HIV. According to the same presentation of preliminary BSS data, only 47% of MSM reported that they had ever been tested for HIV. MSM are thought to play a significant role as a bridge population to the general population through female partners. Surprisingly, according to a presentation of preliminary BSS data, over 30% of MSM surveyed believed HIV-infected persons should be quarantined.

2b. **Female Partners of MSM** -- Female partners of MSM are likely to be unaware of their male partners’ true behavior. Given the high rates of HIV and STD prevalence among MSM, this means that their female partners are at considerable risk, but are unlikely to know this. This is a particularly poorly understood group in need of further study.
3. People Living with HIV/AIDS (PLHA) and those Affected by HIV/AIDS (PLHA) and those affected -- Data about PLHA and those affected in Guyana come mostly from qualitative studies, program reports (including those of G+), and anecdotal evidence collected from PLHA themselves, health care providers and relatives/friends of PLHA.

PLHA face little or no support for their health and psychosocial needs. As a consequence of lack of accessible, quality services, stigma, discrimination and low self efficacy, PLHA do not access the services that are available to them in Georgetown. There are serious problems with confidentiality. Few if any support groups exist for PLHA and those affected in most parts of Guyana. Linkages to income generation opportunities for PLHA should be explored.

PLHA behaviors to address include health care seeking; prevention (secondary) and co-infection; lack of knowledge of existing BCC materials, self stigma/discrimination. Fear of disclosure is a main issue to address.

4. Orphans and other Vulnerable Children (OVC) (Including Street Children) -- OVC face stigma, discrimination, sexual and employment-related exploitation, low self esteem, refusal of basic human rights, including rights to health care, education, security, psychosocial support and inheritance. Sexual predators take advantage of OVC’s innocence and economic need. They also face poor nutrition and lack of food.

5. STI Patients/Clients -- Recent data put HIV seroprevalence at 15% among patients who present for STD treatment. STDs facilitate transmission of HIV. Data find high rates of casual, unprotected sex, multiple sex partners and limited condom use among STD patients.

6. Health Care Workers -- Health care providers have been found through program assessments and anecdotal information to often fail to provide confidential services and exhibit stigmatizing and discriminatory attitudes/behaviors to PLHA and others affected. The reasons for a visit to a provider or facility should not be shared with community members. These factors hinder uptake, behavior change, adherence and positive living among PLHA.

Although injection safety does not seem to be a major issue, studies have found that there is a tendency among some providers to over-prescribe injections over oral medication. Providers should be trained/sensitized to offer patients a choice between oral and injectable medications.

7. Policy Makers -- Policy makers generally lack specific knowledge about HIV/AIDS and about their role in fighting the epidemic. There is a lack of unity among them regarding priorities for addressing specific populations as well as the Guyanese general population. Policy makers need to be educated about their roles and engaged to demonstrate commitment and take action.
Advocacy and promotion of political commitment among policy makers is needed to ensure the rights of PLHA and those affected in Guyana. Specific action is needed to pass legislation protecting:

- The rights of PLHA, particularly those affected such as OVC, to quality, confidential health care services
- The rights of PLHA to protections in the workplace, to obtain and keep shelter/home and educational institutions
- The rights of PLHA to health care and other insurance
- The need for a family court in Guyana
- The rights of OVC and other children to protection from sexual abuse, sexual exploitation and employment exploitation

8. Out-of-School Youths -- Seventy-five percent of cumulative AIDS cases in the period 1989-2002 were estimated to be among youth, 20-44 years.

According to a recent presentation of preliminary BSS data, almost 73% of out-of-school youth reported that they were sexually active. Several years of prevention programming intended for segments of out-of-school youth have contributed to relatively high rates of awareness and knowledge about HIV/AIDS basics (transmission, prevention methods, etc.) 84% of OSY reported (preliminary BSS data) that they knew that abstinence prevents transmission of HIV; 81% said a condom protects against HIV transmission. Despite this, only 58% of out-of-school youth reported that they had used a male condom at first sex. Consistent condom use rates are low, particularly with non-commercial “personal” partners. Only 32% reported consistent condom use with non-commercial partners. The median age at first sex is 16.

Girls are particularly vulnerable, being likely to have relationships with older men, often for material/financial gain.

Lifestyles are focused on socializing, having fun, “partying” and liming and sex. Typically, they have big dreams but no plans to realize them. Self efficacy is low. Girls believe that since they AND partners are “faithful” they are not at risk for HIV/STIs.

Anecdotal evidence shows high rates of mixing with in-school youths, particularly in the mini-bus environment for example. However, further research may be needed to confirm and further substantiate this.

9. Mobile Populations (miners, loggers, construction workers) -- In general, miners, loggers and some construction workers work in remote areas, they work alone (in the absence of women), and they often mix in the same living space with CSWs. (They establish temporary living arrangements with CSWs near worksites.) All three categories of mobile populations engage in frequent casual, unprotected sex, and regularly abuse alcohol. They have low rates of health care seeking behavior and are likely to have stigmatizing attitudes toward persons they believe or know to be PLHA. In all three
categories, comprehensive workplace programs that link prevention to counseling and testing are recommended. Specific data/considerations:

Miners – 3.9% rate of seroprevalence among miners. Unpublished 2004 data, MOH

Loggers - Need to have data

Construction Workers – Need to have data

10. In-School Youths -- Over 63% of in-school youth (ISY) are sexually active (preliminary BSS). The reported median age at first sex (preliminary BSS) is 15. Many relationships for in-school youths are of a “transactional nature” rather than commercial. Something material or otherwise is being gained (usually by girls) in exchange for sex. In-school girls are often sought after by older men and out-of-school youth. The values of many in-school girls are likely to be of a materialistic nature, often owing to economic need. They want to be rich and famous.

ISY do benefit by comparison with OSY from the protection of family and school to a certain extent. Of those who are sexually active, almost 76% reported that they used a condom with their last non-commercial partner, compared with just under 52% of OSYs. Most know about condoms and where they can be obtained. Some in-school boys regard carrying a condom as a sign of maturity, even if they do not intend to have sex. Qualitative and anecdotal reports suggest that most ISY believe they are not at risk for HIV/STIs. Of those who have not had sex, many obsess about relationships and sex. Some believe their friends are sexually active. While many hold stigmatizing attitudes (just 26% would share a meal with a PLHA), ISYs were slightly less stigmatizing in their attitudes toward PLHA than OSY, according to a presentation of preliminary BSS data. An exception to this is that 63% of ISYs as opposed to 48% of OSY would keep it a secret that someone in their family had HIV/AIDS.

For BCC interventions, in-school youth represent a “captive audience.” It should be noted that the MOE has developed and is about to launch a FLE curriculum for ISY, forms 1-3. In addition, the MOH Adolescent Health Unit is developing prevention interventions and youth-friendly health services in collaboration with PAHO/OPEC, UNFPA, UNICEF and USAID.

Despite the existence of National programs targeting in-school youth, this group requires further research to explore mixing patterns of ISY with OSY, which are probably a factor for HIV transmission among ISY.
Other Priority Populations Include:

- **General Population** -- UNAIDS estimated that at the end of 2004, Guyana was facing a generalized epidemic with seroprevalence in the general population at 2.5%. However, GOG estimates of HIV prevalence are currently at between 3.5%-5.5% in the general population. Transmission is predominantly heterosexual. 80% of those who are HIV+ do NOT know their serostatus. There is anecdotal evidence of significant and undisclosed bisexuality among some Guyanese males.

BCC efforts targeting the general population should focus on particular contextual themes, as well as reinforcing basic prevention messages (ABCDs). Contextual themes to emphasize in the next 5 years include:

- Machismo and male sexuality in general
- Vulnerability of girls/women to sexual abuse and exploitation in Guyana
- Promotion of national, community and partner discussion about HIV/AIDS, sexuality, gender, machismo, sexual and emotional abuse of children/women, and stigma and discrimination
- Reduction of stigma and discrimination, rights of PLHA, racism

Specific behaviors that should be addressed include unwillingness to test for HIV; denial of HIV/AIDS as a risk or concern, stigmatizing attitudes and general discriminatory behavior toward those infected and affected, practice of “serial monogamy,” in which couples may be “faithful” to each other for periods of weeks or months, but then move on to another relatively short-term relationship. (Such couples are likely to regard themselves as “safe” from HIV/STD transmission.) In addition, male attitudes and multiple partnering behaviors and inconsistent and incorrect use of condoms are also believed to be predominant.

In addition, although injection of medications at health facilities has been found to be generally safe in Guyana, programs should promote the right of clients/patients at health care facilities to choose between oral and injectable medications. This should be promoted at facility and community level.

- **Interior Populations (including Amerindians, people of mixed race, etc.)** -- Although data are insufficient (see research gaps below) populations in the interior, including Amerindians and people of mixed race are vulnerable due to isolation and limited access to health care, poor health care seeking behavior. Anecdotal reports cite transactional sex by these populations with miners, loggers and other mobile populations. Some suggest that that sexual debut of girls in interior communities is earlier than that of Guyanese girls in coastal and urban communities. Multiple partners may be common. Interventions should specifically target community leaders to build their capacity and commitment to addressing HIV/AIDS issues in their communities. The upcoming AIDS Indicator Survey will include some questions addressing Amerindians specifically.
• **Uniformed Services -- Need BSS Data.** Men in uniformed services are believed to have high rates of contact with CSWs, high rates of alcohol abuse, multiple partners, MSM activity is no uncommon, there is vulnerability to rape. High rates of STDs. **BSS data did not include security guards**

• **Prisoners -- About 3000 in country – Need more data.** Believed high rates of MSM activity, alcohol/drug abuse, STDs. Few if any interventions intended for them.
Section Four

Behavior Change and Behavior Change Communication: Theory, Guiding Principles and Steps for Strategy Development

A theoretical basis, guiding principles and recommended steps to guide the process of BCC strategy development are presented below to support stakeholders in developing effective, well-targeted BCC interventions that observe international best practices.

Theoretical Background -- Theories of behavior change provide useful insights at the individual and societal/contextual levels for developing and implementing effective BCC for HIV/AIDS programs. They provide a framework for understanding target populations, developing messages, designing effective interventions and activities, monitoring and evaluating interventions and allocating resources.

Behavior change theories offer explanations as to why people choose certain behaviors over others, what prevents them from changing their behaviors, and how they can be motivated to change and/or sustain existing behaviors. Some theories emphasize the individual while others take into account environmental or contextual factors. Certain theories investigate factors that can trigger behavior change, while others stress the stages in which behavior change occurs.

While theories vary, they draw their arguments out of the same factors related to human decision-making, such as the environment, intent, problem recognition or "risk assessment," self-efficacy (belief in one’s ability to change), and perceptions of harm, obstacles and benefits of action. These explanations are not necessarily mutually exclusive, although different theories rank these aspects in different order of priority. Practitioners working in the field often find it most useful to consider a combination of theories, applied to “on the ground” realities of the context in which they are working.

Individual Focus -- Theories focused on the individual suggest that the key to behavioral change lies in one’s perception of risks and benefits associated with a certain type of behavior. For instance, the Health Belief Model suggests that health-related behavior is formed on the basis of expected benefits, barriers and one’s ability to act against the perceived risks and severity of the health threat. In a similar framework, the AIDS Risk Reduction Model interprets behavior change as a result of a personal commitment to reducing high-risk contacts preceded by recognition of one’s behavior as being high-risk. The Theory of Reasoned Action connects behavior change mainly to one’s intentions, which are a product of beliefs about the outcome of certain behaviors, and about other people’s views about these behaviors.

Recognizing that behavioral changes often takes time, the Diffusion of Innovations and Stages of Change theories propose the adoption of new behaviors into several stages.

27
Family Health International has adapted and combined the steps proposed by these theories and suggests the following as stages through which most people progress (often moving “forward” and “backward” as they move toward behavior change. These steps are:

- Unaware
- Aware
- Interested
- Concerned
- Knowledgeable/Skilled
- Motivated/Intending to Change
- Trial Behavior Change
- Maintained Behavior Change

The importance of stages of change for BCC is that people may need different messages, channels and strategic approaches at different stages, and tailoring communication interventions to specific stages makes BCC more effective.

**Contextual Focus** -- While the selected theories above offer valuable insights into what drives human behavior, they do not address the influence of environmental and structural factors on individual actions. People do not always act based solely on their intentions or desires. Social and economic constraints imposed by the environment can hamper adoption of new behaviors or inhibit the maintenance of positive behaviors. At the same time, environmental factors can also encourage behavior change or help sustain positive behaviors. For example, a woman who is economically dependent on her husband may be reluctant to insist on condom use for fear of estrangement and poverty, even though she may fully believe in their importance against infection.

**Social Ecological model/theories**

**The Context of HIV/AIDS in Guyana** -- While the above prioritized populations must be addressed in targeted ways, there are various contextual factors that should also be addressed in order for HIV/AIDS programs and BCC in particular to be effective. These include

- Machismo and male sexuality in general
- Vulnerability of girls/women in Guyana. This is fueled by cultural traditions that put the girl/woman at a severe disadvantage.
- Specific cultural traditions related to British dominance (reserved character) and religious tenets including Christianity, Hinduism and Islam that tend to favor silence and proscription over open discussion of sexuality.
- Stigma and discrimination fueled by the above, but also by the context of small communities where “everyone knows everyone,” leading to gossip, little chance of anonymity and confidentiality
- Need for intensified political leadership. Despite passionate commitment of some leaders, there remains much to do, particularly regarding the rights of PLHA in the workplace, educational setting and domestic environment.
- Influence of race: Afro vs. Indo-Guyanese – this fuels a culture of blame and denial.
- Poverty and lack of economic opportunity lead to transactional sex
• Acceptance of physical and sexual abuse – this is an important topic for further study

A useful way of summarizing these theories is that they break down the factors that influence behavior into two basic categories: barriers and facilitating or motivating factors for change. Each of these categories can be subdivided into internal or external subcategories, as follows:

**Barriers/Facilitating Factors for Change**

**• Barriers:**
  - Internal: What in their minds makes it difficult to change?
  - External: What in their environment makes it difficult to change?

**• Facilitating Factors:**
  - Internal: What in their minds makes it easy to change?
  - External: What in their environment makes it easy to change?

**Internal Influences** – Some examples of factors that influence people on an internal (psychological, emotional) level are:
  - One’s current state of awareness or knowledge
  - An individual’s degree of concern or motivation
  - A person’s intention/readiness to change or maintain a positive behavior
  - Self Efficacy
  - An individual’s self risk assessment
  - Self Image
  - Cultural, religious or other beliefs and values

**External Influences** – External influences can include:
  - Culture (values, beliefs)
  - Spirituality
  - Peer support
  - Counseling
  - Availability and quality of services
  - Products
  - Supporting environment (policies, structures, etc.)
  - Social norms
  - Peer influences
  - Availability and quality of commodities

**The theories most relevant to the Guyanese context** -- On the one hand, many Guyanese place great emphasis on individuality and “going it alone.” Many Guyanese men maintain “machismo,” which includes a kind of stoic independence. “Real men” don’t need to talk about or seek help for their problems, if they even admit to having them. Years of British dominance may have promoted maintaining the “stiff upper lip,” the value that says that one must quietly bear one’s hardships without burdening others with them. In addition, values and influences from the United States reinforce the notion of an individual’s responsible for his/her own destiny.
On the other hand, as mentioned above, there is a variety of environmental factors that present ongoing pressures on Guyanese people to remain silent about HIV and AIDS, sexuality, gender imbalances, physical and sexual abuse. These forces promote stigma and discrimination and make it difficult for women to address serious gender imbalances. These factors are barriers to prevention. But as important, these environmental factors and others make provision of care, support and treatment of PLHA very challenging. BCC interventions in Guyana must include creation of an “enabling environment” for prevention, care, support and treatment. This must transcend the social and cultural level. This must also be backed up by political commitment to enforce existing and pass new legislation that would protect the rights of PLHA in the workplace, educational setting, at service delivery level and at the level of family/community.

The most effective application of relevant theories for Guyana will include a combination of individually and contextually focused theories. Programmers may wish to use different theories for different populations. Individually-focused theories can help understand the internal and external barriers and motivating factors that influence behavior. Contextual theories stress the role of environmental factors such as stigma, discrimination, gender, etc. in influencing behavior. Both should be addressed simultaneously for an effective response.

Guiding principles for BCC in Guyana -- In order to be effective, BCC should:

- **Integrate with program goals from the start** – BCC is an essential element of HIV prevention, care, support and treatment programs. Its strategic objectives should derive from program goals

- **Be evidence-based** – Developing well targeted BCC interventions depends on baseline data and formative assessments of target populations. These assessments should provide data that include:
  a. Knowledge/attitudes about HIV/AIDS
  b. Risk behaviors
  c. “Psychosocial” factors (attitudes, values, etc.)
  d. Barriers and motivating factors for change
  e. Descriptions of community infrastructure
  f. Analysis of social/economic networks
  g. Information about habits/communication channels used
  h. Information about credible persons
  i. Services accessed

- **Use an appropriate combination of linked communication channels** with consistent messages, through referrals, through collaboration with stakeholders and target populations as interventions are developed; and through other shared design elements to provide a consistent “look” and “feel” to creative elements
• **Include pre-testing** -- Pre-testing is essential to help ensure that messages and materials are acceptable, understood, culturally appropriate, believable, realistic, appealing, and that they motivate target populations to take action.

• **Involve people living with HIV/AIDS (PLHA)** – PLHA should be involved in all phases of planning, design, development, implementation, monitoring and evaluation. They have a perspective on the epidemic that non-PLHA do not have.

• **Involve target populations** - in all phases of BCC development and implementation.

• **Be positive and action oriented** – BCC specialists have found that to a great extent, messages and materials that are positive in tone are usually more effective than fear-based approaches. Messages that tell the target population what to do are also likely to achieve greater impact.

• **Involve stakeholders** – Stakeholders (political, religious and other community leaders, PLHA) need to be involved from the design stage and throughout the entire strategy development process.

• **Integrate with commodities and services** – To most effectively impact on behavior, BCC must be integrated with provision of commodities and services. To work effectively, BCC depends on high quality, accessible services and commodities that are available in sufficient quantities to meet demand.

• **Plan for monitoring and evaluation at the design phase and be results oriented (M&E)** – Monitoring and evaluation should be ensured to help demonstrate results. Anecdotal information regarding an intervention’s success/challenges is not sufficient.

• **Be flexible and adapt to evolving local circumstances** – BCC is not an exact science and functions in the context of changing environments. Programmers should be ready to adapt interventions to better reach target populations as new information comes in.

• **Be sustainable** – Interventions and programs should be designed so that they can be sustained by the public and private sectors when donor resources are no longer available

• **Promote and create partnerships** with other organizations engaged in:
  - Policy Initiatives and other Advocacy
  - Community mobilization
  - Social marketing
  - Income generation
  - Economic empowerment
  - Faith-based interventions
  - Gender issues
- Social mobilization
- Political and social change

**Steps for developing and implementing effective BCC strategies** -- Based on successes and lessons learned from past BCC interventions in Guyana, the GOG recommends that certain key steps be included in the process of developing effective BCC strategies. The exact order of the steps will vary depending upon circumstances, but all steps should be included at some point in the process to ensure effective strategic approaches.

- Proceed based on program goals and conduct situational assessment
- Involve stakeholders from the start and throughout the entire process
- Identify target populations and form hypothetical/draft behavioral objectives for further investigation
- Conduct baseline and formative assessment to better understand target populations and to investigate hypothetical behavioral objectives
- Further segment target populations if necessary based on research results
- Finalize behavioral objectives based on research
- Design targeted BCC strategy (See “Elements…” below) and monitoring and evaluation plan
- Develop BCC interventions, channels, activities, materials etc. based on BCC strategy
- Pre-test all messages, materials and BCC products
- Implement BCC interventions in coordination with services and commodities, and monitor
- Evaluate BCC interventions in the context of an overall program
- Analyze “feedback” from monitoring and re-design as necessary

**Elements of An Effectively Targeted BCC Strategy** – A well-designed BCC strategy should include certain key elements:

- Clearly identified primary/secondary target populations
- Statement of the problem
- Target population profiles
- Objectives
- Barriers for Change (internal and external-See above)
- Facilitating Factors For Change (internal and external)
- Key benefit statement
- Themes and Key messages
- Supporting statements
- Desired action response
- Selection of Channels and Activities – This should include an appropriate mix per population of:
  - Interpersonal channels
  - Traditional/small media channels
  - Mass media (See appendix: The Media Landscape)
Themes and Key messages – Effective themes and messages depend on analysis of formative assessments about the specific target populations for whom they are designed. This analysis should lead to specific objectives, an understanding of behavioral determinants (barriers and facilitating factors,) and development of key benefit statements, the essential precursor of effective messages. Likewise, an effective theme should be linked to specific population-related objectives and determinants, in order to help ensure that the theme addresses a specific audience in the way desired.

The GOG recommends that messages and themes be designed as part of a population specific strategy that includes the strategic elements discussed above. That strategy should be developed with the fullest participation and collaboration of target populations, stakeholders including PLHA, and communication experts possible. Resulting messages, themes and sample BCC products/materials should always be pre-tested with members of target populations.

BCC in Context of Services and Commodities

BCC & Services (PMTCT, VCT, ART, etc.) – BCC has multiple roles in area of services, including to:
- Increase community, family and client understanding of service objectives
- Strengthen client-provider interaction
- Support adherence to treatment
- Reduce stigmatizing attitudes and discriminatory behaviors of health care providers, staff, family and community members
- Increase uptake of services by clients
- Strengthen follow-up behaviors by clients

BCC & Commodities (Condoms, ARVs, universal precaution/equipment) – BCC can enhance and strengthen awareness and knowledge of and access to commodities such as condoms, anti-retroviral medication, equipment for universal precautions, (including post-exposure prophylaxis). BCC can:
- Improve access to and supply of condoms
- Improve access to ARVs
- Improve knowledge of providers of universal precautions
Advantages and Disadvantages of Different Types of Communication Channels

Channels and activities can be broken down into three main categories:

1. **Mass media** – involving widespread diffusion to a large number of people through radio, television, newspapers, billboards, posters and stickers

2. **Small media, traditional media, advocacy, community mobilization, drama/music** – Small media include print materials like booklets, comic books, photo novellas, audio and video cassettes/CDs and exhibits. Traditional media includes events and festivals unique to a given culture like Mashramani, walk-a-thons, Ramadan, Festival of Lights, etc. Advocacy involves ongoing efforts to bring important issues to the attention of policy maker and other influential people. Channels include mass media, particularly print media, events, information kits, personal outreach. Community mobilization involves grassroots discussions to identify problems, solutions, activities and structural changes to achieve specific goals. Channels for CM often include advisory boards, community events, community forums for discussion, “open houses” at clinics and schools, etc. Drama and music can be incorporated into mass media, small media and interpersonal channels.

3. **Interpersonal channels** – Interpersonal channels include peer education, small group discussions, support groups, meetings, training, counseling, home and site visits, role-playing

How Should Communication Channels be Chosen?

- **A combination works best** – Finding the right combination of channels works better than choosing just one option
  - Communicating the same messages through a variety of channels increases the chances that target populations will be exposed to messages and will be persuaded to act or change

Other factors to consider include:

- **Access** -- Will the target population have access to the channels chosen?
- **Credibility** -- Will the target population believe the messages in the context of the channel chosen? If they do not trust the channel or source of information, they may not be persuaded to change or act
- ** Appropriateness** -- Is the channel an appropriate way to deliver the message? For example, if you want to build skills, television may not be as suitable as interpersonal channels.
- **Cost** -- Is the channel affordable?
Main characteristics of certain channels include:

- Mass media reach many people quickly and are cost effective per person reached. However, overall cost of production and broadcast over campaign time period can be expensive. Mass media are good for raising awareness, “setting the stage” for a campaign. However, they are not very effective, by themselves, in promoting behavior change or maintenance of positive behaviors.

- Small media are good at reaching small groups of people with specific messages, stimulating community/group discussion. They are more expensive than mass media.

- Interpersonal channels are most persuasive, credible and effective in promoting behavior change or maintenance of positive behaviors. However, they are expensive on a cost-per-person-reached basis, requiring considerable human and financial resources.

See Appendix D for a more detailed analysis of the advantages and disadvantages of specific channels/activities.
Section Five

Gaps for Future Programming

Specific gaps for future HIV/AIDS programming include:

- **Lack of adequate data** – The main challenge to BCC in Guyana is lack of adequate data about specific populations. In addition, an Economic Impact Study is necessary as a tool for advocacy. An assessment of mass media outlets in Guyana would strengthen capacities to effectively reach and monitor mass media interventions (See research gaps below).

- **Orphans and Other Vulnerable Children** – Children are Guyana’s future. A UNICEF OVC study says that OVC are impacted by a range of negative factors, including HIV/AIDS, stigma and discrimination, lack of access to food, security, education, medical and emotional care. OVC programs should be a crucial part of the ongoing response to HIV/AIDS in Guyana. Some organizations, agencies and government Ministries are providing services to OVC. These include the Ministry of Health, Education and Ministry of Labour Human Services and Social Security. A PAHO National Plan of Action for OVC is scheduled for development beginning in August 2005. The UNICEF report contains a listing by region, of what the NGOs/FBO/CBOs are doing. Gaps will be addressed during an August 10th consultative meeting. These include legislation on poverty related issues.

- **Anti-Retroviral Therapies** – As increasing numbers of Guyanese PLHA begin anti-retroviral therapies (ART), they will need support from counselors, family, and their communities. BCC can play an important role in strengthening adherence to ART, and creating an enabling environment to support PLHA and reduce stigma and discrimination. In particular, a package of materials for client-provider interaction, individual and family support is needed.

- **Home-Based Care/Palliative Care** – As home-based care/palliative care interventions grow in Guyana, they will need to be supported by materials for providers, health care givers, family and community members. These should be linked to other BCC interventions to optimize their effectiveness.
Ongoing Reduction of Stigma and Discrimination – Reduction of stigma and discrimination should be an integral part of all BCC interventions in Guyana. Over 80% of PLWHA do NOT know that they are living with HIV/AIDS in Guyana! Stigma and discrimination act as major barriers to behavior change and the maintenance of positive behavior in Guyana and elsewhere. Specifically, stigma and discrimination:

- Stifle information seeking, community discussion and disclosure of HIV status among partners, family members and others
- Create an “Us vs. Them” mentality which prevents people from looking at their own behavior and seeing the relevance of HIV/AIDS to their own lives
- Inhibit testing for HIV, STIs and TB
- Inhibit disclosure and health care seeking behaviors among people living with HIV and AIDS
- Inhibit quality care and treatment by health care providers
- Inhibit care and support by family and community members for PLHA and those affected by HIV/AIDS

Recommended interventions to reduce stigma and discrimination include:

- Information dissemination and awareness raising about how HIV is and IS NOT transmitted
- Coping skills acquisition or “imaging” exercises carried out through peer education sessions (e.g.; the “wildfire” exercise and other exercises from the Bodywork Peer Education manuals)
- Counseling approaches and support groups
- Contact with PLHA through participation in care and support activities, outreach and community mobilization activities
- Creating a supportive legal environment by monitoring and addressing violations of human rights
- Training and sensitization of providers, staff, media and others
- Building service delivery capacity (e.g.; universal precautions, post-exposure prophylaxis, safe injection practices, offering oral medications)
- Carefully monitoring, evaluating, documenting and reporting on all interventions involving any of the above

Addressing the “D” (Drugs/Alcohol Abuse) – As preliminary BSS results show, drugs/alcohol are important factors that facilitate high risk behaviors.

Sexual abuse/gender issues – Issues related to sexual abuse, gender imbalance, exploitation of girls, boys and women must be addressed to reduce these populations’ vulnerability to HIV/AIDS.

Links to economic opportunity/income generation – Without opportunities to sustain themselves, people will continue to turn to commercial and transactional sex to survive. Long term approaches to HIV/AIDS must address economic conditions if sustainable progress is expected.

Research gaps (see below)
Research Gaps – Research gaps for effective HIV/AIDS programs include:

- **Men Who Have Sex With Men (MSM)** – Little is known about the true extent of MSM/bi-sexual behavior in Guyana due to intense stigma/discrimination. With seroprevalence above 21% among MSM, they must be better understood to better target BCC interventions and programs overall. Studies of the female partners of MSM, if feasible, should also be considered.

- **Economic Impact Study** – This would have value as an advocacy tool. Policymakers and employers must make hard decisions based on projected economic realities. They need solid evidence about the impact of HIV/AIDS on the Guyanese economy as a basis for future policy decisions.

- **PLHA Health Services, Care and Support Assessment; Policymakers (attitudes, etc.)** – Providers (confidentiality, stigma, etc.) – Program assessments have found anecdotal evidence of stigma, discrimination and lack of confidentiality at facility level. These factors hinder uptake, behavior change, adherence and positive living among PLHA.

- **Ethnic factors** – that facilitate HIV transmission, including cultural attitudes, practices, and traditions, etc. Specific areas for study include Indo-Guyanese, and Amerindian cultures. These should either be a separate study or be a specific part of various other studies.

- **Clients of CSWs** – With seroprevalence between 26-45% among CSWs, their paying and non-paying partners are important bridge populations to the general population. They are, however, hard to reach and poorly understood.

- **Drug Users** – Drug abuse has been shown to be a strong factor that accompanies high risk behaviors. However, the true extent of the problem is not fully understood.

- **Interior populations, including Amerindians and People of Mixed Race** – there is considerable anecdotal evidence that high-risk behaviors are taking place in the interior, while interior populations lack access to prevention, care, support and treatment services. Solid data are required to guide programming. The AIS will assess limited numbers of Amerindians in several communities. However, this may not be enough to fully guide future programs for these and other hard-to-reach groups in the interior.

- **Prisoners** – Although the total number of prisoners in Guyana is thought to be under 3000, this population may be involved in high rates of MSM activity, drug and alcohol abuse and sexual violence. Denial of vulnerability to and willingness to discuss HIV/AIDS are probably strong factors.

- **Media Landscape plus advertising; PR; printing companies’ capacity** – Guyana lacks data on the extent and nature of reach of the various broadcast and print outlets in country. Such data would lead to more accurate and cost-efficient application of resources in reaching Guyanese with HIV/AIDS-related information.

- **Physical and sexual abuse** – Violence against children/women, incest, rape and abuse fuel HIV transmission and vulnerability. Anecdotal evidence suggest that these practices are widespread, but further study is needed.

It should be noted that a number of studies are currently underway and/or planned. These include: disease control, MOH: BSS, AIS, SPA, routine data, miners’ survey, NBTS data. Please see Appendix E.
Section Six

Partnerships for a Comprehensive Response

Given limited resources, HIV/AIDS programs can have greater impact if organizations active in HIV/AIDS are willing to coordinate and collaborate with others directly or indirectly involved. Possible areas for partnership include:

Specific HIV/AIDS collaborations envisioned

- **Non-governmental Organizations/Faith-based organizations** – International best practices have demonstrated that the most effective response to HIV/AIDS comes about through close, open collaboration between governments and community-based organizations, including non-governmental organizations (NGOs) and faith-based organizations (FBOs.) Each should recognize the important role the other has to play and collaborate as much as possible.

- **Workplace Programs** – Collaboration, through the International Labor Organization with private companies to develop comprehensive workplace programs that include prevention, counseling and testing and links to other care, support and treatment interventions. Organizations involved include: ILO, Guyusuco, UNAIDS, UNDP.

- **Private Sector Involvement** – Ongoing efforts should strive to engage the private sector to support HIV/AIDS programs financially and through in-kind assistance. The long term sustainability of HIV/AIDS programs will depend on such support. Private companies involved include Guyana Telephone & Telegraph Company, Guyana Revenue Authority, Guyana Post Office Corporation, Le Meridien Pegasus Hotel, National bank of Industry and Commerce, GEB Security Services, MMC Security Services, Cara Lodge Hotel, Consultative Association of Guyanese Industry, Guyana Forestry Commission, Trade Union Congress, Continental Agencies, Barama Gafoor Ltd., Vanessa (Guy) Inc, North American Resources Inc. L among others

- **Collaboration with the Media** – The Media can play an important role in promoting reduction of stigma and discrimination and in providing information about prevention, care, support and treatment topics and services to the Guyanese public. Several workshops have been held with journalists from television, radio and newspaper outlets across Guyana. Media Guidelines for Journalists Reporting on HIV/AIDS Issues are currently under development. Organizations involved include the Guyana HIV/AIDS reduction and Prevention Project, Artistes in Direct Support and an ad hoc committee which is being headed by Neaz Subhan.

- **Safer Injecting Program** – USAID recently supported a pilot program implemented by Initiatives aimed at improving injection safety at facilities throughout Guyana. Links between this program and other HIV/AIDS interventions can help to ensure injection safety among providers, increase demand at community level for oral medications, and help to ensure safer disposal of injection equipment/sharps. Organizations involved include Initiatives, all Town and City Councils in Guyana, Neighbourhood Democratic Council and the MOH.

- **Policy Initiatives and other Advocacy** – Linkages should be explored between HIV/AIDS programs and Civil Society/Governance and Democracy programs. Such
collaboration can strengthen efforts to ensure human rights of PLHA. Organizations involved include *inter alia* National AIDS Committee, National AIDS Programme Secretariat, and The Network of People Living with HIV/AIDS.

- **Community Mobilization** – The participatory methodology of community mobilization is complimentary to the participatory BCC process recommended in this strategy, and used with success in Guyana. HIV/AIDS programmers should explore linkages with community mobilization programs as a way to enhance the reach and ownership of communities for HIV/AIDS issues and programs. Organizations involved include NGOs, FBOs, CBOs, NDCs.

- **Income Generation** – The link between poverty and HIV/AIDS is clear. Populations that are hungry are more likely to engage in risky behaviors like transactional sex and less likely to care about “long-term” consequences like HIV/AIDS. Linkages with income generation programs are an important way to provide economic empowerment to such audiences. Organizations involved include EMPRETEC, IPED

- **Gender issues** – As discussed in this strategy, gender issues are at the heart of high-risk behaviors and vulnerability to HIV/AIDS. Linkages with such programs can strengthen a program’s capacity to address these issues in the context of HIV/AIDS. Organizations involved include Red Thread.
Section Seven

Monitoring and Evaluation

Monitoring and evaluation (M&E) of BCC interventions should be well informed by ongoing technical support from M&E specialists. While interventions should support the overall objectives and indicators cited on pages 8-9, objectives and indicators specific to each population and intervention must be developed.

M&E should emphasize two categories of data to be collected:

1) Population-based data regarding number of programs, reach of programs, channels, messages, and

2) Program-based data regarding uptake, quality of care, etc.
Section Eight

The Strategy Development Process and Next Steps

The Process -- This Strategy document was developed through the following process:

1. In June 2005, a Core BCC Working Group was established to initiate and agree on a process, and to develop an outline of the National BCC Strategy, supported by a BCC consultant from GHARP/Family Health International (FHI.)

2. The BCC Working Group identified partners and stakeholders for participation in a National BCC Strategy development workshop and subsequent review process.

3. Roles and responsibilities were established within the group and planning of the BCC Strategy development workshop was undertaken.

4. As assessment was carried out and additional literature/research was reviewed and provided to participants of the upcoming workshop.

5. The National BCC Strategy Design Workshop was held in Georgetown from Wednesday, July 20 to Friday July 22. Main components of the document were discussed and outlined. Next steps were agreed upon for completion of a draft document for broader review. It was agreed that participants would re-convene on Thursday, August 11th, to discuss the draft document and reach consensus on its content. A National BCC Advisory Committee was proposed (see below.)

6. Draft 1 was submitted to the National AIDS Committee, the Minister of Health, the Health Sector Development Unit, participants of the Workshop and other stakeholders for review on Tuesday, August 8. Deadline for comments was set at August 22, 2005.

7. A deadline for incorporation of comments and finalization of the document by GHARP/FHI was set at August 29, 2005.

8. The Minister of Health and GHARP confirmed a date for dissemination of the Strategy in the first quarter of 2006.

Next Steps for The National Strategy Development Process –

Next steps recommended include:

1. Follow-up Meeting Proposed – A meeting of stakeholders to review the latest draft of the National BCC Strategy has been proposed for Thursday, August 11th, 2005, at 9:30 a.m. at the GHARP office.

2. Proposed National BCC Advisory Committee – Participants at the July 20-22 stakeholders’ meeting proposed that a National BCC Advisory Committee be formed by the Government of Guyana to report to the National AIDS Committee/MOH/GOG to provide ongoing oversight and to: coordinate BCC, ensure standards and principles are applied across all BCC interventions in Guyana and make sure programs are flexible to adjust to changing needs. Proposed Terms of Reference follow:
Proposed Terms of Reference for the National BCC Advisory Committee

1.) The BCC committee should be headquartered in the National AIDS Programme Secretariat of the Ministry of Health.

2.) The committee should oversee/coordinate all BCC under the National BCC Strategy relating to HIV/AIDS and provide direction to stakeholders, including donors and implementing agencies. However, the committee will NOT function as a censoring body, but rather will provide supportive guidance (see point #3 below.)

3.) The BCC committee should ensure standard use of guiding principles and should ensure a supportive process to donor agencies in a constructive spirit that recognizes the limitations of developing and implementing BCC in a resource-constrained setting. The committee will review new materials for endorsement before their dissemination.

4.) The committee should also ensure that the work of the committee coincides with and compliments the national strategy on HIV/AIDS.

5.) The committee should be recognized and supported by the national HIV/AIDS committee

6.) The committee shall report to the National AIDS Programme Secretariat

7.) The chairperson of the committee will be appointed by the MOH and will have authority to:
   a. Call special meetings as needed

7.) Special meetings of the committee may also be called by a quorum of committee members

8.) A co-chair will be elected by a majority of committee members and will be a representative of civil society organizations (NGOs/FBOs)

9.) Members must have knowledge and direct experience with BCC and HIV/AIDS

10.) At least one member will be a person living with HIV/AIDS (PLHA)

11.) The membership of the committee will be no more than nine (9) members, no fewer than seven (7)

12.) The committee will meet once every quarter, plus for special purpose as requested by chair/co-chair, plus or by majority of members vote (see above.)
13.) The committee shall share information with stakeholders and others implementing BCC for HIV/AIDS programs in Guyana.

14.) The committee will meet at least once a year with interested stakeholders (for example, the stakeholders who attended the July 20-22 workshop) to discuss new ideas, developments, future plans, etc.

15.) There shall be one focal point person, who will be entrusted to provide ongoing consultation and coordination among other committee members, interested stakeholders and others implementing BCC interventions in Guyana.

16.) The committee focal point person shall liaise with, advise and support the media to better understand and report on the National BCC Strategy

17.) The committee will seek out a facility within the NAPS to serve as a documentation centre to collect and archive BCC materials.

18.) The capacity of committee members should be built as needed/appropriate through participation in trainings in BCC and other relevant HIV/AIDS program areas. This training can include:
   - Participation by invitation from donors/stakeholders in training on an ad hoc basis
   - Formal training as arranged by the Government of Guyana. Training-of-trainers approaches are particularly recommended as the National BCC Advisory Committee may take on a capacity building role in the development of BCC in Guyana in the future.
Main Contacts for the National BCC Strategy Process

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Dr. Jomo Osborne, Technical Director, GHARP, josborne@fhiguyana.org

Nazim Hussain, Community Mobilization Officer, NAPS/MOH, lumisan1963@gmail.com

Contacts at Organizations Working in the Field of HIV/AIDS in Guyana

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<td>Catholic Relief Services</td>
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<td>Ministry of Labor, Human Services and Social Security</td>
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Appendices

- **Appendix A** – Suggested Objectives, Indicators, Program Areas and Activities per Priority Target Population
- **Appendix B** -- The media landscape in Guyana (TV, radio, print)
- **Appendix C** – Analysis of Specific Past BCC Interventions/Campaigns
- **Appendix D** – Advantages and Disadvantages of Different Types of Communication Channels and Activities
- **Appendix E** – MOH Surveys and Studies
- **Appendix F** – Timeline
- **Appendix G** – Tips for Developing Mass Media Campaigns
- **Appendix H** – Summaries of Organizations Working in the field of HIV/AIDS in Guyana
## APPENDIX A – Illustrative Objectives, Indicators, Program Areas and Activities per Priority Target Population

<table>
<thead>
<tr>
<th>Target Populations</th>
<th>Illustrative Objectives*</th>
<th>Illustrative Indicators**</th>
<th>Illustrative Program Areas***</th>
<th>Illustrative Suggested Activities****</th>
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</table>
| 1a. Commercial sex workers (CSWs) | 1. Increase condom use  
2. Increase self risk assessment for HIV  
3. Increase HIV testing  
4. Increase access to STI services  
5. Increase use of STI services  
6. Increase interpersonal discussion of prevention methods  
7. Increase interpersonal discussion of HIV testing  
8. Increase access to prevention services  
9. Increase discussion of prevention and testing between | 1. # reporting correct and consistent condom use (with commercial & regular partners)/ # reporting correct condom use at last commercial sex  
2. # who believe they are at risk for HIV/STI transmission  
3. % increase who have tested for HIV  
4. # of STI services accessible to CSWs/% increase of CSWs using STI services  
5. % increase who have discussed HIV/AIDS with another CSW or partner  
6. # CSWs accessing prevention services  
7. # CSWs discussing | 1. CSW Programs  
2. Prevention  
3. Condom social marketing  
4. STI Services  
5. C&T  
6. Advocacy  
7. Income generation  
8. Links to PLHA NGOs | 1. Mapping/formative assessment through key informants;  
2. IPC/C (peer education, outreach counseling, support groups);  
3. Drop-In centers; client-friendly services;  
4. Condom promotion in ABCD context;  
5. Targeted print materials;  
6. Advocacy w/pimps, brothel, bar owners & law enforcement;  
7. Links to STI services and C&T;  
8. Provider training at STI/C&T services on CSW needs & IPC; |
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<th><strong>1b. Clients of CSWs</strong></th>
<th><strong>1c. Regular/intimate partners of CSWs</strong></th>
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<tr>
<td>1. Increase condom use</td>
<td>1. Increase discussion about prevention methods, testing, disclosure, and S&amp;D, between regular partners and CSWs</td>
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<td>2. Increase fidelity to primary partners</td>
<td>2. Increase fidelity</td>
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<td>3. Reduce S&amp;D</td>
<td>3. See ABCD indicators below</td>
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<td>4. Increase HIV testing</td>
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<td>5. Increase discussion/IPC about HIV/AIDS, prevention (ABCD), testing, S&amp;D</td>
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<td>6. Increase access to and use of STI services</td>
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<td>10. Increase in # tested</td>
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<td>11. Prevention Mass media</td>
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<td>12. Condom social marketing</td>
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<td>13. C&amp;T</td>
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<td>14. STD Services</td>
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<th><strong>Prevention</strong></th>
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<th><strong>C&amp;T</strong></th>
<th><strong>STD Services</strong></th>
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<tr>
<td>6. Advocacy w/owners of commercial establishments. Reach through CSWs themselves</td>
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<th><strong>9. Client-provider materials</strong></th>
<th><strong>10. Skills training (condom negotiation)</strong></th>
<th><strong>11. Income generation activities</strong></th>
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<td>1. Client-provider materials</td>
<td>2. Skills training (condom negotiation)</td>
<td>3. Income generation activities</td>
</tr>
</tbody>
</table>
between regular partners and CSWs (from partner side)
3. Increase condom use between regular partners and CSWs
4. Increase HIV testing

| 2a. Men who have sex with men (MSM) | 1. Increase condom use (and A and B) (especially among MSM who visit FSWs, MSWs, and/or have female partners) | 1. See ABCD indicators below
2. # using water-based lubricants
3. # discussing HIV/AIDS issues
4. # testing
5. # MSM-friendly services available/# using STI services
6. # reporting reduced alcohol intake/abuse
7. # who would provide care and support to MSM/PLHA
8. #/% increase seeking health care
9. See S&D indicators below | MSM Programs
Prevention
Condom social marketing
STI Services
C&T
Advocacy
Links to PLHA NGOs

1. Map social networks;
2. “advocacy” to gatekeepers at MSM establishments where MSM congregate;
3. Build networks of providers;
4. Peer education;
5. Condom promotion;
6. Internet plus web-based counselors;
7. Outreach to providers to build cooperative networks;
8. Drop-in centers;
9. Support groups;
10. Links to PLHA NGOs for psychosocial support;
11. BCC materials.
<table>
<thead>
<tr>
<th>2b. Female partners of MSM</th>
<th>1. Increase discussion of HIV/AIDS, STIs, HIV testing, prevention, between MSM and their female partners</th>
<th>1. # MSM reporting increased discussion about HIV/AIDS issues with their female partners</th>
<th>Prevention Mass media Peer education C&amp;T STD services</th>
<th>1. Reach through MSM; 2. Promote partner discussion, testing and disclosure at STD and C&amp;T services; 3. Peer education/outreach should include relevant topics</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2. Increase condom use between MSM and their female partners</td>
<td>2. # MSM reporting increased condom use with female partners</td>
<td></td>
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</tr>
<tr>
<td>3. People living with HIV/AIDS (PLHA)</td>
<td>1. Increase health-care seeking behavior among PLHA</td>
<td>1. # PLHA accessing key services (specify)</td>
<td>NGO programs IPC/C C&amp;T ART Services PMTCT HBC/PC Links to OVC programs</td>
<td>1. IPC/C including support groups; 2. BCC for HBC/PC, and facility level interventions: 3. ART, PMTCT, VCT; 4. Integrate PLHA in development of all BCC; 4. Focus on client-</td>
</tr>
<tr>
<td></td>
<td>2. Increase access to treatment</td>
<td>2. # PLHA accessing ART</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>3. Increase care and support services for PLHA</td>
<td>3. # services available to PLHA</td>
<td></td>
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<td></td>
<td>4. Promote prevention among PLHA</td>
<td>4. See Prevention/ABCD indicators below; also # PLHA who</td>
<td></td>
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<tr>
<td>4. Orphans and other vulnerable children (OVC)</td>
<td>can cite key facts about secondary prevention</td>
<td>OVC programs IPC/C</td>
<td>provider interaction, family, community, partner levels.</td>
<td></td>
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<td>-----------------------------------------------</td>
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</tr>
<tr>
<td>1. Increase community awareness about effects of HIV/AIDS on children</td>
<td>1. # general population, policy makers, or others who can correctly identify key OVC issues</td>
<td>Links to Community Mobilization Care and Support for Children Outreach/Education</td>
<td>1. SBC should work closely with OVC programmers;</td>
<td></td>
</tr>
<tr>
<td>2. Increase knowledge among community about how best to help children</td>
<td>2. # who can identify priority needs of children</td>
<td>Links to Advocacy, Social mobilization</td>
<td>2. Mass media to create enabling environment for ALL children, awareness of children’s issues;</td>
<td></td>
</tr>
<tr>
<td>3. Increase awareness among general population of national GOG OVC strategy</td>
<td>3. # who know there is an OVC strategy/# who have seen/read it</td>
<td></td>
<td>3. Advocacy for rights of children: right to health care, security, education, psychosocial support and inheritance;</td>
<td></td>
</tr>
<tr>
<td>4. Increase knowledge among schoolchildren of safety of having PLHA/OVC in schools</td>
<td>4. Increase # of schoolchildren who say PLHA/OVC should be allowed to study in school with non-PLHA children</td>
<td></td>
<td>4. Promote legal support for children against abuse;</td>
<td></td>
</tr>
<tr>
<td>5. Increase general populations’ knowledge of human rights of children to the following: right to health care, education, security, psychosocial</td>
<td>5. # general population (or specific population) who can identify 5 basic rights of children</td>
<td></td>
<td>5. Promote permanency planning and training;</td>
<td></td>
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<tr>
<td></td>
<td>6. # of court cases defending rights of</td>
<td></td>
<td>6. Provide material support for vulnerable children (food, shelter, medicine, etc.)</td>
<td></td>
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<tr>
<td>6. Increase observance of human rights of children to the following (right to health care, education, security, psychosocial support and inheritance)</td>
<td>children to one of 5 basic rights</td>
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<tr>
<td>7. Increase understanding in community of priority of family as best place for a child -- institutions as last resort.</td>
<td># population who cite family as best place for a child</td>
<td></td>
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<tr>
<td>8. Increase number of orphans placed in families</td>
<td># orphans placed in families</td>
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<tr>
<td>9. Increase child protection against abuse.</td>
<td># child abuse cases being tried in court</td>
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<tr>
<td>10. Increase awareness of community role and services for abused children</td>
<td># of population who can cite 3 services for vulnerable children in community</td>
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<tr>
<td>11. Increase access of children to health care</td>
<td># of children accessing health care</td>
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<tr>
<td></td>
<td>12. # children participating in OVC programs</td>
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<tr>
<td>5. STI patients/clients</td>
<td>6. Health care workers</td>
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<tr>
<td>1. Increase health care seeking behavior of STI patients</td>
<td>1. Increase observance of confidentiality among health care workers</td>
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<tr>
<td>2. Increase access to STI services</td>
<td>2. Reduce S&amp;D among health care workers toward PLHA</td>
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<tr>
<td>3. Increase use of STI services</td>
<td>3. Increase quality of</td>
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<tr>
<td>4. Increase condom use among STI patients</td>
<td>4. # of providers who do not discriminate</td>
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<tr>
<td>5. Reduce number of partners among STI patients</td>
<td>5. # health care workers trained in importance of client confidentiality/# health care workers observing confidentiality of clients</td>
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<td></td>
<td>6. Ensure communities build children's participation in OVC programs</td>
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<td></td>
<td>7. Increase health care seeking behavior of STI patients</td>
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<td>8. Increase access to STI services</td>
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<td>9. Increase use of STI services</td>
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<td></td>
<td>10. Increase condom use among STI patients</td>
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<td></td>
<td>11. Reduce number of partners among STI patients</td>
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<td></td>
<td>12. STI service capacity building in IPC/C</td>
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<tr>
<td></td>
<td>Mass media</td>
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<td></td>
<td>Peer education</td>
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<tr>
<td></td>
<td>Links to C&amp;T, PMTCT, ART, OI, HBC/PC; Condom social marketing</td>
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<tr>
<td></td>
<td>1. IPC/C at STD service delivery, client-provider interaction packages/materials, print materials, links to peer education, links to community discussion/events</td>
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<tr>
<td></td>
<td>1. Training/sensitization of PLHA issues; client-provider support materials for PMTCT, VCT, ART, HBC/PC; referral guides for providers; 2. Training of Providers in IPC/C; PEP; Universal Precaution; Safe injection; waste Management &amp; Stigma and Discrimination.</td>
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<tr>
<td>7. Policy makers</td>
<td>care through training and observance of PEP, and universal precautions</td>
<td>against PLHA</td>
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</tr>
<tr>
<td>1. Increase knowledge about HIV/AIDS and policy makers’ roles in HIV/AIDS arena</td>
<td>3. # providers trained in PEP/Universal precautions/# providers observing PEP/Universal precautions</td>
<td>1. # policy makers who demonstrate public commitment to HIV/AIDS issues, need for quality services, through public appearances</td>
<td></td>
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<tr>
<td>2. Increase demonstrated commitment among policy makers re: HIV/AIDS issues, especially reduction of S&amp;D</td>
<td>4. # providers trained in IPC/C</td>
<td>2. # laws enacted, or revised protecting PLHA</td>
<td></td>
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<tr>
<td>3. Increase demonstrated commitment to provision of quality,</td>
<td>5. # oral medications prescribed/# providers trained in safe injecting practices</td>
<td>3. Family court established</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>4. # laws enacted or revised protecting children from abuse</td>
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</tbody>
</table>

| Advocacy | 1. Advocacy for increased commitment; information kits, one-on-one ongoing outreach, |
|----------|---------------------------------------------------------------|--------------|
| Mass media | Precautions; safe injecting practices; waste management of sharps; S&D; Links to Safe Injection Programs |
confidential health services to PLHA, OVC, etc.  
4. Increase legal/policy protection for PLHA in workplace, schools, right to shelter/homes, right to health care insurance  
5. Establish a family court in Guyana  
6. Strengthen legislation protecting OVC and other youth from sexual abuse and exploitation

| **8. Out-of-school youth (OSY)** | 1. Increase knowledge about prevention methods, including ABCD  
2. Increase practice of prevention methods, including AB and condom use  
3. Increase self efficacy and negotiation skills of OSY to resist exploitative sex  
4. Increase HIV testing  
5. Increase health care | 1. # OSY who can cite at least 3 prevention methods  
2. See Prevention/ABCD indicators below  
3. # of OSY who can cite key negotiation skills  
4. # OSY receiving counseling and testing  
5. # OSY who access specific health care services | Mass media 
Prevention C&T  
STI services and Care, Support and Treatment  
1. Mass media; IPC/C, links to counseling/testing services, targeted peer education;  
2. CM events, music/drama, work with social network leaders;  
3. Links to PLHA NGOS and OVC programs;  
4. links between STD services and NGOs/FBOs |
<table>
<thead>
<tr>
<th><strong>9. Mobile populations (miners, loggers, etc.)</strong></th>
<th><strong>1. Increase condom use during sex with Commercial Sex Workers</strong>&lt;br&gt;2. Reduce alcohol abuse/illegal drug use&lt;br&gt;3. Increase health care seeking behavior&lt;br&gt;4. Increase HIV counseling and testing&lt;br&gt;5. Reduce S&amp;D</th>
<th><strong>1. # using condoms at every sex with CSW</strong>&lt;br&gt;2. # using condoms at last sex with CSW&lt;br&gt;3. # accessing health care services&lt;br&gt;4. # receiving counseling and testing&lt;br&gt;5. # who say they would work with PLHA</th>
<th>Prevention/Workplace programs&lt;br&gt;C&amp;T&lt;br&gt;STD services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>10. In-school youth (ISY)</strong></td>
<td><strong>1. Increase median age at first sex</strong>&lt;br&gt;2. Reduce transactional sex&lt;br&gt;3. Increase prevention knowledge and practice (ABCD)&lt;br&gt;5. Reduce S&amp;D&lt;br&gt;6. Increase FLE in schools</td>
<td><strong>1. Age at first sex</strong>&lt;br&gt;2. # engaging in transactional sex&lt;br&gt;3. See Prevention/ABCD indicators below&lt;br&gt;4. See S&amp;D indicators below&lt;br&gt;5. # FLE programs in schools</td>
<td>Prevention&lt;br&gt;Family Life Education (FLE)</td>
</tr>
<tr>
<td></td>
<td><strong>1. IPC/C, peer education, outreach, referrals to services, workplace programs,</strong></td>
<td><strong>1. IPC/C, school curricula, mass media, school events;</strong>&lt;br&gt;2. Prevention in school emphasizing A&amp;B; links to Care, Support and Treatment services, OVC programs</td>
<td></td>
</tr>
<tr>
<td><strong>11. General Population – Various Ethnic Groups</strong></td>
<td><strong>1. Increase knowledge and practice of prevention (ABCD) for HIV and STIs</strong>&lt;br&gt;2. Reduce S&amp;D&lt;br&gt;3. Increase community/national discussion about HIV/AIDS, S&amp;D</td>
<td><strong>1. # who can cite key facts about ABCD. See Prevention/ABCD indicators below</strong>&lt;br&gt;2. See S&amp;D indicators below&lt;br&gt;3. # who have discussed HIV/AIDS, S&amp;D etc. with a</td>
<td>Mass media&lt;br&gt;Referral systems&lt;br&gt;Prevention&lt;br&gt;C&amp;T&lt;br&gt;STD services&lt;br&gt;Condom social marketing</td>
</tr>
<tr>
<td></td>
<td><strong>1. Mass media through TV, radio and print; billboards, posters, bus stickers;</strong>&lt;br&gt;2. Referral systems with referral guides for clients (and providers)**</td>
<td><strong>Prevention using</strong></td>
<td><strong>Prevention using</strong></td>
</tr>
<tr>
<td>4.  Increase counseling and testing for HIV</td>
<td>1. # health care services available to interior populations</td>
<td></td>
<td></td>
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<tr>
<td>5.  Increase use of oral vs. injectable medications where appropriate</td>
<td>2. # seeking/accessing health care services</td>
<td></td>
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<tr>
<td>6.  Increase use of STI services</td>
<td>3.  See page 10 for ABCD indicators</td>
<td></td>
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<tr>
<td><strong>12. Interior Populations (Including Amerindians, people of mixed race, etc.)</strong></td>
<td>4.  # partners in last year</td>
<td></td>
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</tr>
<tr>
<td>1.  Increase access to health care</td>
<td>5.  # receiving counseling and testing services</td>
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</tr>
<tr>
<td>2.  Increase health care seeking behavior</td>
<td>Prevention</td>
<td></td>
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<tr>
<td>3.  Increase prevention practices, including condom use in commercial/transactional sex</td>
<td>Limited mass media</td>
<td></td>
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<tr>
<td>4.  Reduce number of partners</td>
<td>C&amp;T</td>
<td></td>
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<tr>
<td>5.  Increase HIV counseling and testing</td>
<td>STI services</td>
<td></td>
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<tr>
<td><strong>13. Uniformed Services</strong></td>
<td>Advocacy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Increase condom use during sex with CSWs</td>
<td>Prevention/outreach</td>
<td></td>
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<tr>
<td>2. Reduce alcohol abuse</td>
<td>Links to C&amp;T</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Reduce number of partners</td>
<td>Links to STI services</td>
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</tbody>
</table>

**Prevention** |

**Advocacy** |

**Links to C&T** |

**Links to STI services** |

**Condom social marketing** |

**1. Prevention activities should be tailored to the hierarchical military system, need to stress advocacy and get permission of “top**
4. Increase health care seeking behavior  
5. Increase access and use of STI services  
6. Increase HIV counseling and testing  

| 3. # partners in last year  
4. # seeking health care  
5. # STI services available to uniformed services  
6. # receiving counseling and testing services |

| 1. Increase prevention, including ABCD, particularly condom use  
2. Increase discussion of HIV/AIDS issues  
3. Reduce drug abuse  
4. Increase counseling and testing for HIV |

| 1. See Prevention/ABCD indicators below  
2. # who have discussed HIV/AIDS issues with fellow prisoners, visiting partner or family member  
3. # reporting drug abuse  
4. # receiving counseling and testing services |

| Prevention/outreach C&T |

| 1. NGO prevention programs can aim to establish peer leaders and counselors in prisons;  
2. Or bring same to prisons from outside |

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* Actual objectives need to be “SMART” (Specific, Measurable, Appropriate, Realistic and Time-bound) and will depend on National Goals and/or specific individual program goals/objectives. An example of a “SMART” objective would be: “Increase in correct and consistent condom use with each commercial partner by 30% among FSWs ages 18-24 at brothels in Georgetown in a one-year period.”

** Actual indicators will vary depending upon objectives selected/emphasized per program or intervention
<table>
<thead>
<tr>
<th>Objective</th>
<th>Illustrative Indicators</th>
</tr>
</thead>
</table>
| **Reduce stigma and discrimination**          | # of persons who would share a meal with a PLWHA  
3 of persons reporting accepting attitudes to PLWHA  
# of persons willing to disclose HIV status of a family member  
# of persons who would provide care for a relative PLWHA  
# of persons who think that an infected teacher should be allowed to teach their child  
# of persons who would buy from a shopkeeper who has HIV/AIDS  
# of public statements per year on Stigma and Discrimination |
| **Increase prevention using ABCDs as appropriate** | Increase of median age at first sex  
# of persons sexually active  
# of persons who have reduced their partners  
# of persons who reported having more than one partner  
Increase in consistent and correct condom use  
# of persons ever use drugs  
# of persons who use alcohol habitually  
# of persons who use drugs habitually  
# of persons who use drugs occasionally  
# of persons who use alcohol occasionally                                                                                                                                 |
| Additional Illustrative Indicators            | # of persons reported having family discussions on HIV/AIDS  
# of national consultations held on HIV/AIDS  
# of Community discussions held on HIV/AIDS  
# of groups participating in national discussions on HIV/AIDS  
# of groups participating in community level discussions                                                                                                                                 |
<p>| Improve access to ART and OI treatment for    | # of persons who are on ART treatment                                                                                                                                                                                   |</p>
<table>
<thead>
<tr>
<th>PLHA</th>
<th># of persons on OI treatment</th>
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<tbody>
<tr>
<td>Increase policy maker commitment to issues relating to HIV/AIDS, creating an enabling environment for program planning.</td>
<td># of newspaper articles, press releases which address HIV/AIDS issues</td>
</tr>
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<td></td>
<td># of statements by Ministers, parliamentarians which address HIV/AIDS issues</td>
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<td></td>
<td># of workplaces which have HIV/AIDS policies</td>
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</tbody>
</table>
### Appendix B

#### MEDIA LANDSCAPE OF GUYANA

<table>
<thead>
<tr>
<th>NAME OF TV STATION</th>
<th>REACH</th>
<th>COMMENTS</th>
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<tbody>
<tr>
<td>Channel 6- (CNS) TV Station</td>
<td>Georgetown, East Coast Demerara, East Bank of Demerara, Mahaica, Mahaicony (Region 4); West Bank, West Coast, Leguan (Region 3) and all of Essequibo Coast (Region 2)</td>
<td>Much locally produced programs. It has a very popular talk show. Many East Indian movies; has wide viewership. Has its own newscast.</td>
</tr>
<tr>
<td>Channel 8 -Dave TV (DTV)</td>
<td>Berbice (Region 6)</td>
<td>Station located in Region 6. Shows a lot of US programs. It has localized programs and advertisements. Soap operas, international news</td>
</tr>
<tr>
<td>Channel 2 GWTV</td>
<td>Georgetown, Mahaica, Timehri, (Region 4); Bartica (Region 7) &amp; Parts of Essequibo (Region 2)</td>
<td>Many movies; talk shows with a Christian bias. Has its own newscast. Soap operas, international news</td>
</tr>
<tr>
<td>Channel 10 (LRTV) Station</td>
<td>Berbice (Region 2)</td>
<td>Localized in Region 6. Shows USA programs. Has many localized programs and advertisements. Soap operas</td>
</tr>
<tr>
<td>Channel 14 Cable 65 (MTV)</td>
<td>Georgetown, Soesdyke, Timehri (Region 2); Skeldon, (Region2); Anna Regina (Region 2)</td>
<td>Many modern East Indian movies. Many government programs. Some local programs. Soap operas</td>
</tr>
<tr>
<td>(NTN) Channel 18 Cable 69</td>
<td>Georgetown, Linden Highway, Timehri, Essequibo up to Pomerroom &amp; Bartica, Mahaica, Mahaicony &amp; 40 Mile into Abary Creek,</td>
<td>Many ‘old’ East Indian and American movies. A lot of government shows.</td>
</tr>
<tr>
<td>Channel 11 National Communications Network (NCN)</td>
<td>Georgetown, East Coast of Demerara, East Bank of Demerara, West Bank of Demerara, West Coast of Demerara, Berbice, Linden</td>
<td>The national TV station. Mostly local (Guyanese) programs.</td>
</tr>
<tr>
<td>Channel 28 Vieira Communications Television (VCT)</td>
<td>Georgetown, East Coast Demerara, East Bank Demerara, West Coast, West Bank Demerara, (Region 4) West Coast Berbice, (Region 5) Corentyne, (Region 6) Anna Regina, (Region 2); Timehri, Linden Highway</td>
<td>Very few local programs. A lot of movies and other programs from North America. Soap operas, international news, talk shows</td>
</tr>
<tr>
<td>Channel 46 Cable 102 Vision Television (VTV)</td>
<td>Georgetown (Region 4)</td>
<td>A few local programs. Lots of movies. Talk shows</td>
</tr>
<tr>
<td>Channel 67</td>
<td>East Coast, some parts of Georgetown (Region 4)</td>
<td>Some local programming and many movies</td>
</tr>
<tr>
<td>Channel 13 RBS</td>
<td>Georgetown, East Coast of Demerara, East Bank of Demerara, West Coast of Demerara, West Bank of Demerara (Region 4); parts of Region 3</td>
<td>Sitcoms, soap operas, movies and a few local programs</td>
</tr>
<tr>
<td>Channel 4 Cable 21 STVS</td>
<td>Georgetown (Region 4)</td>
<td>Some local programs, Indian movies, American movies, music videos</td>
</tr>
<tr>
<td>Channel 7 (WRHM) TV</td>
<td>Georgetown, East Coast of Demerara, East Bank of Demerara, West Bank of Demerara, Timehri, Yaracarbo, Mahaica, Mahaicony, (Region 4); Parika (Region 2)</td>
<td>Local news cast, movies, international news</td>
</tr>
<tr>
<td>Channel 89</td>
<td>Region 4</td>
<td>Sports, international news</td>
</tr>
<tr>
<td>Channel 5 Tarzie TV</td>
<td>Region 7 Bartica</td>
<td>Localized programs, movies</td>
</tr>
<tr>
<td>Channel 8 - RCA</td>
<td>Region 2 Essequibo</td>
<td>Localized programs, movies</td>
</tr>
<tr>
<td>Newspapers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stabroek News</td>
<td>National</td>
<td>Wide circulation. Very analytical</td>
</tr>
<tr>
<td>The Guyana Chronicle</td>
<td>National</td>
<td>The national newspaper</td>
</tr>
<tr>
<td>Kaieteur News</td>
<td>National</td>
<td>Wide circulation. Popular due to sensationalized reporting</td>
</tr>
<tr>
<td>The Sunday Mirror</td>
<td>National</td>
<td>Circulated mainly among ruling party members</td>
</tr>
<tr>
<td>Radio Stations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NCN 560</td>
<td>Georgetown (Region 4) Essequibo (Region 2) Bartica, (Region 7); Linden, (Region 10); Berbice, (Region 6)</td>
<td></td>
</tr>
<tr>
<td>98.1</td>
<td>Georgetown, rural</td>
<td>Music station.</td>
</tr>
<tr>
<td>Radio Pairomack</td>
<td>This is in Region 9</td>
<td>Set up by UNESCO; Serves Region 9 only</td>
</tr>
</tbody>
</table>
APPENDIX C

Analysis of Specific Behavior Change Communication Campaigns & Interventions

Below is a summary of several past BCC campaigns and interventions in Guyana:


This was the main theme of the BCC program implemented for the Guyana HIV/AIDS/STI Youth Project for the period 2001-2004. The strategy promoted the ABCDs of HIV/AIDS prevention through mass media, peer education, events and print materials to address specific issues linking to prevention, care and support themes to community activities, traditional events, holidays, etc. Key features of the campaign were as follows:

- Developed on the basis of data obtained in the course of study of knowledge, attitudes and practices (KAP)
- Involved a diverse array of vehicle including mass media, advocacy, peer education, theatre, special events and materials to address specific issues
- Targeted Guyanese youth between the ages of 8-24
- Was intended to be implemented in 10 phases or waves

Key successes of the Ready Body campaign include:

- The strategy played an important role in increasing the level of HIV/AIDS awareness in Guyana
- The strategy assisted youths in addressing their general health issues
- Materials and ads featured youths of all ethnic origins in campaign ads
- The theme appeared to very popular among ‘at risk’ Guyanese youth and other youth between the ages of 15 and 25
- Ads made use of local Guyanese locations, high-risk “hot spots” (seawall, mini-bus environment, etc.)
- The target audiences identified with the ads and materials
- The media liked the theme and provided good coverage of the campaign events
- Free air time was donated to the campaign by some media houses
- The first campaign with an advertisement featuring young Indo-Guyanese

Some challenges encountered include:

- Although initial awareness of the theme was high, specific knowledge of what it meant to have a “ready body” appeared in the first wave to be lacking. This gap was addressed in the second wave of the campaign
- There was difficulty in reaching some audiences, particularly Indo-Guyanese youths
- Due to a significant media “spill-over effect,” the general public became well acquainted with the messages and products of the strategy. Some
older persons did not identify with the campaign (of course, they were not the intended audience for the strategy)

• The ads were regarded by a few as being merely funny or entertaining – the seriousness of the messages did not reach some members of the audience
• Feedback suggested that more Indo-Guyanese and other ethnic groups should have been made more visible
• More peer education needed to reach others
• Explanations of the theme were still needed among some youth

“Words Have Power” (2003)
This was a three-month campaign developed under the Youth Project to promote reduction of stigma and discrimination, primarily in the urban Georgetown minibus environment. Key features of the campaign include:

• The campaign employed a comprehensive approach, using mass media, interpersonal communication and traditional/community events.
• A formative qualitative assessment was conducted to gather information assessing the knowledge, attitudes and behaviors of minibus operators, “riders” (youths who spend leisure time on/around the buses) and travelers (people who merely use mini-buses as a transportation means) toward HIV/AIDS in general and people infected or thought to be infected by HIV/AIDS in particular.
• A follow-up assessment was conducted to gauge responses to the campaign
• The campaign was aimed at promoting positive talk about HIV/AIDS toward PLHAs on minibuses and in the minibus environment.
• Primary audience was the minibus operators, who were used as “change agents” for secondary audiences, including “riders” and the travelers on the minibuses
• The desired response was that words of respect be used when talking to and about PLHAs - the practice of non-discriminatory behavior towards PLHAs and others - correctly defining stigma and discrimination and persons must ask about S and D, the WHP campaign and HIV/AIDS
• The campaign utilized all aspects of the media – TV, radio, Newspapers, outdoor media – billboards, brochures posters and peer education
• Representatives of Indo-Guyanese and other ethnicities were featured in mass media ads, posters, brochures, stickers

Results of the campaign include:

• The recently completed BSS found that recall for the campaign among respondents in Regions 3, 4, 6, and 10 (the campaign did NOT target populations in Region 3) was over 75%
• The follow-up qualitative assessment found that:
  • Operators of minibuses with the WHP posters appeared to be making an effort to behave differently
• Minibus operators said that the general public treated them with more respect since their involvement in the campaign
• PLHAs said that the campaign was an avenue through which the issues of stigma/discrimination pertaining to HIV/AIDS could now be better addressed. This is the first campaign they had encountered that promoted respect for them
• Exposure to the campaign helped persons to reflect on their own discriminatory behavior
• Persons indicated that because of the campaign they wanted to get involved in HIV/AIDS work/education

Challenges of the campaign include:
• Some persons objected to the phrase “big up people living with HIV/AIDS”
• Some thought that HIV was portrayed as “cool”
• Its seemed to many that the campaign was abruptly discontinued
• Some thought Indo-Guyanese bus operators were not specially targeted or involved
• Some rural Indo-Guyanese did not identify with the slang “big up”
• The campaign was too short -- campaign efforts needed to continue longer than 3 months
• NGOs needed to participate in more follow-up activities


This initiative targeted pregnant women and aimed to increase the use of prevention services as well as prevent mother-to-child transmission of HIV. Key features of the campaign include:

• Assessments were done to identify the barriers to accepting PMTCT services
• Client-provider materials were developed to assist providers in interpersonal interactions with clients
• Materials included community poster, clinical posters, brochures, and buttons and laminated client-provider cue cards
• Health providers were sensitized in the subject
• Bodywork #2, a guide to care and support for peer educators was developed featuring PMTCT-related exercises
• The campaign was launched in the mass media; services were promoted through newspaper articles

Campaign Successes:
• Uptake in service attendance increased from 67%-84% in ________ months?
• Over ________(#) health care providers were sensitized on stigma and discrimination issues related to the clinic environment
Some challenges include:

- The general public was unaware of the service and more persons needed to be made aware of the service (budget constraints limited BCC at mass media level)

Me-To-You, Reach One, Save One (2004)

The aim of this Ministry of Health campaign was to create personal commitment to fight HIV/AIDS in Guyana through pledges from Guyanese around the country to “take immediate actions to prevent the spread of HIV and to respect persons living with HIV and AIDS.” The campaign received technical support from USAID/Population Services International (PSI).

The campaign included:

- Mass media including TV spots with testimonials by known athletes, actors and others
- “Pledge-a-thons,” and press conferences where prominent Guyanese took the pledge, including Guyanese President Bharrat Jagdeo, Prime Minister Samuel Hinds and other prominent Guyanese
- Launch events in all 10 of Guyana’s regions featuring Guyana’s Minister of Health, Dr. Lelsie Ramsammy
- BCC print materials and novelties

Successes of the Campaign include:

- The campaign received regional and international recognition (CARICOM, UNAIDS)
- The campaign achieved 55% of its target despite various challenges: By the end of 2004, 55,000 of the target of 100,000 pledges had been collected
- The campaign was launched in all ten of Guyana’s regions
- The campaign received endorsements by prominent celebrities and political leaders

Some challenges of the campaign include:

- The full goal of 100,000 pledges was impeded by:
  - Insufficient human resources and funding
  - A limited network for retrieving pledges
  - Challenges in collaboration between implementing partners

Some lessons learned from the campaign include:

- Community, political and religious groups require ongoing motivation to maintain consistent involvement
Comprehensive logistical planning for such a campaign is needed to retrieve and process pledges.

Roles and responsibilities among partners must be clarified from the start and throughout the campaign.

Earlier celebrity endorsements should be leveraged to gather event more of such endorsements.

**Vive Condom Social Marketing Campaign (2004)**

Guyana’s first condom social marketing campaign was launched by USAID/PSI on March 11, 2004 to promote Vive condoms targeting high-risk youth nationally. The campaign included mass media promotion (TV, radio, print and novelty items;) point of sale promotions, outdoor signage, and interpersonal promotion of the “ABCs” in 7 of the 10 regions of Guyana through peer outreach. NGOs/FBOs were supported to participate at the community level. The Vive campaign was accompanied by a generic condom promotion campaign (See Below) to stimulate demand for condoms in general.

**Successes included:**
- 526 sales outlets were established.
- Condom sales increased over the prior year of the campaign by nearly 70%.
- Availability of condoms increased dramatically, especially in urban areas

**Challenges included:**
- Implementation delays caused by relationships between the partners and change in the U.S. Administration position on condoms promoted to the general population.
- A prior study questioning the efficacy of condoms in preventing HIV infection funded by the Catholic Church.
- Strong competition from commercially available condoms and the need to combat the impression that Vive was a cheap, inferior brand.

**ABC Mass Media Campaign (2004)**

The campaign ran from January to October, 2004 and featured mass media promoting the “ABCs” of prevention: abstinence, being faithful and (generic) condom use, through television spots, BCC print materials and novelty items.

**Successes of the ABC Campaign include:**
- Produced and distributed 30,000 ABC pamphlets, 5,000 abstinence and 5,000 be faithful posters

**Challenges of the ABC Campaign include:**
• There are notable limitations among local ad agencies in terms of technical communication and HIV/AIDS issues
• There are limitations in Guyana in terms of production capacity
• There is a need to better measure media reach in country, despite low research capacity in Guyana

**New Start VCT Campaign (2004)**

The *New Start* campaign ran between January and October 2004 (during the same 9 months as the ABC campaign) and featured mass media (television, radio and paid print) promoting VCT services and messages addressing stigma.

**Successes of the *New Start* Campaign include:**

- The campaign established four NGO-franchised VCT sites; one stand-alone site and one VCT mobile unit in 6 months
- The mobile van reached all 10 regions; 1,383 people were counseled and tested
- 27% of those counseled and tested heard about the *New Start* site from a friend or relative; 24% saw an ad on TV

**Challenges include:**

- Existing policies for VCT were weak, thus delaying finalization of revised policies
- Coordination between NAPS and PSI was logistically challenging at times
- Limited NGO presence led to limited choice for site location
- Need for an additional mobile unit and better promotion, particularly at the Parika site
- Compliance issues by some franchised NGOs with respect to Project standards and protocols
# Appendix D

## Advantages and Disadvantages of Different Types of Communication Channels

<table>
<thead>
<tr>
<th>Channel</th>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Radio</td>
<td>Wide reach, even in rural areas in less developed countries</td>
<td>One-way (except for talk show format)</td>
</tr>
<tr>
<td></td>
<td>Inexpensive</td>
<td>Ill-suited for complex content</td>
</tr>
<tr>
<td></td>
<td>Can reach low-literate audiences</td>
<td>Difficult to assess degree of interest to audience</td>
</tr>
<tr>
<td></td>
<td>Good for mobilizing community to attend public events</td>
<td>Needs to be tied in with other means to be effective</td>
</tr>
<tr>
<td></td>
<td>Flexible formatting</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Well-suited for regular tune-ins</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Good for creating awareness and setting agendas</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Expensive (overall)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Receivers not always available in remote, rural areas</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Low audience participation (except for talk show format)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>More customary for political and entertainment content than education/development</td>
</tr>
<tr>
<td>Television</td>
<td>Popular</td>
<td>For literate audiences only</td>
</tr>
<tr>
<td></td>
<td>Combination of sound and picture allows complicated messages to be tackled</td>
<td>Difficult to reach remote areas</td>
</tr>
<tr>
<td></td>
<td>Well-suited for regular tune-ins</td>
<td>Expensive to produce quality items</td>
</tr>
<tr>
<td></td>
<td>Flexible formatting</td>
<td>One-way</td>
</tr>
<tr>
<td></td>
<td>Good for low-literate audiences</td>
<td>Feedback is difficult</td>
</tr>
<tr>
<td></td>
<td>Good for creating awareness and setting agendas</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Cost effective on per-person reached basis</td>
<td></td>
</tr>
<tr>
<td>Print</td>
<td>Can be detailed</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Good for clear explanation of technical issues</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Good for creating awareness and mobilizing public opinion</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Can be shared/re-used and referenced</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Good for development topics</td>
<td></td>
</tr>
<tr>
<td>Cinema/Film</td>
<td>Captures attention</td>
<td>Distribution can be difficult</td>
</tr>
<tr>
<td></td>
<td>Very wide reach (with traveling cinemas)</td>
<td>Good films are hard to make</td>
</tr>
<tr>
<td></td>
<td>Can be re-used</td>
<td>One-way</td>
</tr>
<tr>
<td></td>
<td>Effective when linked to interpersonal channels/discussions</td>
<td>Requires costly equipment</td>
</tr>
<tr>
<td>Theater</td>
<td>Culturally relevant</td>
<td>Incomplete control over message</td>
</tr>
<tr>
<td></td>
<td>Credible</td>
<td>Format can distract</td>
</tr>
<tr>
<td>Billboards</td>
<td>Wide reach</td>
<td>Can be easy to ignore</td>
</tr>
<tr>
<td></td>
<td>Inexpensive if well-located</td>
<td>Limited to simple messages</td>
</tr>
<tr>
<td></td>
<td>Good for simple messages</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Good “reminder” medium</td>
<td></td>
</tr>
<tr>
<td>Leaflets,</td>
<td>Good for in-depth presentation of technical issues</td>
<td>Can be expensive per item</td>
</tr>
<tr>
<td>brochures, etc.</td>
<td>Easy to reference and personalize</td>
<td>Need to be well-written and produced to be effective</td>
</tr>
<tr>
<td></td>
<td>Use of graphics improves presentation</td>
<td></td>
</tr>
<tr>
<td>Method</td>
<td>Advantages</td>
<td>Disadvantages</td>
</tr>
<tr>
<td>-------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| **Video**               | Good for teaching small groups  
Good for explaining complicated and technical issues  
Good at stimulating Immediate feedback                                                                                                             | Expensive; requires costly equipment  
Needs to cover all members of community to avoid strife  
Needs professional facilitator for sessions  
Needs to be combined with booklets and leaflets for maximum effectiveness                                                                 |
| **Flipcharts/Discussion Cards** | Can be stopped at any point  
Good for explaining ideas in a sequence  
Good for strengthening client-provider interaction                                                                                          | Can be seen only by a few people at a time  
May be difficult to explain complex ideas  
Wear out quickly if not laminated                                                                                                              |
| **Models and displays** | Good for detailed illustrations of ideas  
Suitable for different occasions                                                                                                                | Requires skill in building  
Can be difficult to store or move                                                                                                               |
| **Maps, charts, diagrams** | Visually appealing  
Permit study at one’s own pace                                                                                                               | Can oversimplify complex ideas  
Symbols and layout need to be chosen carefully                                                                                                     |
| **Slides**              | Easy to make with local photos  
Flexible and topical  
Good for illustrating a concept                                                                                                               | Could be expensive  
Needs good commentary                                                                                                                          |
| **Interpersonal Channels (Counseling, support groups, peer education)** | Most effective in promoting behavior change/positive behaviors  
Most interactive and engaging for target populations  
Important to link to mass media to explain mass media messages                                                                                   | Expensive: require considerable training, human and financial resources, monitoring and evaluation                                                  |
| **Events**              | Offer good opportunities for interpersonal communication  
Lend cultural credibility to message delivery  
Opportunities to distribute small/print media                                                                                                     | Difficult to monitor/evaluate effectiveness                                                                                                        |
# Appendix E

## MINISTRY OF HEALTH-DEPARTMENT OF DISEASE CONTROL
### HIV/AIDS/STI-/Related Surveys and Studies

<table>
<thead>
<tr>
<th>Name of Study</th>
<th>Funding</th>
<th>Executing agency</th>
<th>Date Start</th>
<th>Date finish</th>
<th>Status</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behaviour Surveillance</td>
<td>USAID</td>
<td>FHI, MACRO, GRPA</td>
<td>March 200</td>
<td>Dec 2004</td>
<td>Final Draft of Vol. 1 (Youths, CSW, MSM, GUYSUCO) submitted to MOH, Completion of Data collection from the discipline services. Comments from MOH team on report forwarded to Minister and FHI Final report to be written MOH to publish Seminar to present findings</td>
<td>Baseline 3-5 years</td>
</tr>
<tr>
<td>HIV/AIDS Service Provider Assessment (SPA)</td>
<td>MACRO GHPA</td>
<td></td>
<td></td>
<td></td>
<td>Data collection completed PMTCT site inventories, observation data and exist interviews with FHI for analysis Survey indicators identified Analysis to be done by MACRO Report preparation in progress Plan for seminar on “Data Use” developed</td>
<td>Baseline 5 years</td>
</tr>
<tr>
<td>Demographic health Survey (DHS) All Population Groups</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Plan for full DHS in 3 years. Some DHS indicators will be provided by AIS</td>
<td>Every 5 years</td>
</tr>
<tr>
<td>AIDS Indicator Survey (AIS) (Partial DHS)</td>
<td>USAID</td>
<td>MACRO GHPA</td>
<td>Jan 2005</td>
<td>Sept 2005</td>
<td>Study Committee established Survey questionnaire revised and finalized, includes malaria and TB. No HIV testing in this survey. Interviewees selected, training completed</td>
<td>5 years</td>
</tr>
<tr>
<td>Study/Project Description</td>
<td>Implementor</td>
<td>Year(s)</td>
<td>Main Data Collected (Phase)</td>
<td>Description</td>
<td>Lead Agency</td>
<td>Reporting Frequency</td>
</tr>
<tr>
<td>---------------------------------------------------------------</td>
<td>-------------------</td>
<td>---------</td>
<td>-----------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-------------</td>
<td>---------------------</td>
</tr>
</tbody>
</table>
| Ante- natal Care Survey (ANC)                                 | CAREC             | 2001    | 2002 2003                   | Field practice/ Pilot testing in progress  
Sample frame (ED’s and listing) for rural communities completed  
ED mapping and listing for Urban areas commence  
Bureau of Statistics to supervise the mapping/listing | MOH PAHO     | Completed for 2004 Yearly report | yearly |
| ANC Sentinel Surveillance                                    |                   |         | 2004                        |                                                                                                                                             | CDC         | Report for 2004                                              |       |
| Prevention of Mother to child transmission Drop out Study (PMTCT Uptake) | USAID             | March 2005 | Aug 2005                   | Study Committee established March 2005  
Study protocol developed  
Instrument tested  
Data collection (Phase I) Apr 5-May19  
Data Collection (Phase II) Apr 18 – May 27  
MACRO and MOH to analyze data and prepare reports | MOH         | Protocol for review of charts of HIV+ persons with baseline CD4 counts prior to commencement of ART been developed | Baseline 2 years |
<p>| HIV Treatment Impact Evaluation Pilot (HTIE) Cohort Study | MOH               | June 2005 | Aug 2005                   | Protocol for review of charts of HIV+ persons with baseline CD4 counts prior to commencement of ART been developed | MOH         | Protocol for review of charts of HIV+ persons with baseline CD4 counts prior to commencement of ART been developed | Baseline Yearly |
| Anti- Retro Viral Adherence Study (ARV-AS)                    | USAID             | 2005    | 2006                        | Protocol for review of charts of HIV+ persons with baseline CD4 counts prior to commencement of ART been developed | MACRO MOH   | Protocol for review of charts of HIV+ persons with baseline CD4 counts prior to commencement of ART been developed | Baseline 2 years |
| Multiple Indicator Control Study (MICS)                      | UNICEF            | 2006    |                             |                                                                                                                                             | UNICEF MOH  | Protocol for review of charts of HIV+ persons with baseline CD4 counts prior to commencement of ART been developed | Baseline 5 years |</p>
<table>
<thead>
<tr>
<th>STI typing and sensitivity study</th>
<th>CIDA</th>
<th>2003</th>
<th>2005</th>
<th>CSIH MOH</th>
<th>Baseline 3 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV Drug Resistance (HIVDR)</td>
<td>No Funding</td>
<td>2006-2007</td>
<td></td>
<td>Not planned</td>
<td></td>
</tr>
<tr>
<td>Most At Risk Populations Surveillance (MARP) Youths, CSW (M &amp;F) Men Sexuality Female Sexuality Study</td>
<td>2006-2007 Individual studies</td>
<td></td>
<td>Not planned</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sample Vital Registration with Verbal Autopsy (SAVVY)</td>
<td>MOH</td>
<td>2006-2007</td>
<td>Onwards</td>
<td>MOH</td>
<td>The registry of Births and Deaths supplies up to date information on all deaths to the MOH Mortality is calculated on a yearly basis and the top ten causes of death by age group is published yearly</td>
</tr>
</tbody>
</table>
## APPENDIX F

### Timeline for Addressing Priority Populations

<table>
<thead>
<tr>
<th>Priority Target Population</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Commercial sex workers (CSWs)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>-Clients of CSWs</td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>-Regular/intimate partners of CSWs</td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>2. Men who have sex with men</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Female partners of MSM</td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>3. People living with HIV/AIDS (PLHA) and those affected by HIV/AIDS (PLHA)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>4. Orphans and other vulnerable children (OVC, including street children)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>5. STI patients/clients</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>6. Health care workers</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Policy makers</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>8. Out-of-school youth</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>9. Mobile populations (miners, loggers, construction workers)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>10. In-School youth</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>11. General Population</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Interior Populations</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>13. Uniformed Services</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>14. Prisoners</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>
APPENDIX G

Tips for Developing Mass Media Campaigns

A mass media campaign is a planned set of communication activities designed to inform and/or persuade one or more target populations within a set time period. Mass media campaigns usually include a combination of some of the following channels: television, radio, paid print advertising, free media coverage, outdoor signage, print materials such as leaflets or brochures, internet, text messaging, etc.

Budget permitting, a mass media campaign can be an effective way to reach many people quickly and in a way that is cost efficient per person reached.

Experience in Guyana and elsewhere has shown that mass media campaigns are best conducted as part of an overall BCC strategy, linked to interpersonal and other BCC channels and/or interventions.

Some tips for developing effective mass media campaigns include:

- **Develop a unifying theme, logo and consistent messages** – Effective campaign themes and logos can get the attention of target populations and make a campaign memorable. Examples of themes that have been used in Guyana include: Me-To-You, Reach One, Save One (2004); Words Have Power (2003); and “Ready Body, Is it Really Ready” (2001-2004). See Appendix C for a detailed discussion of these and other campaigns implemented in Guyana.

- **Involve stakeholders** – Stakeholders support is crucial to the success of any campaign. They should be included in every step of the development and implementation of any campaign. They should approve of campaign messages, materials and activities BEFORE they are finalized.

- **Involve communities** – Community members are important “stakeholders” who should be included in development, implementation and monitoring of any campaign. Be sure to include mechanisms for monitoring community responses to mass media campaigns.

- **Financial and human resources** – Campaign implementers should be able to justify the cost of a campaign in terms of the numbers of individuals reached. There should be sufficient human resources to work on the campaign: a full-time coordinator and team of specialists is usually required.

- **Timing** – Be sure that the campaign does not conflict with other important events. Also be sure that any services or commodities being promoted are ready in ample quantity and quality BEFORE the campaign begins.

- **Location** – Campaign activities should be strategically placed to ensure maximum community exposure and involvement.
• **Monitoring and Evaluation** – Every campaign should have a monitoring and evaluation plan. Since behavior change takes time, campaigns often measure the “antecedents” of behavior change, such as awareness, knowledge, concern, motivation and partner or community discussion. Examples of indicators for these outcomes include:
  o % of target population who can describe unprompted the logo for a campaign
  o % of target population who can recall unprompted the theme or main messages of a campaign
  o % change of target population who can cite at least three modes of transmission of HIV (if campaign addressed this)
  o % change of target population who can cite at least three methods of preventing HIV transmission (if campaign addressed this)
  o # of target population who discussed campaign theme or messages with a partner, family or community member
## APPENDIX H

<table>
<thead>
<tr>
<th>Organization</th>
<th>Past Work</th>
<th>Current Areas of Assistance/BCC</th>
<th>Timeline/Estimated Funding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adolescent Health Unit</td>
<td>Health promotion in Primary and secondary schools. Focus will be on promoting/educating on healthy lifestyles including HIV/AIDS prevention</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CAREC</td>
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<tr>
<td>CARICOM (PANCAP)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CDC</td>
<td>Laboratory strengthening, treatment, testing surveillance</td>
<td>MARCH – soap operas, IPC material to support mass media</td>
<td>Annually/ $1-3 million</td>
</tr>
<tr>
<td>CIDA/BCCI</td>
<td>HIV/AIDS prevention, communicable disease control, Pilot health management information system, stigma and discrimination, DOTS expansion</td>
<td>2003-2006/ $3 million</td>
<td></td>
</tr>
<tr>
<td>CRN+/G+</td>
<td>Peer Education Training</td>
<td>Peer Education trainings</td>
<td></td>
</tr>
<tr>
<td>Catholic Relief Services</td>
<td></td>
<td>Development of posters</td>
<td></td>
</tr>
<tr>
<td>DFID</td>
<td>Accelerating private sector action on HIV/AIDS in the tourism sector</td>
<td>Partnerships for scaling up regional and sub-regional responses</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Strengthened donor coherence programme areas. Knowledge, Behaviour, Stigma and Discrimination, STI Care and treatment, Capacity Building and ARV Procurement.</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>Faith Based Groups will be held in Guyana in November 2005 in collaboration with the Caribbean Council of Churches.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>European Union</td>
<td>Strengthen national capacity to respond to HIV/AIDS</td>
<td></td>
<td>Limited</td>
</tr>
<tr>
<td>FXB</td>
<td>Was involved in the Development of a Guyana</td>
<td>ARV therapy</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>HIV-TB care</td>
<td></td>
</tr>
<tr>
<td>Organization</td>
<td>Activity</td>
<td>Description</td>
<td>Funding</td>
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<tr>
<td>-------------------------------</td>
<td>---------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-----------</td>
</tr>
<tr>
<td>PMTCT curriculum for training health care providers</td>
<td>Development of a strategic national HIV training curriculum and plan for in-service personnel Developed the first ever Guyana HIV Management guidelines for HIV treatment for adults and children Pioneering family centered and pediatric HIV care Development and expansion of PMTCT Plus activities in 6 clinics</td>
<td>Laboratory support</td>
<td></td>
</tr>
<tr>
<td>GFTAM</td>
<td>Multifaceted proposal for HIV/AIDS prevention, treatment, care and support. Training of personnel, management information system, upgrade laboratory capacity and capability, strengthen surveillance systems, quality care for persons living with HIV/AIDS, expand VCT, reduce stigma and discrimination, condom social marketing</td>
<td>$10-20 million/2002-2008</td>
<td></td>
</tr>
<tr>
<td>ILO/USDOL</td>
<td>Formulation of HIV/AIDS policy at specific workplaces</td>
<td>Development if work programs, trainings and communication materials for the workplace BCC strategies developed for specific sectors</td>
<td></td>
</tr>
<tr>
<td>IDB</td>
<td>Small grants for HIV/AIDS programs</td>
<td></td>
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</tr>
<tr>
<td>Ministry of Education</td>
<td>HIV/AIDS Prevention and Control Project launched Creation of a ministerial committee on HIV/AIDS which coordinate and implement HIV/AIDS activities Activities focusing on</td>
<td>Interactive Radio Programme which will help parents, teachers and other members of the public how to relate to children early on HIV/AIDS and other related topics Implementation of projects to educate the staff om the impact of HIV/AIDS on the workplace</td>
<td></td>
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<tr>
<td>Organization</td>
<td>Activities</td>
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<td>-----------------------------------------------------------------------------</td>
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<td></td>
</tr>
<tr>
<td>Ministry of Health</td>
<td>Prevention of HIV/AIDS and STIs through training, education and behaviour communication, condom distribution, information dissemination, treatment and care for infected and affected families, workplace policy formulation including stigma and discrimination and HIV/AIDS impact and assessments. Distribution of HIV/AIDS material</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ministry of Health (HSDU)</td>
<td>Implementing the World Bank and Global Fund</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ministry of Labor, Human Services and Social Security</td>
<td>Coordinating the formulation of Guyana’s national Strategic Plan Coordinating efforts to draft national M and E plan</td>
<td></td>
<td></td>
</tr>
<tr>
<td>OXFAM</td>
<td>Coordinating the formulation of Guyana’s national Strategic Plan Coordinating efforts to draft national M and E plan</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PAHO (WHO/MOH)</td>
<td>Prevention Education on HIV/AIDS, other STI's, Teenage pregnancy, Promotion of health living for non remunerated blood donors Care and support for PLWHs and OVC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Peace Corps</td>
<td>Volunteers are working in the health sector</td>
<td></td>
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<tr>
<td>Red Cross</td>
<td>Peer Education, Palliative Care Training, Advocacy Against Stigma and Discrimination</td>
<td></td>
<td></td>
</tr>
<tr>
<td>UNAIDS</td>
<td>Coordinates HIV/AIDS activities for the United nations Theme Group</td>
<td></td>
<td></td>
</tr>
<tr>
<td>UNDCP</td>
<td>Supports the Ministry of Labour in implementing an AIDS in the</td>
<td></td>
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<tr>
<td>UNDP</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Organization</td>
<td>Activities</td>
<td>Focus Areas</td>
<td>Grants/program details</td>
</tr>
<tr>
<td>-------------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------</td>
<td>--------------------------------------------</td>
</tr>
<tr>
<td>Training and educational approaches to build capacity in leadership, emotional intelligence and other interpersonal skills and including HIV/AIDS</td>
<td>Workplace project Will continue support in capacity building, support to civil society, advocacy, partnership development, resource mobilization and coordination and harmonization of project with partners</td>
<td>UNFPA/OPEC</td>
<td>2001-2005/$1.6 million</td>
</tr>
<tr>
<td>UNFPA/OPEC</td>
<td></td>
<td>Is committed to continue to work in the area of HIV/AIDS Prevention among youth in especially difficult circumstances National Program of prevention among vulnerable youth Community based approach which will involve parents, teachers and community leaders</td>
<td></td>
</tr>
<tr>
<td>UNICEF</td>
<td>Youth friendly spaces Youth fairs Advocacy and sensitization activities with religious communities</td>
<td>Healthy Family Life Education program with Ministry of Education; Dutch government support to Linden Care Foundation for work with orphans</td>
<td></td>
</tr>
<tr>
<td>USAID/GHARP</td>
<td>Promote positive attitudes and practices including Delayed Sexual Debut, (abstinence) Consistent Condom Use and Reduction of Sexual Partners or Faithfulness through targeted mass-media campaigns and below the line (BTL) communication materials. VCT/PMTCT – encouragement of use of services Anti Stigma and discrimination campaign</td>
<td>Promote positive attitudes and practices including Delayed Sexual Debut, (abstinence) Consistent Condom Use and Reduction of Sexual Partners or Faithfulness through targeted mass-media campaigns and below the line (BTL) communication materials. VCT/PMTCT – encouragement of use of services Anti Stigma and discrimination campaign</td>
<td>2001-2005/$1.6 million</td>
</tr>
<tr>
<td>USAID/Initiatives</td>
<td>Promoting safe injection practices and safe waste management</td>
<td>Promote safe injection and safe waste management in more sites</td>
<td></td>
</tr>
<tr>
<td>USAID/MACR O(AIS)</td>
<td>Surveys</td>
<td>Surveys and KAPS</td>
<td></td>
</tr>
<tr>
<td>WHO</td>
<td>Technical assistance for HIV/AIDS prevention, TB and malaria control; small grants scheme management</td>
<td></td>
<td>Ongoing</td>
</tr>
<tr>
<td>World Bank</td>
<td>Possible grant for HIV/AIDS Program</td>
<td></td>
<td>$6 million</td>
</tr>
</tbody>
</table>
CAREC
CAREC will base their priorities on the National Strategic Plan. (for more information please contact:
Cherryl O’Neil: oneilche@carec.paho.org or
Jones Madeira: madeirjo@carec.paho.org

CARICOM/PANCAP

CDC

CIDA/BCCI

The Caribbean Regional Network Of People Living with HIV/AIDS (CRN+)

The Caribbean Regional Network of People Living with HIV/AIDS (CRN+) was established in 1996, with a Secretariat based in Trinidad and Tobago. It is part of the Global Network of People Living with HIV/AIDS (GNP+), headquartered in the Netherlands, whose overall aim is to improve the quality of life of people living with HIV/AIDS.

CRN+ is dedicated to raising awareness about issues concerning PLWHA and to empowering and supporting persons affected and infected with HIV/AIDS through information exchange, advocacy, lobbying, research, partnerships, capacity building and resource mobilization.

CRN+ carries out its mission through national networks in its member territories that emphasize skills training and capacity building (both human and institutional) in all the above-mentioned focus areas. CRN+ has representation in the Caribbean including: 6 Dutch speaking; 14 English speaking, including Guyana; 5 French speaking and 2 Spanish speaking territories.

Some Networks associated with CRN+ are currently supported by the European Project, Strengthening Institutional Regional Response to HIV/AIDS in the Caribbean (SIRHASC).

In addition, CRN+ is also developing/implementing the following:
Ø Peer education trainings
Ø Development of posters – in the process of creating a new concept for the Commonwealth Youth for positive living.
But what specifically is CRN+ supporting or doing in Guyana? Is it mainly supporting G+? If so, how?

Commonwealth Youth Programme (CYS)

The Commonwealth Youth Programme (CYP) Caribbean Centre is located in Georgetown, Guyana and is one of the four Centres established to serve other countries of the Commonwealth spread across the globe. The Caribbean Centre serves the Commonwealth Caribbean and Canada. These eighteen countries together have a total population of 33.6 million people and a youth population of approximately 5.4 million.

On March 27th, 2003, a Memorandum of Understanding was signed between CYP and The Network of Guyanese Living with HIV/AIDS (G+), to establish a forum of youth living with and affected by HIV/AIDS as it was observed that youth with HIV/AIDS often went into denial and hiding which in turn lead to an overall avoidance of family assistance, social support groups and medical care treatment.

Initially this intervention was intended to for only youth living with HIV/AIDS but due to high stigma and discrimination, the youths affected by the epidemic were merged into the group. Twenty - two persons were trained in positive living and to date these peers appear on radio talk shows, conduct educational sessions with youths in and out of school and are also trained by G+ to address issues related to living with HIV/AIDS as peer educators of the network. CYP was also very supportive in providing some necessary and urgent funds for travels overseas for one of its members.

Catholic Relief Services (CRS)

DFID

European Union

FXB

FXB has been involved in HIV/AIDS programming in Guyana since 2002, when CDC Guyana requested their support as a technical partner under a Global Aids program cooperative agreement.

To date, FXB activities in Guyana have included:
1.) Development of a Guyana PMTCT Curriculum for training health care providers
2.) Development of a strategic National HIV training curriculum and plan for in-service personnel
3.) Development of the first ever Guyana HIV Management guidelines for HIV treatment for adults and children
4.) Pioneering family centered and pediatric HIV care in the country
5.) Development and expansion of PMTCT-Plus activities in 6 clinics
Plans for 2006 include the following targets:
1.) 1100 patients on ART, 5-10% of whom will be children
2.)  HIV-TB care for 150 persons
3.) 4000 CD4 counts carried out in laboratory
4.) Establishment of a treatment site in Bartica and Madhia

Longer term treatment goals include contributing toward attainment of the following targets in Guyana by 2008:
   1.) Preventing 15,000 new infections
   2.) Providing care for 13,200 persons
   3.) Providing antiretroviral therapy for 1,800 persons

GFTAM

GLOBAL FUND

Project Title:
National Initiative to Accelerate Access to Prevention, Treatment, Care and Support for Persons Affected by HIV/AIDS

The goal of this program component is to reduce the spread of HIV/AIDS in Guyana, reduce morbidity and mortality, and mitigate the social and economic impact of the epidemic. This goal will be achieved by providing a comprehensive and integrated program of stigma reduction, prevention, care and support and by increasing national capacity to fight the epidemic. Existing prevention, treatment, care and support services will be improved and expanded to all regions of the country and new services will be introduced where needed. Successful implementation of this project is expected to result in widespread impact, including the following:

1. Decreased incidence of HIV, both in the general population and within defined sub-populations, such as youth, CSWs, MSMs and prisoners;
2. Decreased stigma and discrimination associated with HIV/AIDS;
3. Increased willingness to seek early testing and treatment;
4. Increased length and quality of life for PLWHAs;
5. Improved social and economic outcomes for PLWHAs and their families;
6. Decreased productivity losses for both the private and public sectors;
7. Improved management, laboratory and surveillance infrastructure and systems.

ILO/USDOL

IDB

Ministry of Education
Ministry of Health

-Adolescent Health Unit – The unit is currently involved in overseeing implementation of programs that include HIV/AIDS Prevention, Treatment and Care components. Prevention programs include:
  1. PAHO/Health Promotion in Primary and Secondary schools, supported by PAHO. Focus will be on promoting/educating on healthy lifestyles, including HIV/AIDS prevention. Activities include health clubs and national camp/meetings 3X per year
  2. UNFPA/OPEC – National program of Prevention among vulnerable youth. Includes community-based approach involving parents, teachers, community leaders. Advocacy component involves young parliamentarians. Targets poor youth living near miners and other mobile working populations
  3. UNICEF/UNFPA/USAID – Youth-Friendly Health Services. New program to promote wellness instead of absence of disease. Hope to overcome barriers to friendly services, including staff attitudes, dress codes. Includes training all staff to offer friendly services, including VCT, STI, RH, etc.

Ministry of Health/ Health Sector Development Unit (HSDU)

Ministry of Labor, etc.

Network of Guyanese Living with HIV/AIDS (G+)

The Network of Guyanese Living with HIV/AIDS (G+) was formed in 1997 as a Non Governmental Organization, with the support of CRN+ (see above.) The mission of G+ is to enable persons living with HIV/AIDS to empower themselves and sustain their quality of life through mutual support and collective action. G+ aims to promote the involvement of PLHA as part of the solution to impacting on the HIV/AIDS epidemic, not the problem.

The objectives of G+ include to:
  (a) Actively lobby and advocate for the equality and human rights of persons living with HIV/AIDS.
  (b) Foster individual and community development through information exchange systems and capacity building.
  (c) Promote and advocate for proper health care services, health care facilities and access to treatment for persons living with HIV/AIDS.
  (d) Create a safe environment where people living with HIV/AIDS can meet, interact and give mutual support.
  (e) To network with persons and groups with mutual interest nationally, regionally and internationally.
The Government of Guyana regards the involvement of G+ and other organizations of PLHA as crucial to an effective, comprehensive response to the epidemic.

G+ will be conducting a self assessment on treatment adherence for people living with HIV/AIDS.
Collaborate with GHARP, NGOs and other stakeholders in their mass media campaign implementing programmes with behavioral change communication in the following areas; article writing jingles on the radio, flyers distribution, sporting activity/focus on behavioral change communication and short stories and painting activity.

**Trainings**
Trainer of trainer treatment adherence and peer supportive counseling.
Information technology.
Conduct 3 behavioral change & communication workshops among two hundred
(200) PLWHA to reduce the number of re-infection and new infection of HIV/AIDS
Conduct forth-nightly therapeutic sessions within the support groups that were previously established in regions 3, 4, 5, 6 & 7 for two hundred (200) PLWHA sharing experiences, challenges of adherence and reinforcement of behavioral change communication.

Due to circumstances beyond my control, a lot of other trainings which were initially in the work-plan cannot be implemented because of the timeline project comes to an end, which is September 2005.

**OXFAM**

**PAHO/WHO**

**PAHO PRIORITIES**

In the past years PAHO-Guyana has focused on providing technical assistance to all areas related to HIV/AIDS.

At the request of the Ministry of Health, PAHO will coordinate national efforts for the formulation of the National Strategic Plan through organization of a series of workshops in different areas of HIV/AIDS activities. Also, PAHO is coordinating efforts to draft a national M&E Plan.
PAHO's foremost priority in the HIV/AIDS field will be working towards "Universal access to health services": creating equal access to care and treatment, and encouraging people to seek care. This encompasses both improving the quality of care as well as increasing the access to services, which cover all aspects of health as related to HIV/AIDS: promotion of care and treatment, PMTCT, VCT, stigma and discrimination. Target groups are vulnerable populations and hard to reach populations. PAHO will also continue providing technical support where needed.

Peace Corps

Red Cross

UNAIDS

UNDCP

UNDP

UNDP has maintained a portfolio of HIV/AIDS work in Guyana. In 2003, UNDP supported training-of-trainer workshops on Leadership and HIV/AIDS for more than eighty national stakeholders working in HIV/AIDS programs. In 2004, UNDP supported three organizations -- The Hope Foundation, Dare to Change.COM (DTC.COM) and The Future Club 2003 -- with training and educational approaches to build capacity in leadership, emotional intelligence and other interpersonal skills and including HIV/AIDS.

Currently, UNDP supports the Ministry of Labour, Human Services & Social Security in implementing an AIDS in the Workplace Project. A main output of this project will be a National Tripartite Policy on HIV/AIDS and the world of work. The project also includes establishment of an oversight committee of NAC, NAPS, ILO, UNAIDS, UNDP, Trade Unions and HSDU, and training for management of 27 firms in Guyana.

Over the period 2005-2006, UNDP will continue to support the Guyana Government in the following areas: capacity building, support to civil society, advocacy, partnership development, resource mobilization and coordination and harmonization of project with partners.

UNFPA (OPEC)
UNITED NATIONS POPULATION FUND HIV/AIDS INTERVENTION IN GUYANA

The United Nations Population Fund in its previous cycle (1999-2002) funded an Adolescent Sexual and Reproductive Health Project with the aim ‘to improve the quality of life, well being and the sexual and reproductive health of adolescents and youth’ in four communities – Port Mourant, Beterverwagting, St. Cuthbert’s Mission and Victory Valley. This project commenced in 1999 and concluded in 2002. The executing agencies were the Ministry of Health and the Guyana Responsible Parenthood Association. One of the outcomes of the project was the establishment of an Adolescent and Young Adults Health and Wellness Unit within the Ministry of Health to integrate adolescent health and wellness into the Ministry’s delivery of services.

Currently The United Nations Population Fund is providing financial resources for the Director of the Adolescent and Young Adults Health and Wellness Unit under which falls the UNFPA/OPEC Fund HIV/AIDS Prevention Project for Youth in especially difficult circumstances.

On July 9, 2004, the Government of Guyana, the United Nations Population Fund, UNFPA and the OPEC FUND signed an agreement for a project titled “GOG/OPEC FUND/UNFPA HIV/AIDS Prevention Project for Youth in especially difficult circumstances”. The goal of the project is to contribute to the Government of Guyana’s efforts towards the attainment of the ICPD targets and Millennium Development Goals through a decrease in the incidence of HIV AIDS among youth in especially difficult circumstances. This project provides technical assistance, research, training, institutional strengthening including the purchase of equipment and vehicles to boost Guyana’s capacity to deal with HIV/AIDS awareness, reduction and adolescent, sexual and reproductive health and rights.

PARTNERS
- Ministry of Education – Health and Family Life Education
- Ministry of Culture, Youth and Sports
- Community Based Groups

The main beneficiaries are:
- Young males and females (10 – 24 years)
- Parents, Community and religious leaders, Minibus drivers and conductors, Night club owners and Disk Jockeys
- Staff and volunteers of government and non-government agencies in civil society, who serve the beneficiaries. These include health personnel, social workers and counselors.

Activities are implemented in the communities of Parika, Beterverwagting/Truimph, Sophia, Lodge, Mibicuri, Port Mourant, Fyrish, Angoy’s Avenue, Madhia and Linden. This project comes to an end in December 2006.

UNFPA does not at present have a strategy for HIV/AIDS work (or BCC) for after 2006 UNFPA is however committed in continuing to work in the area of HIV/AIDS Prevention among youth in especially difficult circumstances in Guyana.
UNICEF

UNICEF has supported interventions, including HIV/AIDS-related programs targeting youth and children in Guyana since __________. Programs have included various BCC interventions, including:

**In 2002 UNICEF Guyana completed several activities, these include:** The establishment of Youth Friendly Spaces, upgrading of Youth Friendly Spaces to include VCT sites, organisation of Youth Fairs on HIV/AIDS with “edu-tainment” methods, advocacy and sensitisation activities with religious leaders, building of capacity of Youth organisations in project management issues, organisation of a Youth Camp, sensitisation of indigenous communities, undertaking of life skills education for out-of-school youths and street children, supporting of national PMTCT coordinator, and training of health care workers.

**Some of the main activities planned for 2005 include:** Building of managerial and institutional capacity of partner NGOs (incl. networking and communication skills), advocacy and sensitisation of religious leaders, also linking to UN Social Cohesion Project, supporting of establishment and upgrading of Youth Friendly Spaces and VCCT sites, Evaluation of impact of Youth Fairs and peer education trainings, review and consolidation of peer education initiatives supported by UNICEF, improvement of knowledge management of data and information, initiation of advocacy initiatives utilizing sports and sports role models.

USAID/GHARP

D. History of USAID Assistance

Until 2000, USAID/Guyana supported activities primarily in the areas of economic growth and democracy and governance. In June 1999, two consultants completed a rapid assessment of the HIV/AIDS situation in Guyana. Their report concluded that, given the rapid spread of HIV/AIDS in Guyana, USAID should include support for HIV/AIDS in its Mission strategy. The report recommended that the initial effort should concentrate on prevention activities. Given the known weaknesses within the Ministry of Health, general consensus was that USAID should work through NGOs. A special objective—"Improved HIV/AIDS Knowledge and Prevention Strategies"—was approved in 2000 and aimed at increasing Guyana’s prevention efforts and slowing the rate of new infections. An amount of $200,000 was allocated in FY 2000. Major activities included:

- An HIV/AIDS/STI Youth Project implemented through nine local, youth-orientated NGOs;
• A healthy youth initiative with the Ministry of Health to address the growing number and severity of health-related issues affecting youth;
• Commodity logistics support to the Ministry of Health with technical assistance of the Deliver project managed by John Snow, Inc.;
• A social marketing program focusing on behavioral change interventions to delay initial sexual activity or to continue abstinence, partner reduction, and condom social marketing through Population Services International;
• Strengthening voluntary counseling and testing services by providing technical assistance to the Youth Project NGOs to create care and support programs and expand services to include voluntary counseling and testing.

Funding for the special objective has grown rapidly from the initial $200,000 in FY 2000, to $800,000 in FY 2001, to $1,500,000 in FY 2002, and to $1,700,000 in FY 2003.

Guyana is one of 14 countries included in President Bush’s International Mother and Child HIV Prevention Initiative, with funding of $2,100,000 for FY 2003. In FY 2004, the International Mother and Child HIV Prevention Initiative will become a component of the President’s Emergency Plan for AIDS Relief.

E. Other International Assistance

Between 1988 and 2000 the Government of Guyana was the main source of financial support for HIV/AIDS programs. Since then, external funding has surpassed domestic sources of funding by approximately 50 percent. USAID continues to be the largest source of financial and technical assistance to the national program.

Table 1 matches other international donors with their areas of HIV/AIDS assistance.

**USAID/Initiatives**

**USAID/MACRO (AIS)**
Survey provider assessment – AIS issues related to knowledge sexual practices

**WHO**

**World Bank**
Project Title

**HIV/AIDS PREVENTION & CONTROL PROJECT**

This project intends to slow the increase of or reverse this trend by:
(a) preventing and controlling the transmission of HIV and Sexually Transmitted Infections (STIs);
(b) prolonging and improving the quality of life of people living with AIDS; and
(c) mitigating the negative impact of HIV/AIDS on persons infected and affected by the disease.
There are three main project components.

Component 1 will support institutional capacity building for scaling up the response through financing of technical advisory services, training, staffing, equipment, goods and general operating costs. It also funds monitoring, evaluation, and research,

Component 2 supports the scaling up of the response to HIV/ATDS by line ministries, civil society organizations, and the private sector.

Component 3 expands health sector prevention, treatment and care services for HIV/AIDS.
Table 1: Foreign Donor Assistance to HIV/AIDS
*U.S. dollars and funding time period.

<table>
<thead>
<tr>
<th>Donor</th>
<th>Major Areas of Assistance</th>
<th>Estimated Funding*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Canadian International Development Agency</td>
<td>HIV/AIDS prevention; communicable disease control; Pilot health management information system; stigma and discrimination; DOTS expansion</td>
<td>$3 million</td>
</tr>
<tr>
<td>U.S. Centers for Disease Control and Prevention</td>
<td>Laboratory strengthening, treatment, testing, surveillance</td>
<td>$1–3 million</td>
</tr>
<tr>
<td>European Union</td>
<td>Strengthen national capacity to respond to HIV/AIDS</td>
<td>Limited</td>
</tr>
<tr>
<td>GTZ with Caribbean Epidemiological Centre</td>
<td>Technical support for VCT surveillance; HIV/AIDS and STI prevention; HIV prevention among commercial sex workers</td>
<td>Limited</td>
</tr>
<tr>
<td>Global Fund to Fight AIDS, TB and Malaria</td>
<td>Multifaceted proposal for HIV/AIDS prevention, treatment, care and support. Training of personnel; management information system; upgrade laboratory capacity and capability; strengthen surveillance systems; quality care for persons living with HIV/AIDS; expand VCT; reduce stigma and discrimination; condom social marketing</td>
<td>$10–$20 million</td>
</tr>
<tr>
<td>Inter-American Development Bank</td>
<td>Support for health sector reform</td>
<td>TBD</td>
</tr>
<tr>
<td>Japan International Cooperation Agency</td>
<td>Small grants for HIV/AIDS programs</td>
<td></td>
</tr>
<tr>
<td>Japanese Trust for Human Resource Development/ UNESCO</td>
<td>HIV/AIDS education within public school curriculum</td>
<td>$0.1 million</td>
</tr>
<tr>
<td>PAHO/WHO</td>
<td>Technical assistance for HIV/AIDS prevention, TB, and malaria control; small grants scheme management</td>
<td>Ongoing</td>
</tr>
<tr>
<td>UNAIDS</td>
<td>Coordinate HIV/AIDS activities of the United Nations Theme Group</td>
<td>Ongoing</td>
</tr>
<tr>
<td>UNDP</td>
<td>Chairs UNAIDS Theme Group; limited HIV/AIDS activities</td>
<td>No estimate</td>
</tr>
<tr>
<td>UNICEF</td>
<td>Healthy Family Life Education program with Ministry of Education; Dutch government support to Linden Care Foundation for work with orphans</td>
<td>$1.6 million</td>
</tr>
<tr>
<td>UNFPA- OPEC Fund</td>
<td>Caribbean–Central America project for HIV/AIDS prevention among youth as part of adolescent health program</td>
<td>$0.442 million</td>
</tr>
<tr>
<td>U.S. Department of Labor/Int'l. Labor Organization</td>
<td>HIV/AIDS workplace education with Family Health International as the implementing agency</td>
<td>$0.3–0.4 million</td>
</tr>
<tr>
<td>Organization</td>
<td>Description</td>
<td>Funding</td>
</tr>
<tr>
<td>-------------------</td>
<td>-----------------------------------------------------------------------------</td>
<td>---------</td>
</tr>
<tr>
<td>U.S. Peace Corps</td>
<td>20–25 volunteers working in health; 7 currently working with NGOs with expansion possible</td>
<td>No estimate</td>
</tr>
<tr>
<td>World Bank</td>
<td>Possible grant for HIV/AIDS program</td>
<td>$6,000,000</td>
</tr>
</tbody>
</table>