policy

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# GUYANA

## HOW THE DECLINE IN PEPFAR FUNDING HAS AFFECTED KEY POPULATIONS

*Brief*

## The Issue

Due to social and political barriers, many governments have been slow to directly support HIV services for key populations (KPs)—men who have sex with men (MSM), sex workers, people who inject drugs (PWID), and transgender people (TG). This hesitation has historically led donors to provide the bulk, or in some instances all, of the funding for KP-specific programs. As donor budgets for HIV have flat-lined, funding for HIV services and programming has decreased, particularly in countries with higher income status and concentrated HIV epidemics. This trend has left key populations especially vulnerable.

PEPFAR funding in Guyana has historically been high in comparison to the country's HIV prevalence, but has been decreasing steadily since 2007. In 2015, in order to examine the implications for key populations of reduced donor funding in Guyana and to provide guidance for future transitions, the USAID- and PEPFAR-funded Health Policy Project (HPP) conducted a desk review and interviewed 17 key informants from civil society, local government, and international donors. The resulting case study offers lessons learned on how donors can ensure the resiliency of HIV programming for key populations while undergoing funding transitions.

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# The Context

Guyana is a small, lower-middle income country situated on South America's northern coast. While Guyana's national HIV prevalence is relatively low (1.4% among adults ages 15-49), AIDS remains one of the leading causes of death (Guyana Presidential Commission on HIV/AIDS, 2015). The majority (60%) of the country's 7,700 people living with HIV (PLHIV) live in just one of Guyana's ten administrative regions (Region Four), which is home to 42 percent of the country's population and Guyana's capital city (Bureau of Statistics, 2014).

As in many countries, HIV prevalence is notably higher among key populations, ranging from approximately 5 percent among female sex workers (FSW) and MSM to over 8 percent among TG people (NAPS and MEASURE Evaluation, 2015). Injection drug use is thought to be relatively uncommon in Guyana, although there have been no HIV prevalence studies among PWID.

## The legal and social context

Key populations face a number of social and political challenges in Guyana that affect, not only access to healthcare, but livelihood options, civil rights, and other determinants of health (Centro de Orientacion e Investigation Integral et al., 2014). Sex work, same-sex relations, and drug use are heavily stigmatized.
Sex work is effectively criminalized due to prohibitions against brothels and KP-focused organizations report routine harassment by police (KI, 2015). Same-sex relations are prohibited under ill-defined legal statutes against "gross indecency" and "buggery" and, while prosecutions are relatively rare, police harassment of MSM is common (KI, 2015). Guyana law also criminalizes cross-dressing, although the provision was recently invalidated by the Supreme Court.

# The Funding

Although the Government of Guyana (GoG) provides the majority of public health financing, as of 2012 (the most recent year for which data is available), 90 percent of Guyana's estimated US$29 million HIV budget was sustained by donor funding (Figure 1) (National Aids Programme Secretariat, 2013).

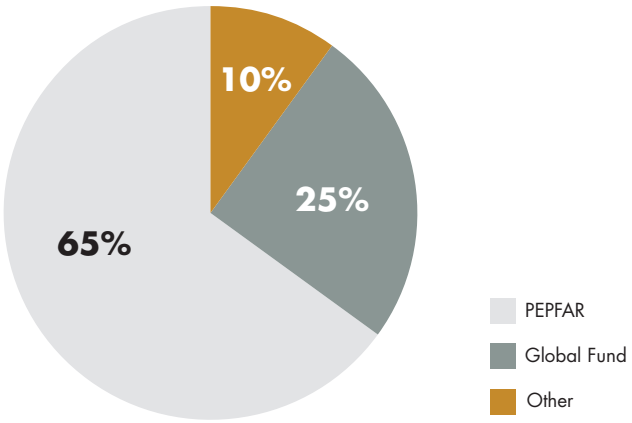
## Guyana At-a-Glance[1]

**Population:** 763,900
**GDP per capita (current US$):** 4,050
**HIV epidemic type:** Concentrated epidemic
**Number of PLHIV:** 7,700
**HIV prevalence:**
- Adults: 1.4% (ages 15-49)
- FSW: 5.5%
- MSM: 4.9%
- TG: 8.4%
- PWID: Data not available

**International HIV funding:** US$26.1 million
**Domestic HIV funding:** US$2.9 million
**Existence of laws criminalizing:**
- Any aspect of sex work: Yes
- Consensual same-sex relations: Yes
- Drug use: Yes

[1]Population and GDP data come from World Bank, 2014; PLHIV data come from PEPFAR, 2015; Prevalence rates for adults come from Guyana Presidential Commission on HIV/AIDS, 2015; FSW, MSM, and TG prevalence rates come from NAPS and MEASURE Evaluation, 2015; International and domestic HIV funding data come from NAPS, 2013; Data on existing laws come from UNAIDS, 2015

**Figure 1.** HIV Program Funding by Source, 2012




Source: National Aids Programme Secretariat, 2013

PEPFAR has been the country's largest international donor for HIV programming since 2004. PEPFAR funding topped US$28.4 million in 2007, after which it has decreased steadily to its current level of US$6.6 million in 2015 (Figure 2).

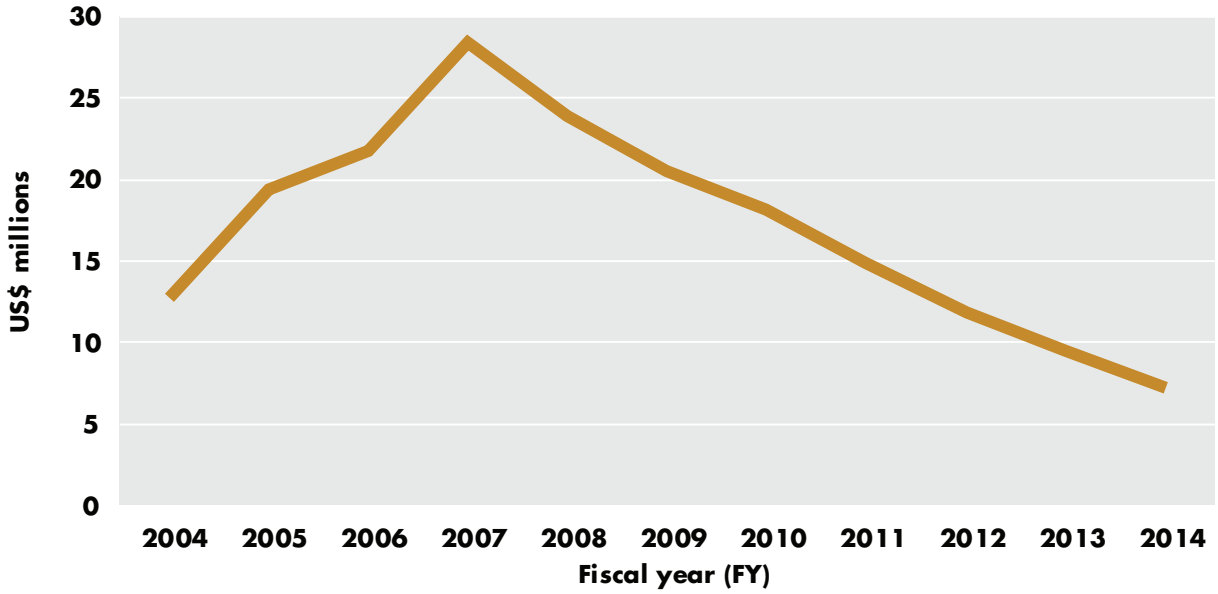
In its early years, PEPFAR covered direct service delivery costs, providing salaries for Ministry of Health (MOH) staff, purchasing antiretrovirals (ARVs) and commodities, and establishing a case-based surveillance system. PEPFAR supported partners throughout the country to provide services for MSM, FSW, miners, loggers, and orphans and vulnerable children. However, the program has steadily moved towards a technical assistance model with a focus on key populations, transitioning funding for MOH staff and most ARVs to the national government. This process remains underway and by 2017 PEPFAR funding is expected to stabilize at a lower level.

The country's second largest HIV donor, The Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund), has supported Guyana's HIV response since 2005. In 2012, the Global Fund's HIV grant shifted from one that supported general population services to one focused on key populations, defined as MSM, FSW, miners, and loggers. The current grant, which requires that 50 percent of funding support KP programming, is set to conclude on December 31, 2017. The prospect of additional funding is unknown, although several stakeholders felt it was unlikely (KI, 2015).

## PEPFAR's Transition

In 2012, in recognition of declining PEPFAR resources for Guyana, the PEPFAR Guyana team developed a five-year plan to move from direct service delivery to technical assistance. The plan aimed to ensure a thoughtful transition of PEPFAR-funded activities to the Guyana government through a phased approach. However, stakeholders reported that the plan was hurriedly constructed and that assumptions about increases in national HIV funding—for ARV procurement, for example—were overly optimistic (KI, 2015).

**Figure 2.** HIV Program Funding by Source, 2012




Source: Compiled by HPP from PEPFAR Dashboard data, https://data.pepfar.net/

Recognizing the financial limitations of the national government and other donors, the Guyana team revised this plan in 2014. The subsequent draft reflected input from in-country implementing partners, Global Fund representatives, and the national government, and resulted in the establishment of a Joint Transition Committee to develop the strategy and monitor its implementation. The plan was submitted to the Office of the Global AIDS Coordinator (OGAC), but formal approval was never received.

Soon after, the team began planning for the 2015 PEPFAR Country Operational Plan (COP), which required PEPFAR countries to propose data-driven approaches to achieve sustained epidemic control. Data from PEPFAR partners in Guyana demonstrated low numbers of new HIV cases in remote regions, which also require greater resources for program implementation. In light of this and new surveillance data suggesting a significant drop in HIV prevalence among KP groups, it was decided in April 2015 to reduce PEPFAR programming and to focus resources exclusively on MSM, FSW, and TG in Region Four. Region Four is home to 42 percent of the country's population, 60 percent of PLHIV, and has the highest HIV prevalence rates among these three groups.

Upon receiving word from OGAC, the country team quickly informed programs operating outside Region Four that activities would be discontinued. Though funding had been steadily declining, CSOs outside of Region Four still expressed surprise at having funding pulled. One key informant commented, "We were hearing all the time that the funding is going to dry up one day, but we didn't expect it so fast."

Community-based care and support activities in the remaining regions are expected to be transitioned by September 2016. Likewise, at the start of the 2016 fiscal year, the Guyana program will be subsumed within the PEPFAR Caribbean Regional Program.

## The Challenges

Despite attempts to transition Guyana away from donor funding, PEPFAR and the Global Fund continue to support nearly all of the country's KP programming. In interviews, stakeholders identified a number of concerns about the sustainability of KP programming and KP-led organizations:

### Harmful legal and policy environment

In general, stakeholders agreed that the continued criminalization of key populations and deep-rooted stigma makes it unlikely that the GoG will fund programming delivered by KP-led organizations. As one development partner said, "Key populations may face a challenge [securing funding], because they still are not regarded as legal entities." Some members of civil society are hopeful about the prospect of legal reforms, although it is unclear whether the government will expend the political capital necessary to push through what would arguably be unpopular changes. While Guyana's 2013–2020 HIV strategic plan emphasizes the need to systematically address key populations, including improving the legal and policy environment, the government has yet to take action. However, there are some reports of recent progress: The Minister of Health recently approached the Joint United Nations Programme on HIV/AIDS (UNAIDS) for assistance in assessing the need to update current HIV stigma and discrimination policies, and the United Nations Development Programme is expected to convene a national dialogue on HIV and the law. Though cautious, stakeholders view this as a positive sign.

### Poor coordination and communication among key stakeholders

Interviews suggest that coordination among government, international donors, and implementing partners focusing on key populations—which would ideally be managed by the National AIDS Program Secretariat (NAPS)—can be perfunctory.

The NAPS convenes quarterly meetings among CSOs, yet they are typically attended by lower-level personnel, and stakeholders described the meetings as informative, rather than consultative. One civil society representative described their relationship with NAPS as "schizophrenic," noting that the government engages with them only to the extent needed to meet PEPFAR and Global Fund requirements (KI, 2015). Informants also report that collaboration between donors on program planning has occurred inconsistently and sometimes retrospectively, after funding cuts or decisions have been made. Some CSOs spoke of duplicative PEPFAR and Global Fund programming, particularly in Region Four (KI, 2015). While most agreed that coordination had increased in recent years, it was generally felt that NAPS will need to take greater ownership over this effort moving forward (KI, 2015).

There is also evidence of miscommunication between the Guyana PEPFAR team and counterparts in Washington, DC, concerning the short- and long-term trajectory of the country's program. The revised transition plan, which was produced in 2014, is one example of crossed lines; it was never approved by OGAC and was therefore never enacted in-country, representing a missed opportunity to better prepare for funding changes. Notably, Guyana did not have a PEPFAR Coordinator from 2012–2014.

## Uneven CSO capacity

Virtually all prevention services targeting key populations in Guyana are delivered by CSOs, with funding from either the Global Fund or PEPFAR, both of which report substantial capacity challenges among local CSOs. Governance, administrative, and programmatic capacity among Guyanese CSOs is generally mixed, and is particularly weak among KP-led groups. In some cases, such groups had been previously denied funding or defunded because of improprieties. Without significant capacity building of Guyana's CSOs, these organizations' ability to sustain KP-targeted services is in jeopardy.

## Ineffective national HIV financing mechanisms and budgets

Interviews pointed to the need for GoG to take greater ownership of its HIV program and to develop and/or strengthen the systems required to administer the program. NAPS has not yet developed a national HIV budget that includes national and international revenues, and the country's HIV strategic plan has yet to be costed. Though NAPS recently completed a National AIDS Spending Assessment (NASA) with support from UNAIDS, the report was never publicly released.

Informants also stressed that the government does not currently have mechanisms to contract with CSOs directly. The government does not provide financing to any organizations providing prevention services, although it does supply commodities such as rapid test kits and condoms. It is unclear how CSOs will be funded for HIV programming once all existing donor mechanisms expire in 2016 and 2017. A CSO representative working outside of Region Four considered, "Who are we transitioning to if the government is not ready?"

## Inadequate data to inform a comprehensive HIV response

While sensitive to the need to target priority populations and regions, some informants felt that a withdrawal based on existing HIV prevalence data overlooks hard-to-measure populations and other vulnerable populations, such as miners and loggers located in the country's hard-to-reach interior. One respondent reflected, "PEPFAR is retiring from the other regions and focusing on the region from which they have data…which is Region Four." While KPs in Region Four may be served by Global Fund programs, PEPFAR's withdrawal from other regions leaves

populations in remote areas with even less access to HIV prevention, care, and treatment services.

Additionally, the country's 2014 behavioral and biological surveillance survey suggests a significant drop in HIV prevalence among FSW and MSM since 2009, from 16.6 percent to 5 percent and 19.4 percent to 4.9 percent, respectively, although methodological differences may partially account for the difference (National AIDS Program Secretariat and MEASURE Evaluation, 2015).While many respondents hold that the recent survey provides a more accurate picture of the country's epidemic, others expressed concern about the validity of the recent estimates, contending that prevalence estimates are too low and population size estimates are too high. The data informed the development of new PEPFAR and Global Fund targets, which many people feel are unrealistic.

## Lessons Learned

The sustainability of KP programming in Guyana may be jeopardized due to insufficient readiness among primary, in-country stakeholders, including the government and civil society, and exacerbated by a lack of collaborative and transparent planning. Based on interviews with a range of stakeholders leading and implementing HIV programs in Guyana, HPP developed the following recommendations:

1. **Align roles, responsibilities, and planning priorities with OGAC and local stakeholders.** For the future successful transition of KP programming, it will be essential for PEPFAR Guyana's actions in-country to be intentional, strategic, and transparent. This will require consistent and clear directions and expectations from OGAC and clear communication in country with other donors, government, and local stakeholders. OGAC and PEPFAR Guyana should mutually agree on goals and a five-year timeline. PEPFAR Guyana should then collaborate with stakeholders (including the Global Fund, government, and civil society) to develop a transition plan that falls within those parameters.

2. **Engage other donors, particularly Global Fund, in program planning, monitoring, and evaluation.** Insofar as the Global Fund is undertaking its own transition, it is imperative that the two largest funders of KP-services in Guyana continue to collaborate to avoid duplication, ensure the integrity of services, and to the extent possible, act in concert to negotiate with the government.

3. **Provide the GoG with technical assistance in health finance and strategic planning.** To strengthen Guyana's health finance system, accurate data are essential. PEPFAR should encourage the government to take ownership of the transition in Guyana's HIV and AIDS program by investing in reliable data to support realistic budgeting and resource allocation. Priority needs include:

    - Cost estimates for the current HIV strategic plan
    - An annual HIV budget that captures revenues from international donors
    - A national AIDS spending assessment

4. **Build the capacity of NAPS to play a more proactive role in convening stakeholders and coordinating programs across donors.** A sustainable HIV response is only possible if the Guyanese government has the capacity to coordinate and lead the national response. Government leadership will be essential to develop, scale up, monitor, and sustain effective KP programming.

5. **Build the capacity of KP-focused CSOs to sustainably deliver high-quality HIV services.** Though some CSOs have improved management and accountability systems, many still have a need for organizational and technical capacity

development—particularly KP-led CSOs. Moreover, technical assistance will likely be needed for some time, based on CSOs' capacity gaps.

6. **Support the collection, analysis, and dissemination of KP-specific strategic information.** Reliable data are necessary to ensure effective HIV programming, including surveillance, program performance, health outcomes, and spending data. While the 2014 behavioral and biological survey represents an important effort, it could be improved upon.

## The Project

This case study is one in a series of four from Bangladesh, Botswana, China, and Guyana that seek to examine the implications for key populations of recent decreases in PEPFAR and other donor funding. Each case study is based on desk research and supplemented by key informant interviews with civil society, local government, and international donor representatives conducted in late 2015. Taken together, these case studies seek to provide lessons learned to guide PEPFAR in ensuring the resiliency of HIV programming for key populations.

For more information on how the decline in donor funding for HIV programming is affecting key populations and to access related case studies, please visit www.healthpolicyproject.com.

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