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UNDERSTANDING THE COSTS OF CSO-DELIVERED HIV SERVICES FOR KEY POPULATIONS IN GUYANA

Policy Implications for Social Contracting

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HP+ HEALTH POLICY PLUS

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Health Policy Plus (HP+) is a five-year cooperative agreement funded by the U.S. Agency for International Development under Agreement No. AID-OAA-A-15-00051, beginning August 28, 2015. The project's HIV activities are supported by the U.S. President's Emergency Plan for AIDS Relief (PEPFAR). HP+ is implemented by Palladium, in collaboration with Avenir Health, Futures Group Global Outreach, Plan International USA, Population Reference Bureau, RTI International, ThinkWell, and the White Ribbon Alliance for Safe Motherhood.

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Abbreviations

CDC	Centers for Disease Control and Prevention
CSO	civil society organizations
HP+	Health Policy Plus
LGBT	lesbian, gay, bisexual, and transgender
MARP	most-at-risk population
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
UNAIDS	Joint United Nations Programme on HIV/AIDS
USAID	U.S. Agency for International Development
USD	U.S. dollars

Introduction

Civil society organizations (CSOs) are vital to Guyana's HIV response, particularly for reaching key populations disproportionately affected by HIV and facing greater barriers to accessing services. Reaching these key populations will be essential for Guyana to achieve its "90-90-90" targets in which 90 percent of people living with HIV knowing their status, 90 percent who know their status receive treatment, and 90 percent receiving treatment are virally suppressed. The Government of Guyana has recognized the importance of CSO services in the national response, which is reflected in the national HIV strategy, *HIVision 2020*, in which CSOs have been designated as lead agencies for delivering strategic objectives. Up to this point, however, CSO HIV services have been almost entirely funded by the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) and the Global Fund to Fight AIDS, Tuberculosis and Malaria. These funds are declining and, as a result, so is CSO capacity to deliver critical HIV services.

This poses a significant threat to sustaining the progress Guyana has made in reducing prevalence rates among key populations and to overall epidemic control. Adult HIV prevalence in Guyana fell from 2.4 percent in 2004 to 1.5 percent in 2016 (National AIDS Programme, 2017). The country has also achieved significant gains in reducing prevalence among key populations. Prevalence among men who have sex with men, for example, fell from 19.4 to 5.5 percent from 2004 to 2014. This progress requires continued investment to ensure sustainability; in recent years, adult prevalence has seen a slight uptick (from 1.3 percent since 2012) and new infections have increased 23 percent since 2010 (National AIDS Programme, 2013; UNAIDS, 2016). Key populations, including men who have sex with men, sex workers, and transgender communities, continue to be disproportionately burdened (see Table 1). As such, there is an urgent need for the government of Guyana to develop and implement financing mechanisms to sustain key CSO-led HIV services that reach these populations.

Table 1: Overview of the Epidemic

Population	Prevalence	Year
All adults	1.5%	2016
Men who have sex with men	5.5%	2014
Female sex workers	5.4%	2014
Male sex workers	5.9%	2014
Transgender	8.4%	2014

Source: National AIDS Programme, 2017

Guyana is not alone in facing these challenges. Globally, countries are grappling with how to sustain CSO-provided HIV services in light of declining external funds. Social contracting—mechanisms through which public funds flow directly to CSOs for specific services—has emerged from a growing body of experience around transitions to domestically-financed HIV programs as an essential strategy for sustainability. Social contracting requires a range of enabling legal and regulatory factors. Establishing social contracting also requires designing the appropriate financing and purchasing mechanisms that establish predictable, effective means of paying CSOs for their services, factoring in national and community priorities, the relative advantages of CSOs, resource availability and needs, and performance (see Box 1).

Box 1: Emerging Best Practices for Social Contracting Financing Mechanisms

Many countries have successfully implemented social contracting as part of sustainable transitions from donor funding for HIV. A range of documented country experiences highlight several key considerations for developing effective financing mechanisms for social contracting. These include:

- Meaningful and consistent engagement of CSOs in defining the payment mechanisms to support social contracting
- Open and transparent processes for determining payment
- Financing that takes into consideration technical quality and intended outcomes, as well as overall costs
- Monitoring and quality assurance mechanisms both for the services provided as well as for how funds are awarded and disbursed
- Predictable timelines, including options for multi-year financing, to allow for longer-term planning and consistent service delivery
- Ongoing, targeted assessment of needs and prioritization of services to be purchased through social contracting

Sources: Global Fund, 2017b; Abdullaev et al., 2016a-f

The Health Policy Plus (HP+) project, funded by PEPFAR and the U.S. Agency for International Development, worked with stakeholders from government, CSOs, and development partners in Guyana to support the country in planning for sustainable transition to a domestically-financed HIV response. Central to this support, HP+ first assessed the potential for social contracting in Guyana and found that, from a legal and regulatory perspective, Guyana is well positioned to implement this model (Cenac et al., 2017).

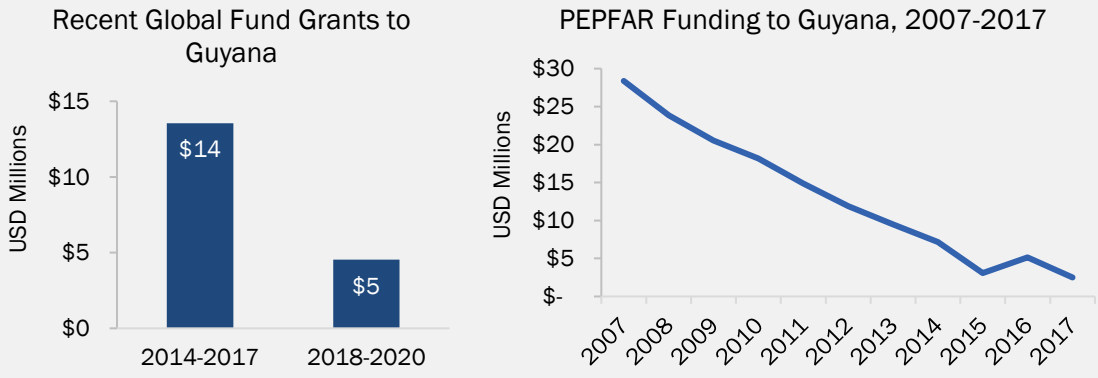
In order to advance social contracting, Guyana must define the appropriate payment mechanisms to support contracting of key services. As a next step in advancing the potential implementation of social contracting, HP+ conducted an analysis of specific CSO-led HIV services in Guyana—such as peer outreach, voluntary counseling and testing, support groups, and treatment support—to better understand the current costs and underlying cost drivers in delivering these services. This analysis proposes key considerations and areas for future analysis to advance the dialogue on appropriate payment modalities for implementing social contracting in Guyana and globally.

Current Role and Financing of CSOs in Guyana's HIV Response

Guyana's achievement of 90-90-90 targets will require reaching key populations with HIV prevention and treatment services. Key populations in Guyana, however, face high levels of stigma and discrimination and other barriers that may make them unable or unwilling to access government services. CSOs, with strong ties and more trust among key populations, act as a critical link to health services. CSOs deliver a range of HIV prevention and non-clinical care and support services that are vital for prevention and for linking and retaining otherwise hard to reach populations in care. These services include demand creation, testing outreach, linkage facilitation, referral systems, patient tracing, adherence counseling, and community/peer support.

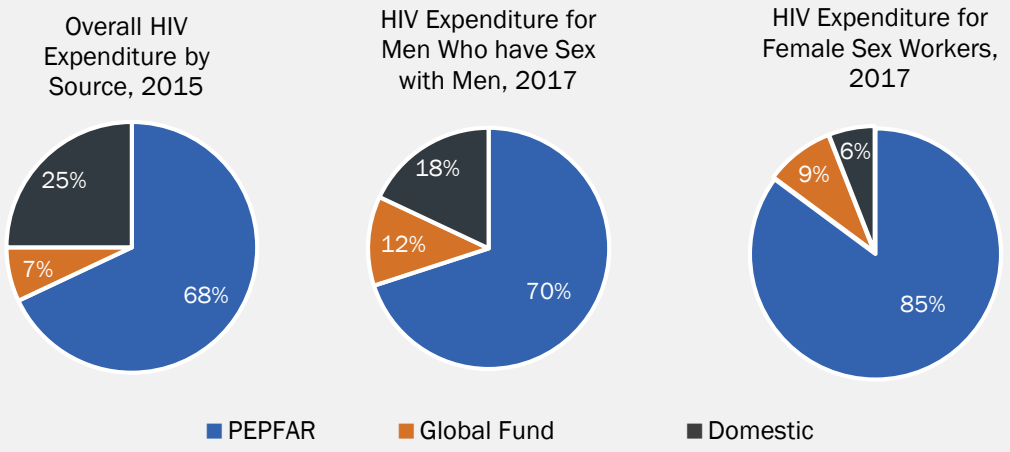
In 2014, the Joint United Nations Programme on HIV/AIDS (UNAIDS) estimated that CSOs in Guyana delivered over 75 percent of programming for people living with HIV, men who have sex with men, commercial sex workers, transgender individuals, and orphans and vulnerable children (Datar et al., 2014). The vast majority of this work has been funded by PEPFAR and the Global Fund. In 2012 for example, among 10 CSOs providing HIV services, including for key populations, more than 80 percent of HIV services were paid for by PEPFAR (Datar et al., 2014). Overall, both Global Fund and PEFAR funding has been steadily declining. PEPFAR funding for Guyana fell from $28.4 million in 2007 to $2.5 million in 2017 (PEPFAR, n.d. and 2017), and the 2018–2020 Global Fund allocation is one-third of the 2014–2017 allocation (Global Fund, 2016 and 2017a) (see Figure 1). However, PEPFAR and the Global Fund remain vital sources of funding available to support targeted key population programs. In 2017, 85 percent of key population prevention services were funded by these two donors (PEPFAR, 2017). A recent study by the U.S. Centers for Disease Control and Prevention found that nearly 95 percent of expenditures on HIV programs for female sex workers and 82 percent of expenditures on HIV programs for men who have sex with men came from PEPFAR and the Global Fund (CDC, unpublished) (see Figure 2).

Figure 1: Trends in External Funding for HIV



Source: Global Fund, 2016 and 2017a; PEPFAR, n.d. and 2017

Figure 2: Targeted Financing for Key Population Services by Donor



Source: CDC, unpublished

Overall, external resources for HIV have shrunk, but the dependency of key population services on these funds remains high. In light of declining donor resources, CSOs already report a significant reduction in their ability to provide HIV services. In the absence of increased domestic resources, and the appropriate, predictable mechanisms, they will not be able to sustain the high quality, accessible key population services that are critical for epidemic control in Guyana.

Methodology: Data, Analysis, and Limitations

This analysis examined the costs of CSO-delivered HIV services to inform the development of a social contracting mechanism in Guyana. Data collection began with a stakeholder consultation to discuss the proposed analysis and collect initial input from a range of CSOs as well as government stakeholders on current service delivery, costs, and data needs. Based on this initial consultation and with input from the CSO National Coordinating Coalition, HP+ identified and interviewed 13 CSOs that deliver HIV services to key populations in Guyana and two additional organizations providing non-key population services. Annex 1 provides more detail on these organizations, including current services delivered (particularly for key populations) and any other information of note for this analysis.

From these CSOs, HP+ collected data on the delivery and costs of services including:

- Program activities, including type, frequency, reach, and methods of service delivery
- Raw cost data, including staff salaries, activity expenses, and overhead costs
- Amount of program activities and staff time dedicated to HIV and key population services

The range of data provided by CSOs presented several significant challenges for the analysis. There was considerable variability among CSOs across a number of dimensions, including variation in:

- The services CSOs provide as well as the distribution of time and resources across services (e.g., the amount of outreach activities a CSO delivers as opposed to the number of clients it supports in treatment)
- Specific methods of delivery of largely non-clinical services
- The level of detail and comprehensiveness of data from different CSOs
- The levels of functionality due to reduced funding

This analysis employed two primary methods to analyze the available information. First, it standardized activities, basing service delivery assumptions on the national guidelines in the *Most-at-Risk Population (MARP) Guidelines and Standards of Non-Governmental Organizations* (National AIDS Programme, 2016). Based on the services CSOs are currently providing, this analysis organized activities and costs under four categories of services defined in the MARP guidelines: peer education and outreach, voluntary HIV counseling and testing, support groups, and HIV care and treatment support.

These services and delivery assumptions are summarized in Tables 2 and 3. Actual service activities may not fall exactly under a single service category (outreach and testing, for example, are often combined) and delivery may differ from the MARP guidelines. The guidelines, however, provide a useful framework for understanding costs in terms of potential government financing. If the government of Guyana ultimately funds CSOs through a social contracting mechanism, it will want to purchase services in-line with defined national standards.

The second mechanism used for analysis was to create a reference model of CSO service delivery. This reference model was based on detailed service delivery data from an organization currently providing all of the services listed in Table 2. This model used the allocation of staff time across services to calculate cost drivers for indirect costs. Using this model as a basis, input and cost data gathered from across CSOs was used to generate unit costs. The analysis varied the model around key assumptions (e.g., the percent of the

organizations' activities devoted to HIV services and the distribution of time and resources to the key population services) to create a range for each unit cost.

It is important to note that these are not definitive costs, given the variability and limitations of the data, however this illustrative costing model provides useful benchmarks for understanding potential resource needs as well as key drivers of costs and variability that a potential social contracting mechanism will need to consider.

Table 2: Key Service Definitions

Service Area	Definition	Unit of Service
Peer education outreach	• Peer educators offer education within the target community where people congregate or live. • Outreach refers to an episode in which a peer educator provides HIV risk information, condoms and lubricant, and specific services (such as risk-reduction or service referral) based on peer needs.	One outreach contact
Voluntary counseling and testing	• Includes testing services provided onsite at CSO facilities as well as through mobile outreach. • Service includes pre-test counseling for informed decisions about testing and post-test counseling for both positive and negative results, including condom promotion, risk reduction, and referrals to health services, including HIV treatment, as necessary.	One test for one person
Support groups	• Monthly sessions of no more than 20 people led by peer educators with the support of a social worker. • Includes both educational and psychosocial support groups: - Educational support groups provide education on HIV and risk reduction. - Psychosocial support groups provide a forum for emotional, moral, and psychosocial support for high-risk negative or HIV-positive individuals.	One support group meeting for one individual (monthly meetings, maximum of 20 people)
HIV care and treatment support	• Includes interventions to maintain the health and well-being of HIV-positive individuals. • This analysis defines this service as *one-on-one* support through some combination of home visits, telephone contact, and outreach of people living with HIV, including positive dignity, health, and prevention interventions, adherence counseling, and linkage to other health services as necessary.	One month of care and treatment support for one person

Based on the Guyana National AIDS Programme's Most-At Risk Population Guidelines.

Table 3: Key Assumptions

Topic Area	Assumptions
Human resources	• Given the funding climate, not all CSOs are currently paying staff and instead rely partially or entirely on volunteer time. Analysis assumes all staff are being paid, using historical data and industry standards to determine the costs of various staff time. • In line with MARP guideline requirements, analysis assumes CSOs have a social worker on staff to oversee and support key population services, in addition to any direct service delivery.
Regional applicability	• The delivery model and costs in this analysis are based on data collected from coastal areas, primarily in regions 3, 4, 5, and 6 (one CSO was interviewed from region 2 and one from region 7, both at reduced capacity due to lack of funding). • According to CSO interviews, costs would be fairly comparable across these regions (with significant variation within regions, depending on the distance services are delivered from more urban areas). • The delivery model and costs do not apply to service delivery in more remote, hinterland regions. Data collected does not accurately capture service delivery cost variations in hinterland regions as interviewed CSOs typically only provide services in these communities in response to specific requests and when additional funding is available. As such, this analysis does not account for hinterland regions variation in input costs, including time, travel, and accommodations required to reach these communities. Additional analysis will be necessary to understand the specific costs of reaching hinterland communities and their transient populations (such as miners and loggers) with the appropriate, targeted services.
Staff training	• The MARP guidelines require all staff and volunteers to have a minimum of 10 days training in peer education, outreach, and navigation. • Training requires significant resources, but its impact on unit cost is highly variable depending on the size of the staff and the number of services delivered by an organization. • This analysis does not include training costs within unit costs. The analysis calculated that these 10 days of training for 15 staff members would cost approximately $4,700 annually. • The government could provide this training (or at least provide the venue or other support) for CSOs. This would allow them to dedicate more resources to service delivery and also spread this cost across more organizations.
Government-provided supplies	• The National AIDS Programme Secretariat currently provides CSOs with a number of supplies for services provision including: condoms, lubricant, testing kits, and the majority of information, education, and communication materials on HIV and sexually transmitted infections. Public procurement of these supplies by the government of Guyana was established by the Procurement Act of 2003; this analysis assumes the National AIDS Programme will continue to provide these materials to CSOs to continue to support CSOs in HIV-service delivery.

Findings

Unit Cost Ranges and Key Cost Drivers

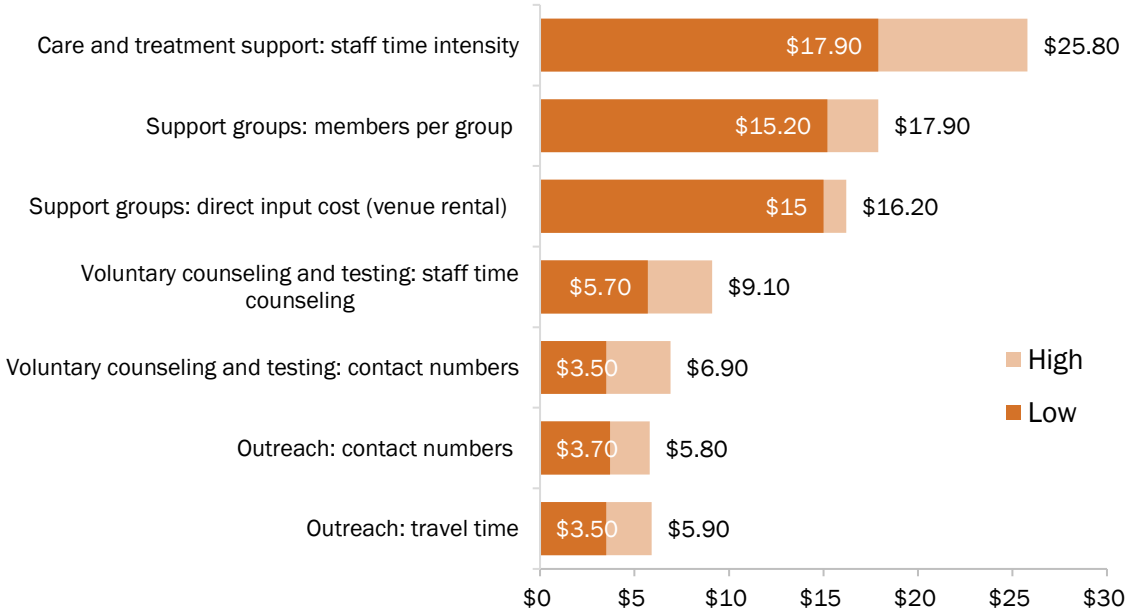
Table 4 shows unit cost ranges for the key services of interest in this analysis. These ranges are useful for understanding potential resource needs as well as exploring key drivers of cost variability that both the government and CSOs will need to consider in designing a viable payment mechanism for social contracting. It is important to note, however, that unit costs based on average delivery and cost mask considerable variation that CSOs and the government must account for when defining funding needs and payment mechanisms.

Table 4: Illustrative Unit Cost Ranges for Key Population Services

Service	Cost per Contact	
	USD	GYD
Peer education and outreach	$3.8–4.2	$791–873
Voluntary HIV counseling and testing	$5.7–6.5	$1,159–1,361
Support group	$15.2–16.6	$3,069–3,335
HIV care and treatment support	$17.9–22.3	$3,732–4,643

To better understand the variation of potential costs, this analysis varied key inputs to account for likely minimum and maximum values and to illustrate their impact. Location, for example, has significant cost implications. Even within coastal areas, CSOs report large ranges of average travel time. One interviewee noted that "average" outreach could require from 30 minutes to four hours of travel. While the estimates presented in Table 4 exclude significant outliers in an effort to represent travel time that is more the norm, many CSOs noted the significant added expense of reaching communities outside of town. Using the illustrative model, the analysis adjusted travel time and associated expenses for two scenarios. The first uses only relatively local travel estimates (e.g., near Georgetown or New Amsterdam for CSOs in region 4 or 6, respectively). The second is based on higher ranges of travel provided by CSOs, assuming three hours roundtrip. Further outreach nearly doubles the unit price (see Figure 3).

Figure 3: Range in Unit Costs Based on Service Variables (USD)



Similar variation in unit costs can be seen according to the number of contacts for a particular service, as shown for both outreach and voluntary counseling and testing costs. Indirect costs account for some of this variation, as costs are distributed across a greater number of units. Indirect costs lessen direct costs per unit as resources like staff time and travel expenses are used more efficiently when they can serve higher numbers of clients. Mobile testing outreach in higher density areas, for example, would have a lower per unit cost than targeting less trafficked or less populated areas. This is not always predictable, of course, as CSOs note there is sometimes low turnout or mobilization for particular activities.

The MARP guidelines state that support groups should not have more than 20 members (which is the assumed membership for the ranges presented in Table 4) and ideally not more than 10 for psychosocial support groups (National AIDS Programme, 2016). These standards, however, increase unit costs compared with higher membership groups of 20–30 people. For all services, the government needs to consider how certain standards impact cost and fund CSOs accordingly. Support group costs are also driven by direct inputs costs, like venue and food costs. Eliminating some of these costs, such as venue rental, has significant impact on the overall unit cost.

Both voluntary counseling and testing and care and treatment support costs are significantly driven by human resource costs. With voluntary counseling and testing, for example, providing services to patients testing positive for HIV requires significantly more staff time to provide proper counseling, resources, and referrals and linkage to care. Similarly, the demands on staff time for care and treatment support vary widely by client needs and by the model of service delivery. The ranges in Figure 3 reflect a more time- and travel-intensive model of support with frequent home visits versus more routine, primarily phone-based support with home visits as necessary.

All of these potential drivers of cost variability must be considered in designing payment mechanisms to support social contracting. CSOs should account for these costs when advocating to the government for appropriate funding. The government must also appropriately compensate for and incentivize reaching key populations.

Discussion and Policy Implications for Social Contracting

CSO service delivery is highly dependent on available funds. According to CSOs, service delivery has long since varied with funding. Organizations adapt the services they deliver, mode of delivery, frequency, and certain inputs (such as purchasing a cell phone to contact clients) based on what they receive funding for. In the current climate of declining external funds, this dependency is even more apparent. Of the 14 CSOs interviewed, 9 explicitly reported significantly reducing service delivery due to lack of funds, all of whom have previously received Global Fund or PEPFAR funding. One of these CSOs has ceased operations all together; another suspended HIV services as of November 2018. Other CSOs reported significant reductions in staffing; one is currently staffed on a purely part time, voluntary basis. Developing predictable mechanisms for channeling adequate resources to CSOs is an urgent priority for Guyana to ensure sustained access to critical services and for ultimate epidemic control.

Guyana has many of the legal and regulatory enabling factors necessary to successfully contract CSOs for HIV services. As it develops and implements frameworks and processes for contracting, it will need to develop the necessary financing mechanisms to support these contracts. Allocating funds will be an important first step. The government of Guyana needs to budget domestic resources for the critical services CSOs are providing, filling gaps left by declining external funding. Budgetary allocations, however, will be just one component of financing CSO services. Social contracting is not just a grant; the government is entering a purchasing agreement with CSOs and needs to do so in an efficient way that adequately compensates CSOs for high quality services and is linked to delivery of defined objectives.

Variability of costs indicates that it will be critical to develop differentiated payment rates depending on both the service and the target population. CSOs must be appropriately compensated and incentivized to provide services to more expensive-to-reach key population members that are critical to reaching 90-90-90 targets. In developing these kinds of payment modalities, and drawing from experience and best practices in countries that have successfully implemented social contracting, Guyana should consider the following actions.

1. *Early, consistent, and substantive engagement of CSOs in defining payment mechanisms.* Particularly in the nascent stages, designing effective CSO payment mechanisms will require ongoing dialogue between the government and CSO service providers. CSOs are best positioned to articulate and advocate for their needs as well as the needs of the populations they reach. Further, payment mechanisms must be carefully designed to align incentives, account for the planning and financial needs of both parties and take into account the operational realities of service delivery. All of this will require that CSOs have a seat at the table.
2. *Ongoing, targeted assessment and prioritization of needs.* Emerging evidence from established social contracting mechanisms highlights the need for consistent assessment and prioritization of needs. In Guyana, this might include assessments disaggregated by region and key population but also, given the variability in costs discussed above, other factors like proximity to urban areas and individual characteristics like health or socioeconomic status. Resources are finite and there needs to be a collaborative approach in deciding exactly what services the government should purchase from CSOs.
3. *Sustained, predictable annual allocation of funds based on resource needs.* As discussed, the government of Guyana will need to mobilize domestic resources to sustain key population services. It should do so through a sustained, predictable mechanism, such as a protected budget line item or multi-year allocations that will allow CSOs to plan for continued and future service delivery. These allocations should be informed by the kind of disaggregated assessment discussed above. Given

specific targets and key priorities, the government must ensure that it is allocating sufficient resources to meet the underlying needs, accounting for key drivers of cost variability.

4. *Selection and payment mechanisms based on more than just activity costs*. Both selection criteria and ultimate payment mechanisms for CSOs should consider more than just specific activity costs. In awarding contracts and determining payment mechanisms, the government should account for varying costs of service delivery, as noted above, and variation in service delivery for specific populations in accordance with MARP technical guidelines. For instance, providing voluntary counseling and testing to someone who has already been tested and is thus already in contact with the health system may be far less resource-intensive than reaching a new client with testing services. Additionally, the government must consider how the services it is purchasing contribute to broader goals and structure payments accordingly. In the long term, it may consider performance-based payments, which link some portion of payment to specific outcomes, such as identification of people living with HIV or viral suppression of patients supported in care. This requires more sophisticated contracting and monitoring mechanisms, but can help ensure resources are targeted effectively and allow CSOs to further demonstrate their value in the HIV response.

The government of Guyana depends on CSOs, with their provision of designated services to key targeted populations, to achieve strategic objectives in the national HIV strategy. Furthermore, legal and regulatory frameworks are already in place (as determined in a companion analysis by HP+ in 2017), enabling social contracting with CSOs. Guyana is well positioned to begin social contracting as it plans for long-term, sustainable transition to a domestically financed HIV response. While developing the appropriate financing mechanisms to support social contracting will take time and continued further analysis, it could begin with a smaller scale pilot. This would help to more immediately fund at least some critical services and also provide valuable insight for defining and refining CSO payments in terms of both value and structure. Further, additional analysis on the cost-effectiveness of CSO services would be particularly valuable in advancing a social contracting model. This would support prioritization of key-CSO led key population interventions for purchasing, evaluating proposed services, and advocating to the government on the critical importance of CSO services for sustainability.

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Annex 1. Profiles of Interviewed CSOs

HP+ thanks the representatives of CSOs for their generous time and valuable input into this analysis. The table below lists the CSOs interviewed and provides a brief snapshot of the organizations, the services they provide (particularly for key populations), and any other information of note for this analysis. The information presented in this table comes predominately from key informant interviews with CSO representatives. Some additional context has been added from CSO webpages, Advancing Partners and Community profiles, and two reports on CSO services in Guyana (HPP, 2016; Via Libre, 2017).

Organization	Region	CSO Profile	Notes
Artistes in Direct Support	4	Artistes in Direct Support's initial focus was on promoting HIV education through theatre programs. With funding from USAID, it expanded its focus to include key population services. It continues to provide sexual and reproductive health education through performance and sexuality training, and provides key HIV services including: • Peer outreach • Voluntary counseling and testing • Support groups • Linkage and navigation support • Psychosocial support	Artistes in Direct Support currently receives funding through a grant from USAID through Advancing Partners and Communities (through July 2018).
Comforting Hearts	6	Comforting Hearts provides a range of prevention, care, and support services to populations in Region 5 and 6. Its HIV work targets key population members, but serves the broader population as needed. Specific current HIV activities include: • Home-based care and support • Support groups • Voluntary counseling and testing • Linkage to care • Outreach and peer education Comforting Hearts has broadened its scope, shifting some focus away from HIV, to include other health, community, and economic activities.	Comforting Hearts received PEPFAR funding through 2017. Recently it has significantly reduced staff capacity. It previously employed 17 full time staff members with PEPFAR funding; it currently employs only 6.
Family Awareness Consciousness Togetherness (FACT)	6	With PEPFAR support, FACT has implemented a range of primary prevention, care, and support activities, including voluntary counseling and testing, support groups, outreach and peer education, case navigation and prevention with positives activities, support for orphans and vulnerable children, and life skills training. HIV activities have been reduced due to lack of funding; FACT is currently providing voluntary counseling and testing and peer outreach.	Before December 2017, the majority of FACT's work was focused on HIV services. Due to lack of funding, FACT estimates it is now only about 15% of their work, based almost entirely on volunteer staff.

Organization	Region	CSO Profile	Notes
The Guyana Business Coalition on Health Awareness (GBCHA)	4	GBCHA's mission is to mobilize and assist the private sector in its response to HIV and AIDS in the workplace and beyond. It facilitates technical assistance and helps businesses identify ways to contribute to the HIV response. In terms of service delivery, it provides walk-in voluntary counseling and testing in its office and implements HIV workplace education programs. It has broadened its mission to include improving health literacy in Guyana by coordinating programs and activities with members and partners to enhance national health and wellness.	GBCHA's HIV services are largely delivered through workplace-based models and are not focused on key population service delivery. The interview was useful for understanding the context of CSO service provision and providing additional information on the costs of specific inputs, but was not used to inform the costing model for service delivery.
Guyana Community of Positive Women and Girls (GCWAG)	4	GCWAG is focused on advocacy for the rights of women and girls living with HIV, including promoting empowerment, sexual reproductive health, and reduction of gender-based violence. In addition to advocacy, it provides monthly peer education, counseling, and multi-day support workshops that use art as a means of expression and provide counseling on adherence, disclosure, nutrition, and gender-based violence.	GCWAG is an entirely volunteer-based organization, not currently funded by PEPFAR or the Global Fund. Through the International Community of Women Living with HIV, it has received some support from the Global Fund and USAID in the past.
Guyana Rainbow Foundation (GuyBow)	4	GuyBow provides support and services to LGBT women, including mental health services and economic empowerment. It previously had more of a specific focus on HIV services, but since 2011 has a very limited HIV scope of counseling and referring clients for testing.	GuyBow receives some external support from COC Netherlands, but is not a PEPFAR or Global Fund recipient.
Guyana Reproductive and Parenthood Association (GRPA)	4	GRPA is dedicated to positive sexual health for all people in Guyana. Through awareness, education, and health services, it promotes individual choice, family planning, and quality sexual and reproductive health services. It also advocates for sexual and reproductive rights, including for the LGBT community. GRPA previously focused more specifically on HIV services, but in 2014 merged with the Family Planning Association of Guyana, focusing on sexual and reproductive health. Currently, only a small portion of its work is HIV-related, predominately voluntary counseling and testing.	GRPA's services focus on general sexual and reproductive health, without particular focus on HIV and key populations, and its delivery model includes fees for service, distinct from other CSOs. The interview was useful for understanding the context of CSO service provision, but was not used to inform the costing model.

Organization	Region	CSO Profile	Notes
Guyana Sex Workers Coalition	4	The Guyana Sex Workers Coalition is dedicated to advocacy and services to promote the rights of commercial sex workers and to improve their economic activities and health. HIV services are central to this and include: • Support groups • Voluntary counseling and testing • Outreach and peer education While the coalition is predominately focused on commercial sex workers (including male, female, and transgender sex workers), it also reaches other members of the population, particularly men who have sex with men and clients of sex workers. The Guyana Sex Workers Coalition Office serves as the Secretariat for the Caribbean Sex Workers Coalition, which provides support in the form of office space and staff time.	The Caribbean Sex Workers Coalition is a Global Fund regional sub-recipient. The Guyana Sex Workers Coalition has received funding from the European Union and USAID, but has suspended HIV services as of November 2017 due to lack of funding.
Guyana Trans United (GTU)	4	GTU's primary objectives are to promote the rights and well-being of trans Guyanese. It provides key HIV services to transgender individuals as well as men who have sex with men, commercial sex workers, and members of the general population. These key services include: • Voluntary counseling and testing • Outreach and peer education • Support groups • Care and support services, particularly information and referrals	GTU currently receives funding through a grant from USAID through Advancing Partners and Communities (through July 2018).
Hope For All	2	Hope for All has four priority areas of work: • Advocacy, policy development, and legislation • Care and support for people living with HV • Prevention of HIV transmission, focused on young people and key populations • Prevention among especially vulnerable groups of men who have sex with men and female sex workers Specific services include: voluntary counseling and testing, home-based care and support, outreach and peer education, and support groups.	Hope For All has considerably reduced services due to lack of funding. Compared to a previous staff of 16 with the support of PEPFAR funding, it currently operates on a purely part time, volunteer basis. Six staff members rotate, working a few half days each week to try to sustain services.

Organization	Region	CSO Profile	Notes
Hope Foundation	7	Hope Foundation provides community-based health and social services, including youth-friendly services. Previously, with support from PEPFAR, Hope Foundation provided a range of HIV services, including: prevention and outreach to remote communities, miners, loggers and sex workers; support groups; voluntary counseling and testing; home-based care for people living with HIV; support for orphans and vulnerable children; and stigma and discrimination training with healthcare workers. Currently, its HIV services include outreach and peer education and voluntary counseling and testing.	Hope Foundation has significantly reduced HIV services without adequate funding to sustain them.
Lifeline Counseling	4	Lifeline's mission is to reduce psychosocial impact of HIV for persons living with or affected by HIV through education, counseling, and care and support. With PEPFAR support, Lifeline's services include home-based care, support groups, case navigation, and skills training for people living with HV as well as support services for orphans and vulnerable children.	Lifeline Counseling has previously received funding from the Global Fund and from PEPFAR through 2017. It is not currently operating due to lack of funding.
Linden Care Foundation	10	Under previous PEPFAR funding. Linden Care Foundation provided prevention services including condom distribution, outreach, support groups for men who have sex with men and sex workers, voluntary counseling and testing, and care and support services.	Linden Care Foundation had previously been funded by PEPFAR until 2016 and was the only CSO providing HIV services within Region 10. Due to lack of funding, however, it has been closed since last year and was unable to be interviewed for this analysis.
Monique's Caring Hands (Caribbean People International Collective)	4	Monique's Caring Hands has been active in HIV services since 2003, although its mission has broadened to a range of community-based services to promote overall well-being development. HIV services have included voluntary counseling and testing, outreach and peer education, support groups, and psychosocial support for people living with HV.	Monique's Caring Hands has provided services for key populations in the past, primarily from private donations but does not currently have sufficient resources to implement HIV activities, except for occasional volunteer and donation-based outreach events.

Organization	Region	CSO Profile	Notes
Society Against Sexual Orientation Discrimination (SASOD)	4	SASOD is dedicated to promoting the rights and well-being of the lesbian, gay, bisexual, and transgender (LGBT) communities in Guyana. As part of this, HIV services constitute approximately one-third of its work, depending on availability of funding. Specific services include: • Voluntary counseling and testing • Peer outreach • Support groups In 2017, SASOD focused on research, including work with MEASURE Evaluation on validating estimates of the key population size in Region 4.	SASOD was selected as a sub-recipient for direct service delivery under the 2018–2020 Global Fund grant. It has been funded by PEPFAR in the past (2015–2016).
United Bricklayers	6	United Bricklayers provides HIV services targeting key populations in Region 5 and 6. It is a membership-based organization and works in partnership with relevant organizations and the broader community to address issues of care and support and prevention in Guyana. Key HIV services include: • Voluntary counseling and testing • Outreach and peer education • Referral for care and treatment services • Support groups	United Bricklayers has been funded by PEPFAR in the past (until 2015) and by the Global Fund from 2014–2017.

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