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LEGAL AND REGULATORY FRAMEWORK FOR SOCIAL CONTRACTING IN GUYANA

Desk Review and Social Contracting Analysis

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PEPFAR

HP+ HEALTH POLICY PLUS

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This publication was prepared by Veronica S.P. Cenac, Sandra McLeish, and Ronald MacInnis for the Health Policy Plus project.

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Acronyms

AIDS	acquired immune deficiency syndrome
ARVs	antiretroviral drug
CCM	Country Coordinating Mechanism
CDC	Centers for Disease Control and Prevention
CSO	civil society organization
GDP	gross domestic product
GTU	Guyana Trans United
GY$	Guyanese dollar
HIV	human immunodeficiency virus
HP+	Health Policy Plus
LGBTI	lesbian, gay, bisexual, transgender, and intersex
MOPH	Ministry of Public Health
NAPS	National AIDS Programme Secretariat
NGO	nongovernmental organization
PAHO	Pan American Health Organization
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PUSH	Positively United to Support Humanity
SASOD	Society Against Sexual Orientation Discrimination
STI	sexually transmitted infection
TB	tuberculosis
TWG	technical working group
UNAIDS	Joint United Nations Programme on HIV/AIDS
USAID	U.S. Agency for International Development
US$	U.S. dollar
WHO	World Health Organization

Executive Summary

In Guyana, donor funding for its HIV program, primarily through the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) and the Global Fund, has been decreasing as the country has achieved middle-income status. However, the country is still heavily reliant on external funding—in 2015, 75% of program funding for HIV came from external sources. Precipitated by the reductions in donor funding, in 2015 the Minister of Public Health prioritized a clear political commitment to greater domestic investment in health and transition to full local ownership via the 2015 *Guyana AIDS Response Progress Report*. The process of assuming full domestic programmatic and financial responsibility for the HIV and tuberculosis (TB) programs is ongoing.

As more countries transition out of eligibility for external funding, one recognized risk is whether governments will begin to fund and support services for key populations and broaden their ability to directly fund and partner with civil society organizations (CSOs), which are funded almost entirely by donor programs and projects. Globally and in Guyana, key populations are disproportionately affected by HIV and face considerable barriers to accessing services. However, significant gains have been achieved in reducing prevalence rates among key populations due to a targeted focus on human rights programming and increasing access and linkages to services. Donors have prioritized investments in CSOs that engage with key populations to improve uptake of HIV prevention, care, and treatment services.

To address these concerns, the Global Fund and APMG Health have developed a Social Contracting Diagnostic Tool, to assess whether civil society may use domestic resources to sustain service provision for those populations most at risk of or affected by HIV (key populations), including persons living with HIV, men who have sex with men, transgender people, sex workers, people who use drugs, and, in Guyana, prisoners and migrant populations of loggers and miners. Specifically, the tool is intended to guide a country in examining whether (1) CSOs are legally permitted to register, receive funds from government, and use those funds to contribute meaningfully to HIV, TB, and malaria responses, particularly among key populations, and (2) civil society is sufficiently and sustainably involved in planning and implementing HIV, TB, and malaria responses among those populations. The tool is not intended to assess the capacity of CSOs to carry out service provision or advocacy work on behalf of key populations.

The Health Policy Plus (HP+) project, funded by the U.S. Agency for International Development (USAID), applied the tool in Guyana, following a detailed desk review and consultations and stakeholder interviews, to:

- Identify any legal or structural/regulatory barriers that hinder the government from directly funding CSOs
    - Identify opportunities for publicly funded contracting of CSOs and which funding mechanism(s) would be the most useful

Key Conclusions

The following are answers to the Social Contracting Diagnostic Tool core questions.

1. Are CSOs legally permitted to register? Yes

- The Constitution guarantees the right to freedom of association; that is, the right to "form or belong to political parties or trade unions or other associations for the protection of his or her interests" (s.147). CSOs can assume legal personality or be registered under various pieces of legislation, including the following: the Companies Act, the Friendly Societies Act, and Incorporation by Act of Parliament and as a Trust Deed.

2. Are CSOs legally permitted to receive funds from Government? Yes

   - There is clear authority in both the Fiscal Management and Accountability Act and the Ministry of Health Act for government funding of CSOs from the Consolidated Fund. Under the Chart of Accounts 6321, "Subsidies and contributions to local organizations," any subventions to CSOs are made on an annual basis. In 2016, the Government of Guyana supported 68 CSOs, with subventions totaling approximately GY$251,918,000.

   - There are opportunities to modify the subvention model to address the issue of transparency and some level of de-politicization so as to transform it into an objective and responsive social contracting model.

3. Can CSOs use those funds to contribute meaningfully to HIV, TB, and malaria responses, particularly among key populations? Yes

   - Other than service delivery activities, there do not appear to be any legal or regulatory restrictions on activities that CSOs funded from government budgets can conduct. (Service delivery activities require training and licensing under existing legislation, must address government priorities, for example, for HIV and TB, and must be consistent with and designed to achieve the outcome indicators of the TB Strategic Plan and the National Strategic Plan for HIV, referred to as "HIVision 2020.")

   - There do not appear to be any restrictions in law or policies preventing or limiting CSOs from working on HIV or TB with the following groups, or dispensing government funding directly to the following populations: lesbian, gay, and bisexual people and men who have sex with men; people who use drugs; transgender people; sex workers; prisoners; migrants; and persons living with HIV and/or TB.

4. Is civil society sufficiently and sustainably involved in planning and implementing HIV, TB, and malaria responses among key populations? No

   - The 2014, the Joint United Nations Programme on HIV/AIDS (UNAIDS) National Composite Policy Index for Guyana, estimated that more than 75% of programming for people living with HIV, men who have sex with men, sex workers, transgender people, and orphans and vulnerable children are provided by CSOs; specifically, CSOs provide 51–75% of HIV counseling and testing, and programming to reduce stigma and discrimination, 25–50% of home-based care and palliative care, 25–50% of know-your-rights/legal services, and just under 25% of clinical services (antiretroviral therapy/opportunistic infections) and prevention programs for persons who use drugs.

   - Despite the critical role of CSOs in providing services to key populations, care and support, and prevention services, their role in the national HIV, TB, and malaria responses have largely focused on implementation, with limited capacity to influence national policies and budgets, and contribute to monitoring and evaluation frameworks.

   - Bringing more voices into health policy from service delivery organizations, like CSOs, in an expanded, formalized and sustained manner has been recognized as a gap and an area the state should address.

Summary of Opportunities, Challenges and Barriers, and Recommendations

Health Systems Context and the Role of Civil Society Organizations in the National Response

Opportunities	Challenges & Barriers	Stakeholder Recommendations
CSOs are acknowledged as strategic partners in key policy documents including Health Vision 2020 and HIVision 2020.	*Administrative/Capacity*: Acknowledgement has not translated to meaningful engagement—participation is limited to implementation, not policy development, budget planning, or monitoring and evaluation. There is limited or token consultation, partially driven by donor mandates for inclusion of CSOs.	
Mechanisms for engagement of CSOs are established. CSOs engage with the national HIV program at the level of the Country Coordinating Mechanism (CCM) for the Global Fund. Of the 25 members of the CCM, there are 12 CSO representatives. At the level of the National AIDS Programme Secretariat (NAPS), CSOs are members of the Key Population Working Group, Prevention Technical Working Group, and the Voluntary Counseling and Testing Steering Committee. The Monitoring and Evaluation Reference Group and the Care and Treatment Working Group which comprise medical, epidemiological, and other Ministry of Public Health (MOPH) personnel co-opt CSO representation on an ad-hoc basis. The MOPH has five technical working groups (TWGs) that provide input on health policy and health systems strengthening in cross-cutting areas to the National Health Policy Committee, however, CSO representatives do not sit on these TWGs as permanent members.	*Administrative/Political Will*: Membership by CSOs on the Treatment and Care Working Group, the Monitoring and Evaluation Reference Group within the NAPS, and MOPH TWGs is ad hoc, limiting participation. Analysis of progress by the Monitoring and Evaluation Reference Group from data submitted by all service providers, including CSOs, on activities conducted as part of the HIV response is not shared with CSOs to allow them to plan more strategically and determine the effectiveness of the services they deliver.	NAPS and MOPH should include CSO representation on all TWGs and reference groups and steering committees; selection of representatives could come from the CCM CSO committee or the National Coordination Coalition.
Of the five priority areas identified in HIVision 2020, CSOs have been identified as lead agencies for all strategic objectives and interventions under prevention, and three of the strategic objectives under treatment and support targeting key populations.	*Resources—Financial/Human*: The major strategic policies, including Health Vision 2020, HIVision 2020, and the National TB Strategic Plan, have not been costed and have no defined budgets for CSO activities. Within NAPS, budgets are externally driven by PEPFAR and Global Fund funding envelopes.	MOPH to cost HIVision 2020, clearly defining budgets and targets for CSO implementation of activities already included under the strategic objectives for prevention, treatment, and support.

Opportunities	Challenges & Barriers	Stakeholder Recommendations
	Administrative/Technical/Capacity: There is no formal modality for the inclusion of CSOs in a budget development exercise within the existing frameworks of the TWGs and reference groups.	In consultation with CSOs, MOPH should develop a modality to build capacity and engage CSOs in budget formulation for the national responses to HIV, TB, and malaria.
The CCM is recognized as a more meaningful, or sole opportunity to engage in policy formulation and program development, and through the oversight committee in monitoring and evaluation.	*Technical/Capacity*: Lack of knowledge/capacity of some CSO members on the functions and processes of the CCM, limiting their ability to contribute meaningfully.	The CCM should engage in formal orientation and capacity building for all members, particularly new and existing CSO representatives.
Two CSOs—The Guyana Business Coalition on Health and Awareness, formerly the Guyana Business Coalition on HIV and AIDS, and the Society Against Sexual Orientation Discrimination (SASOD)—have been selected as sub-recipients for direct service delivery under Global Fund grants, demonstrating the capacity of some organizations to operate in a highly competitive, transparent, and accountable manner.		

Legal and Regulatory Framework Related to the Registration of Civil Society Organizations

Opportunities	Challenges & Barriers	Stakeholder Recommendations
Freedom of association is protected under the Constitution and CSOs can be incorporated under The Companies Act, the Friendly Societies Act, Incorporation by Act of Parliament, and as a Trust Deed.	*Legal:* The existing legal and regulatory frameworks were not originally designed to address the nature of a non-faith based, non-private sector CSO and are inappropriate in their application to the structure and general purposes of CSOs.	CSOs have advocated for the passage of a new NGO legislative framework, along the lines of the Belize Non-Governmental Organisations Act, Chapter 315.
There is nothing in the legal or regulatory framework that prevents CSOs from being formed when the CSO represents the interests of the following groups, or their members or staff comprise persons belonging to the following groups, or the CSO works on HIV or TB issues for the following groups: men having sex with men, people who use drugs, transgender people, sex workers, persons living with TB and/or HIV, or migrants.	*Technical/Capacity:* Lack of capacity of the department in the Ministry of Social Protection responsible for incorporation under the Friendly Societies Act in providing clarity to CSOs on the process, forms, and advantages/disadvantages of registration. No central point of information is available or accessible by CSOs on the various registration forms, requirements and procedures, benefits, and liabilities. Prisoners may not be allowed to register a CSO, having lost the right to associate.	Training of frontline staff of the various legislative bodies in human rights and non-discrimination, customer service, and the laws that allow for registration of CSOs. The National Coordination Coalition could be resourced to administer this role as part of strengthening CSO engagement.
Notwithstanding the harmful legal environment, key population CSOs, including the Guyana Rainbow Foundation, Guyana Trans United (GTU), Guyana Network of Persons Living with HIV, and Guyana Sex Work Coalition, are registered and operate openly.	*Structural—Stigma and Discrimination:* Unreasonable delays and denial of registration after full compliance with requirements without reason have been reported, for example, by GTU when it attempted to register under the Friendly Societies Act. The registration process for GTU as a Trust with the Registry of Deeds was subject to arbitrary requests for additional information or corrections until a non-transgender person was included as a trustee and registered the Trust.	
There are no specific legal or regulatory restrictions applicable to CSOs working on HIV or TB outside of the relevant health regulations applicable to all service providers under existing laws.		

Opportunities	Challenges & Barriers	Stakeholder Recommendations
For clinical services, all health care workers whether public, private, or CSO providers require training and licenses under the Health Facilities Licensing Act 2007 and the Medical Practitioners Act.		
The provision of antiretrovirals and other pharmaceuticals are restricted to licensed medical practitioners by the Pharmacy Practitioners Act.		
CSOs providing prevention services are required to be trained in and adhere to various guidelines developed by the MOPH and NAPS.		
There are no legal or regulatory restrictions or policies on hiring practices within CSOs.		

Legal and Regulatory Framework Related to Funding of CSOs

Opportunities	Challenges & Barriers	Stakeholder Recommendations
There is clear authority in legislation in both the Fiscal Management and Accountability Act, Cap 73:02 and the Ministry of Health Act, Cap 35:01 for government funding of CSOs from the Consolidated Fund. Under the Chart of Accounts 6321, "Subsidies and contributions to local organizations" are referred to as subventions. Applicants are required to submit a detailed programmatic report and audited financial statements. The process is also synced to the Government of Guyana budget formulation process.	*Administrative/Political Will:* There are no guidelines for procurement: • The process is not preceded by the publication and advertising of a Terms of Reference (TORs) or eligibility criteria for applicants. • Selection of awardees is made by the cabinet, following support /approval of a particular ministry, not by an independent body; this process is not transparent and may be politicized. • The range of services funded through the subvention would make it difficult to compare or utilize price control mechanisms. • There are no published criteria for review by the receiving ministry or the cabinet in assessing the request.	Establish an independent approval process, perhaps utilizing the CCM, preceded by publication and advertisement of TORs, eligibility criteria, service provision standards and monitoring and reporting requirements. Templates can be developed for submittal of proposals, monitoring reports and financial reporting. The requirements and approval process should be clear, transparent and accessible to all prospective applicants.

Opportunities	Challenges & Barriers	Stakeholder Recommendations
In 2016, the Government of Guyana supported 68 CSOs, excluding state agencies and commissions, with subventions totaling approximately G$251,918,000.	*Political Will:* It is notable that of the 68 organizations that receive a subvention, only one is an organization working with TB—the Chest Society. There were no HIV or key population-focused organizations.	
There do not appear to be any legal or regulatory restrictions on activities that can be conducted by CSOs funded from government budgets, other than service delivery activities that require training and licensing under existing legislation, and ensuring that activities address government priorities.		
There do not appear to be any restrictions in law or policy preventing or limiting CSOs from working on HIV or TB with, or channeling government funding directly to the following groups: gays, bisexuals, and men who have sex with men; persons who use drugs; transgender people; sex workers; prisoners; migrants; and persons living with HIV and/or TB.		

Actual Funding of Civil Society Organizations from Government Budgets, Areas of Practice, and Procurement Practices

Opportunities	Challenges & Barriers
CSOs provide more than 75% of programming for people living with HIV, men who have sex with men, sex workers, transgender people, and orphans and vulnerable children; 51–75% of testing and counseling and programming to reduce stigma and discrimination, 25–50% of home-based care and palliative care, 25–50% of know-your-rights/legal services, and just under 25% of clinical services (antiretroviral therapy/opportunistic infections).	*Financial/Human Resources/Political Will:* The majority of CSOs working on or providing HIV services are funded by international agencies—principally the U.S. Government under PEPFAR and the Global Fund. There does not appear to be any government funding of CSOs working on TB, HIV, and malaria. A gap exists in capturing data on the level of funding provided by the government in direct contributions of ARVs, test kits, and TB treatment to two Positively United to Support Humanity (PUSH) hospital sites; HIV test kits to other testing sites, including CSOs; and treatment for the TB and malaria programs and other commodities to mining associations.

Opportunities	Challenges & Barriers
CSOs are recognized as the main providers of nonclinical HIV services for awareness, prevention, HIV counseling and testing, sexually transmitted infection screening/rapid testing to expand syphilis and Hepatitis B testing, referrals, peer education, and peer navigation/linkage to services, thus filling a significant portion of care and support and prevention activities in supporting the achievement of the "90-90-90" treatment target.	*Financial/Human Resources/Political Will:* Despite the critical role of CSOs in providing services to key populations, including care, support, and prevention services, their role in the national HIV, TB, and malaria responses have focused largely on implementation, with limited capacity to influence national policies and budgets, and contribute to monitoring and evaluation frameworks.

Planning Service Provision by CSOs

Opportunities	Challenges & Barriers	Stakeholder Recommendations
	Financial/Human Resources/Political Will: The major strategic policies, including Health Vision 2020, HIVision 2020, and the National TB Strategic Plan, have not been costed and there are no defined budgets for CSO activities in them.	Cost HIVision 2020, with defined budgets and targets for CSO activities.
The contemplation of strategic partnerships with civil society articulated in Health Vision 2020 is progressive and establishes a clear policy basis for social contracting of CSOs. Activities to achieve this objective include, among others, "the establishment of a grant mechanism to provide financial assistance to CBOs [community-based organizations] in implementing proposals in support of Health Vision 2020."		MOPH should institutionalize the grant mechanism referred to in Health Vision 2020 to promote strategic partnerships with CSOs.

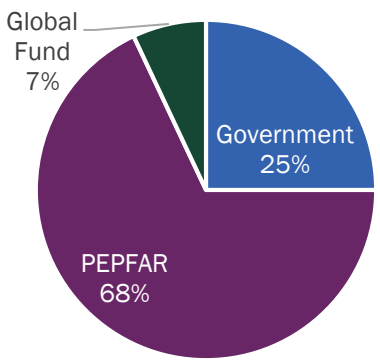
1. Introduction

Transition and Sustainability

Funding for HIV, tuberculosis (TB), and malaria programs from major donor and external sources, including the U.S. President's Emergency Plan for AIDS Relief (PEPFAR), the Global Fund, and the World Bank, have been declining since 2010 (Kates et al., 2011). Also, many low-income countries, including Guyana and many of its Caribbean counterparts, have graduated to middle-income status, thus diminishing their income-related eligibility for access to donor financing and placing increasing burdens on them to fund and manage their priority health programs without external support.

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 US$6.6 million in 2015 (PEPFAR, 2015; Health Policy Project, 2016b). In 2016, the Global Fund, based on its eligibility criteria, reduced funding for Guyana's HIV program from US$13.5 million for January 2014–December 2017 to US$4 million for January 2018–December 2020.[1] In Guyana, donor funding for its overall health programs decreased from 40.7% in 2008 to 7.2% in 2014 (PAHO/WHO, 2017).

Figure 1. Guyana HIV Funding, by Source, 2015



Source: CDC, 2017

Notwithstanding, the national HIV response is still heavily reliant on external funding. In 2015, of the US$9.9 million invested in the HIV response in Guyana, 68% came from PEPFAR, 25% was domestically funded, and 7% came from the Global Fund (CDC, 2017). Thus, of program funding for HIV in 2015, 75% came from external sources (see Figure 1).

Precipitated by the reductions in donor funding of major health programs, in 2015, the Minister of Public Health prioritized a clear political commitment to greater domestic investment in health and transition to full local ownership via the 2015 *Guyana AIDS Response Progress Report* (Guyana Presidential Commission on HIV/AIDS, 2015, p. 27). The process of assuming full domestic programmatic and financial responsibility for the HIV and TB programs is ongoing. In 2014, there was significant transitioning of donor-funded HIV program staff to government-supported positions and absorption of 25% of PEPFAR-supported antiretroviral drugs (ARVs); transitioning of Global Fund-supported ARVs began in 2015. All laboratory supplies in support of the HIV treatment program, along with testing of CD4, viral load, and DNA polymerase chain

> *"In the face of the reducing donor-funded resources for the national HIV response, we will focus our efforts at ensuring that our programs are transitioned to full local ownership while maintaining a comprehensive evidence-based scope and scale."*
>
> *Dr. George A. Norton, Minister of Public Health, 2015*

[1] The TB program has been allocated US$500,000 for April 2019–March 2022 and the malaria program US$1 million from January 2020–December 2022.

reaction (PCR) have been fully transitioned (Guyana Presidential Commission on HIV/AIDS, 2015). Transitioning the TB program is also ongoing, with more than 85% of donor-funded staff integrated into government-supported positions. Since 2012, the government has absorbed the cost for first-line treatment, but second-line treatment is still partially funded from Global Fund resources (Mohanlall, 2017).

Issue: Why Social Contracting?

As more countries transition out of eligibility for external funding, donors have developed sustainability tools and assessments to evaluate readiness and risks to health gains, where countries gradually assume full programmatic and financial responsibility for HIV, TB, and malaria programs in an effort to promote sustainability. For example, PEPFAR has developed the PEPFAR Sustainability Index and Dashboard as part of its annual performance reviews and country operational planning exercises (PEPFAR, 2016).[2] The Global Fund adopted a new Global Sustainability, Transition and Co-financing Policy (2016) on such country transitions, including making their timing more predictable and transparent; conducting country financial sustainability studies, or "transition readiness assessments"; and requiring countries to provide higher levels of domestic co-financing as they approach the point at which Global Fund support ceases (Global Fund, 2016).

As countries conduct these transition and sustainability studies and assessments, one recognized risk is whether governments will begin to fund and support services for key populations and broaden their ability to directly fund and partner with civil society organizations (CSOs), which are funded almost entirely by donor programs and projects.

Globally and in Guyana, key populations are disproportionately affected by HIV and face considerable barriers to accessing services, as shown by the evidence presented in this report. However, significant gains have been achieved in reducing prevalence rates among key populations due to a targeted focus on human rights programming and increasing access and linkages to services. In addition, donors have prioritized investments in CSOs that engage with key populations to improve uptake of HIV prevention, care, and treatment services.

Box 1. What We Know/Lessons Learned

- Ninety percent of key population programs are funded by donors.
- Transitioning out of donor funding can potentially leave key populations and the civil society organizations that serve them vulnerable if key population programming is not locally owned and sustainable.
- Protecting the human rights of key populations and access to HIV services will continue to require targeted attention.

Source: Health Policy Project, 2016a.

The Social Contracting Diagnostic Tool

To address these concerns, and based on the lessons learned as summarized in Box 1, the Global Fund and APMG Health have developed a Social Contracting Diagnostic Tool, which can be used as part of a wider transition readiness assessment or as a standalone. The aim is to assess whether civil society may use domestic resources to sustain service provision for those populations most at risk of or affected by HIV (key populations), including persons living with HIV, men who have sex with men, transgender people, sex workers, people who use drugs, and,

[2] The PEPFAR Sustainability Index and Dashboard assesses the current state of sustainability of national HIV/AIDS responses across 15 critical elements and allows stakeholders to track progress and gaps across these key components of sustainability.

in Guyana, prisoners and migrant populations of loggers and miners. Specifically, the tool is intended to guide a country in examining whether (1) CSOs are legally permitted to register, receive funds from government, and use those funds to contribute meaningfully to HIV, TB, and malaria responses, particularly among key populations, and (2) civil society is sufficiently and sustainably involved in planning and implementing HIV, TB, and malaria responses among those populations. The tool is not intended to assess the capacity of CSOs to carry out service provision or advocacy work on behalf of key populations.

In the Social Contracting Diagnostic Tool, "social contracting" is defined as: the process by which government resources are used to fund entities that are not part of the government (referred to as civil society organizations) to provide services. Social contracting mechanisms must include a legally binding agreement in which the government agrees to pay a CSO for services rendered and the CSO agrees to provide certain deliverables in exchange, either as services provided or health outcomes reached.

This report is an analysis of findings from applying the Social Contracting Diagnostic Tool in Guyana following a detailed desk review and consultations and stakeholder interviews with more than 40 representatives from government, CSOs (including nongovernmental organizations [NGOs], faith-based organizations, and the private sector), and development partners to:

- Identify any legal or structural/regulatory barriers that hinder the government from directly funding CSOs
    - Identify opportunities for publicly funded contracting of CSOs and which funding mechanism(s) would be the most useful

The approach, conducted by the Health Policy Plus (HP+) project, funded by the U.S. Agency for International Development (USAID), consisted of four key steps:

1. Country approval, including from donors, partners, and CSOs, to conduct the diagnosis and follow up on proposed recommendations/solutions
2. Adaptation of the Social Contracting Diagnostic Tool to the country context
3. Desk review of the legal and regulatory framework
4. Stakeholder interviews with representatives from government, CSOs, and development partners

The methodology and full list of entities and individuals interviewed are detailed in Annex 1 and 2. Part 2 of this report presents brief contextual information on Guyana, including basic demographic and epidemiologic data, and the human rights situation. Part 3 presents analysis of social contracting preparedness, identifying legal and structural barriers where applicable. These sections detail the legal and policy framework, followed by findings. Part 4 presents recommendations for implementing social contracting.

The findings from this report will be shared with the Country Coordinating Mechanism (CCM), other stakeholders, and the Government of Guyana for incorporation into the country's transition and sustainability strategies and mechanisms.

2. Guyana Country Context

Demographic Information

Guyana is the third smallest country in South America after Suriname and Uruguay, with just under 800,000 inhabitants. It is the only English-speaking country on the continent. The country gained independence in 1966 and four years later became a democratic republic, changing its official name to the Cooperative Republic of Guyana. The country is divided into 10 regions managed by Regional Democratic Councils, which are administratively responsible for the delivery of public services, including health and education.[3]

Guyana's total expenditure on health as a percentage of gross domestic product (GDP) declined from 7.3% in 2008 to 3.1% in 2013, and increased to 5.25% in 2014 (Table 1). General government expenditure on health represented 13.9% of total government expenditure in 2013. In 2014, government health expenditures averaged 3% of GDP, representing 9% of government spending (WHO, 2016; PAHO/WHO, 2017).

With a rise in per capita income to US$4,090 in 2015, Guyana was reclassified by the World Bank in 2016 from a lower middle-income country to upper middle-income country (World Bank, 2016 and 2017).[4] A consequence of the "elevation" in its income category is decreased access to external grant funding for government expenditures.

Table 1. Health Expenditure

Population (2015)	767,000
Gross domestic product (GDP) (2015)	US$3.166 billion
GDP growth (2015)	3%
Per capita income (2015)	US$4,090
Total expenditure on health as a % of GDP (2014)	5.25%
General government expenditure on health as a % of total government expenditure (2014)	9.45%
Private expenditure on health as a % of total expenditure on health (2014)	40.55%

Source: 2015 data from World Bank, 2017; 2014 data from the WHO, 2016.

The 2016 Human Development Report ranked Guyana 127 out of 188 countries on the human development index and 117 out of 159 countries on the gender inequality index (United Nations Development Programme, 2016).

Status of the Epidemic

Guyana has a moderate burden of HIV, with overall adult prevalence at approximately 1.4%, based on a Joint United Nations Programme on HIV/AIDS (UNAIDS) 2013 estimation exercise,

[3] The Local Democratic Organs Act of 1980 divided the country into 10 administrative regions. The established local government system consists of a Regional Democratic Council in each region, seven mayoralties, and 65 Neighbourhood Democratic Councils. There are also Amerindian Village Councils that operate under separate legislation. Regional and local governments play an important role in the supply of public services in Guyana. In addition to health and education, agriculture and public infrastructure are also delivered through the Regional Democratic Councils.

[4] Upper middle-income economies are those with a gross national income per capita between US$4,036 and $12,475.

but with higher prevalence in key populations (see Table 2). The adult prevalence rate has fallen steadily, from 2.4% in 2004 to the current level of 1.4%. Similar trends have been recorded among key populations, although the rates remain substantially high.

At the end of 2014, 751 cases of HIV were diagnosed, compared with 1,176 cases reported in 2009. A total of 82.5% of persons in care are receiving antiretroviral therapy. However, it is estimated that 36% of persons living with HIV are either undiagnosed or out of care (Guyana Presidential Commission on HIV/AIDS, 2015; Joint United Nations Programme on HIV/AIDS, 2015; PEPFAR, 2015).

Comparing data from the Biological and Behavioral Surveillance Surveys conducted in 2004 and 2014 (Table 3), HIV prevalence declined among female sex workers, men who have sex with men, and miners. Populations surveyed for the first time in 2014 include loggers, male sex workers, and transgender people. Transgender people involved in sex work had a higher prevalence (10.4%) compared to those not involved in sex work (8.4%) (Guyana Presidential Commission on HIV/AIDS, 2015; NAPS and MEASURE Evaluation, 2015).

Table 2. HIV Epidemiology

HIV epidemic type	Concentrated
Number of people living with HIV	7,700
HIV prevalence	
Adults (ages 15—49)	1.4%
Female sex workers	5.5%
Men who have sex with men	4.9%
Transgender	8.4%

Source: NAPS and MEASURE Evaluation, 2015

Table 3. Declining Prevalence Rates

	2004	2014
General population	2.4%	1.4%
Female sex workers	26.6%	5.5%
Men who have sex with men	21.2%	4.9%
Miners	6.5%	1%
Loggers	—	1.3%
Male sex workers	—	5.1%
Transgender people	—	8.4%
Transgender people involved in sex work	—	10.4%
People with tuberculosis	36%	22%

Source: NAPS and MEASURE Evaluation, 2015

Human Rights Context for Key Populations in Guyana

Rights Protections

Constitution: Of the countries comprising the English-speaking Commonwealth Caribbean, Guyana is unique in the scope of protections enshrined in its Constitution—protections that include economic, social, and cultural rights (Constitution of the Cooperative Republic of Guyana, 2001, Cap 1:01). Importantly, s.24 of the Constitution guarantees the right to health. Other economic, social, and cultural rights include the right to work and protection for the environment, housing, and education, among others (s.22, s.25, s.26, and s.27, respectively, and Title 1, Part 2). The Constitution also specifically enshrines equality for women (s.149F), with explicit protections further decreed in the Equality Rights Act 1990. Discrimination based on race, place of origin, political opinion, color, creed, age, disability, marital status, sex, gender, language, birth, social class, pregnancy, religion, conscience, and belief or culture is prohibited.[5]

[5] In 2003, the Parliament passed Constitutional Amendment No. 5, Bill #18, 2000 to amend the Constitution, which would have added discrimination based on sexual orientation as prohibited; however, it lapsed after the President failed to sign it into law.

Note that discrimination based on "gender" and "sex" are listed separately as prohibited grounds for discrimination (s.149(2)).

Incorporated Human Rights Treaties: In addition to the rights enumerated in s.19 to s.29 and Title I, Part 2 of the Constitution, there is explicit incorporation of various human rights treaties that extend protections to the rights contained in those instruments and make them enforceable against the state and all legal persons.[6] Further, the Constitution, s.39(2), requires that the Court shall regard international human rights law in its interpretation of the fundamental rights provisions. Where breaches of rights established in the Constitution occur, the right of redress is to the High Court. Where the breach refers to a separate right contained in an incorporated treaty, the right of redress is to Guyana's Human Rights Commission. However, the Human Rights Commission has not functioned fully in Guyana except on paper in the Constitution.

Rights Commissions: The Human Rights Commission is only one of the various commissions established by the Constitution for "the Promotion and Enhancement of the Fundamental Rights and Rule of Law" (Title 7). The others include the Women and Gender Equality Commission, the Indigenous People's Commission, the Rights of the Child Commission, and the Public Procurement Commission (Title 7, s.212G–s.212EE).

Anti-discrimination Legislation: Other major pieces of legislation (statute law) to protect against discrimination include the Prevention of Discrimination Act (1977), Cap 99:08 of the Laws of Guyana, which precludes discrimination in the areas of recruitment, employment, training, and membership of professional bodies on the grounds of race, sex, religion, color, ethnic origin, indigenous population, national extraction, social origin, economic status, disability, family responsibilities, pregnancy, marital status, and age.

Sector-specific legislation, such as the Health Facilities Licensing Act (2007), extends protection in specific circumstances and on expanded grounds. S.13 of the regulations to the Act states that "all patients shall be treated equally regardless of age, place of birth, race, creed, nationality, gender or sexual orientation" (s.13). The regulations further establish a Bill of Rights for patients, including protection of confidentiality and requirements for informed consent (Health Facilities Licensing Act, Cap 33:03 of the Laws of Guyana, s.13).

The HIV and AIDS Regulations enacted in 2014 under the Occupational Health and Safety Act 1997 seek to enforce the National Workplace HIV and AIDS Policy, and include the right of persons living with HIV to secure employment and be provided with the same health and other benefits accorded to other employees (Occupational Health and Safety Act Cap. 99:01, (HIV and AIDS) Regulations 2013).

Rights Restrictions

Criminal Law: Like its 11 counterparts in the Commonwealth Caribbean (except for the Bahamas, which decriminalized consensual same-sex relations in public in 1991) (Bahamas Sexual Offences and Domestic Violence Act 1991, Chapter 99, s.16(3)), Guyana has several discriminatory laws criminalizing buggery or sodomy, gross indecency, prostitution, and drug

[6] See Constitution, Title 1A s.154A incorporating treaties enunciated in the Fourth Schedule. These include the following: Convention on the Rights of the Child; Convention on the Elimination of All Forms of Discrimination Against Women; Convention Against Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment; International Covenant on Economic Social and Cultural Rights; International Covenant on Civil and Political Rights; and the Inter-American Convention on the Prevention and Eradication of Violence against Women.

use, which, coupled with religious and moral outrage, create a stigmatizing, and in some cases life-threatening, environment for gay, bisexual, and other men who have sex with men; lesbians; transgender people; sex workers; and persons who use drugs.[7] Antiquated and obscure laws—for example, cross-dressing laws in Guyana—are used to intimidate and discriminate against transgender people.[8]

In *McEwan, Clarke, Fraser, Persaud & SASOD V Attorney General of Guyana*, four individuals were arrested and later convicted and fined in February 2009 under Section 153 (1) (xlvii) for "being a man, and in any public way or public place, for any improper purpose, appearing in female attire." On a constitutional motion filed in September 2013, the Constitutional Court ruled that cross-dressing is not a crime, unless it is for an "improper purpose." The motion was filed by the Society Against Sexual Orientation Discrimination (SASOD), one of the leading lesbian, gay, bisexual, transgender, and intersex (LGBTI) organizations in Guyana, with legal support by the University Rights Advocacy Project from the University of the West Indies. In a decision delivered in March 2017, the Court of Appeal upheld the decision of the Constitutional Court. The appellants intend to file another appeal with the Caribbean Court of Justice on the basis that the provision is "vague," discriminates based on gender, and violates multiple equality provisions in the Constitution.

> "The ruling of the Court of Appeal leaves the application of the law to be done on a case by case basis and is very problematic because it allows police officers and other law enforcement to interpret the provisions to give effect to their own prejudices."
>
> – Guyana Trans United member/trans woman who has been repeatedly banned from court for dressing in female attire

Stigma and Discrimination: 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 (COIN et al., 2014). Although data on persons who use drugs is limited, persons living with HIV, gay men and women, transgender persons, and sex workers have reported extreme instances of stigma and discrimination, ranging from verbal harassment and ostracism to denial of employment, healthcare, and other services to physical violence, abuse, and death. In the most recent reports filed by SASOD and other human rights organizations in Guyana before the Human Rights Council and the Inter-American Commission on Human Rights, documented cases have been presented of police extortion of men who appear to be gay and bisexual, dismissals from employment, and police indifference to murders of sex workers and LGBTI persons (IACHR, 2015; UNHCR, 2014; Carrico, 2012; David, 2012).

Among this environment of societal discrimination, at the end of May 2017, the Minister of Foreign Affairs and the Attorney General announced that the Government of Guyana is considering a referendum on decriminalizing buggery. The Guyana Human Rights Association described this "as an 'odious' cop-out, and a substitute for leadership, courage and decency" (Stabroek News, 2017). This view is premised on "the notion [that] putting minority rights to the popular vote is potentially dangerous, and absolves the government of responsibility for discharging its primary task: to provide leadership" (Burnham et al., 2017).

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[7] The Criminal Law (Offences) Act, Cap 8:01, criminalizes: buggery, punishable with life imprisonment (s.354), gross indecency (s. 351), attempt to commit unnatural offences (s. 353), and sex work (various provisions).

[8] Section 153 (1) (xlvii) of the Summary Jurisdiction (Offences) Act Chapter 8:02 makes it an offence for a man to appear in female attire or a woman in male attire "for any improper purpose," in any public way or public place.

3. Analysis of Social Contracting in Guyana

The following analysis corresponds with the five main sections of the Social Contracting Diagnostic Tool. Each section lists the objective and legislation that was reviewed. Findings are provided in each section as well as comments from stakeholder interviews that provide clarification on key findings.

3.1 Health Systems Context and the Role of Civil Society Organizations in the National Response

Objectives: Determine the health systems context and participation of CSOs in the health sector.

Legislation reviewed:

- Ministry of Health Act 2005, Cap 32:01
- The Public Health Ordinance 1934
    - The Regional Health Authorities Act 2005, Cap 32:06

Brief Overview of Health Systems in Guyana

The Ministry of Public Health (MOPH), as principal steward of the public resources for health in Guyana, is mandated through the Ministry of Health Act 2005, Cap. 32:01 to ensure effective oversight, regulation, coordination, and accountability (Ministry of Health, 2013). In 1986, responsibility for the delivery of health services was devolved to the Regional Democratic Councils, which receive funding through the Ministry of Local Government, now the Ministry of Communities. The then named Ministry of Health retained responsibility for the vertical health programs for the entire country, including vector control, rehabilitation services, dental care, mental health programs, Hansen's disease, AIDS, and alcohol and drug use.

In 2005, the then named Ministry of Health planned for the decentralization of health services to Regional Health Authorities with the passage of the Regional Health Authorities Act 2005, Cap 32:06. The Regional Health Authorities would assume responsibility for service delivery from the Regional Democratic Councils, allowing the then named Ministry of Health to focus on its leadership role and strengthening human resources and strategic information support services.

The Guyana Public Hospital Corporation—which became autonomous with its own board and budget—and the Regional Health Authorities were designed to facilitate improved management of the national referral hospital and increased flexibility and capacity to improve resource use and health outcomes across Guyana. Only the Berbice Regional Health Authority was established, despite plans for four other Regional Health Authorities. The Berbice Regional Health Authority does not cover Region 5, as intended, and is not yet autonomous with respect to its budget, thus limiting its capacity to manage its resources as flexibly as the law intended.

The national health strategy, referred to as Health Vision 2020 (p. 31), noted the following:

> *"…in addition, at the regional level, multiple reporting lines and lack of clarity on roles and responsibilities between the regional health offices, the regional democratic councils, the Ministry of Health and the Ministry of Communities contributed to an absence of performance incentives and fragmentation in leadership, communications and management of health programs across the regions."*

The existing model is one of decentralization to semi-autonomous bodies, with the Ministry of Health relinquishing its role in service delivery (PAHO, 2001). The Regional Democratic Councils in the 10 administrative regions, except the Berbice Regional Health Authority to a limited extent, continue to be legally responsible for the delivery of health services, together with the Guyana Public Hospital Corporation in Region 4 (PAHO/WHO, 2017). MOPH formulates policy, sets standards, and monitors and evaluates the health sector. Human and technological resources for the Regional Democratic Council health departments are for the most part provided by the MOPH. Ministry of Communities are engaged in setting budget levels for Regional Democratic Councils.

There are five levels of public sector healthcare in Guyana: Levels 1 and 2 (health huts, posts, and centers) deliver primary healthcare services; Levels 3 and 4 (district, community, and regional hospitals and diagnostic centers) deliver secondary care and diagnostic services; and Level 5 (national referral hospital-Guyana Public Hospital Corporation) delivers tertiary care (NAPS, 2013).

In relation to HIV delivery services, two private hospitals—the Davis Memorial Hospital (Adventist) and St. Joseph Mercy Hospital (Catholic)—are involved in the Positively United to Support Humanity (PUSH) Project funded by the U.S. Centers for Disease Control and Prevention (CDC) to provide HIV care and treatment to patients in Georgetown, including the provision of ARVs and monitoring of patients.

Legal and Policy Framework

This analysis found little evidence of NGOs focused on TB and malaria. The exceptions include the Chest Society in relation to TB, and in relation to the malaria program, private sector entities, such as mining companies and associations that partner with the MOPH, to provide testing and treatment and distribute mosquito nets provided by the ministry through the Global Fund project. This section will thus focus on the role of CSOs in the national HIV response in Guyana.

There is no dedicated HIV law in Guyana. The national response is guided at the policy level by *Health Vision 2020, Health for All in Guyana: A National Health Strategy for Guyana 2013–2020* and *HIVision 2020: Guyana's National HIV Strategic Plan (2013–2020)*. Other important policy documents include the National HIV and AIDS Workplace Policy. This policy has been made law by the *Occupational Health and Safety Act, Cap. 99:01, (HIV and AIDS) Regulations 2013* to guarantee the rights of persons living with HIV to employment.

CSOs engage with the national program at the level of the CCM for the Global Fund and, as part of the CCM, engage in the process of concept note development and monitoring of the Global Fund project. At the level of the National AIDS Programme Secretariat (NAPS), CSOs are members of the Key Population Working Group, Prevention Technical Working Group, and Voluntary Counseling and Testing Steering Committee. The Monitoring and Evaluation Reference Group and the Care and Treatment Working Group comprises medical, epidemiological, and other MOPH personnel and co-opts CSO representation on an ad hoc basis.

The MOPH has five technical working groups (TWGs) that provide input on health policy and health systems strengthening in cross-cutting areas to the National Health Policy Committee; however, CSO representatives do not sit on these TWGs as permanent members.

Findings

Several reports point to the invaluable contribution of CSOs to the HIV program in Guyana, principally in relation to service provision in areas where the government is unwilling or unable to reach key sectors, particularly, key populations; HIVision 2020, for example, concedes that it will not be successful without engagement and coordination with CSOs (Guyana Presidential Commission on HIV/AIDS, 2015; NAPS, 2013; PAHO, 2001).

Under the Global Fund reprogramming request for January 1, 2014 to December 31, 2017 and for the new request from January 1, 2018 to December 31, 2020, CSOs have been selected as sub-recipients for direct service delivery under the grants (the Guyana Business Coalition on Health Awareness under the 2014–2017 grant and SASOD under the 2018–2020 grant), demonstrating the capacity of some organizations to operate in a highly competitive, transparent, and accountable function.[9]

CSOs are acknowledged as strategic partners in the development of policy and delivery of services in health sector policy documents; Health Vision 2020 acknowledges and expresses in clear terms the Government of Guyana's commitment to engage in strategic partnerships to achieve universal health coverage and proposes in relation to CSOs to "develop capacity within civil society to deliver critical, complementary services, address determinants of health and reduce health equalities" (p. 67). Modalities to achieve this include the following:

> *"Support and enable the functioning of forums that give voice to civil society including National Commissions and regional Health Management Committees, and facilitate their participation in relevant NHPC [National Health Policy Committee] discussions" (p. 69).*

Notwithstanding these statements, civil society collaboration with the MOPH on specific health system strengthening issues addressed by the TWGs is limited because CSO participation is ad hoc, depending on whether the TWG invites CSO contributions (Health Systems 20/20 and the Guyana Ministry of Health, 2011).

Stakeholder Comments

Participation in the CCM for the Global Fund was identified as one of the more meaningful or even the sole opportunity to engage in policy formulation, program development, and monitoring and evaluation. Twelve CSO representatives participated, including representatives from key populations.[10]

Health Vision 2020, HIVision 2020, and the Guyana AIDS Response Progress Report describe a consultative process that includes engagement with CSOs. However, during the CSO stakeholder consultation and interviews for this analysis, the role of shaping the policy discussion around health and HIV was redefined by some participants as "a workshop relationship," in that engagement was limited to participation in workshops or other meetings requiring the presence of CSO representatives. Others described it as "rubber stamping," in that participation was

[9] The Guyana Business Coalition on Health and Awareness, formerly the Guyana Business Coalition on HIV and AIDS, with a membership of more than 47 companies, conducted an HIV workplace program through HIV sensitization sessions and integrated gender-based violence awareness, among other activities.

[10] The CCM comprises representatives from 25 organizations: 11 from government, 12 from civil society, and two from multilateral/bilateral development partners.

limited to the mere presence of CSO representatives to approve documents that they had little opportunity to influence or shape.

The USAID PEPFAR Country Co-operation Strategy, which requires inclusion of CSOs, and Global Fund funding premised on an open, transparent consultation process with all sectors, particularly civil society and key populations, was identified by CSOs as a key incentive for government to consult with them. Participation by CSOs appears to be limited to organizations involved with PEPFAR or other U.S. Government projects, including the Advancing Partners and Communities project, many of which had previously benefited from capacity building under the Guyana HIV/AIDS Reduction and Prevention project.[11]

It was also revealed that information sharing between CSOs and the government are not reciprocal. Monitoring reports of activities conducted as part of the HIV response are provided to the National AIDS Programme through the Monitoring and Evaluation Reference Group. The aggregated data that inform national progress reports and evaluate whether the indicators and targets of HIVision 2020 are being met are not shared with CSOs. Such sharing would allow CSOs to plan more strategically and determine the effectiveness of the services they deliver.

There is clear acknowledgement by the government in Health Vision 2020 of limited CSO involvement; based on stakeholder interviews, this view is shared by CSOs involved in the HIV response:

> *"…opportunities for civil society and the private sector to advocate and provide input into health policies and programmes are still ad hoc and limited and need to be expanded, formalized and sustained" (p. 31).*

3.2 Legal and Regulatory Framework Related to the Registration and Service Provision of Civil Society Organizations

Objectives:

1. Determine the procedure for registration based on the applicable legislation and identify potential bottlenecks
2. Determine "allowed" and "restricted" activities by CSOs in accordance with the relevant acts
3. Determine whether licenses to provide services are required and the process for obtaining the appropriate licenses
4. Determine whether there are restrictions on hiring practices within CSOs

Legal Framework for Registration of Civil Society Organizations

Notwithstanding the substantial rights protections in Guyana, certain populations—in particular, LGBTI, men who have sex with men, and sex workers, whose behavior is criminalized and are more likely to be living with HIV—clearly face an environment of everyday societal discrimination which has a "profound impact" on their lives (IACHR, 2015, p. 10). A 2016 case

[11] Some of these organizations are Artistes in Direct Support (AIDS); Lifeline Counselling Services (LCS); Youth Challenge Guyana (YCG); Hope Foundation; Hope for All; Society Against Sexual Orientation Discrimination (SASOD); Linden Care Foundation; United Brick Layers; Guyana Business Coalition on Health Awareness (formerly Guyana Business Coalition on HIV and AIDS); Guyana Network of Persons Living with HIV; and others.

study by the Health Policy Project noted that the harmful legal and policy environment would make it unlikely that the Government of Guyana will fund programming delivered by key population-led organizations (Health Policy Project, 2016b). This section will review the legal requirements for registration of CSOs and whether the law imposes any barriers. The stakeholder and other key informant interviews captured whether barriers exist in practice—for example, unreasonable delays or denials of registration after full compliance with requirements.

Legislation reviewed:

- Constitution of the Co-operative Republic of Guyana Cap 1:01, s.147 (freedom of association)
- The Companies Act, Cap 89:01
- The Friendly Societies Act, Cap 36:04
- The Co-operative Societies Act, Cap 88:01
- Incorporation by Act of Parliament
- Trust Deed
- Corporation Tax Act, Cap 81:03
- Property Tax Act, Cap 81:21
- Value Added Tax Act, Cap 81:05
- Customs Act, Cap 82:01
    - Income Tax Act, 81:01

The Constitution

Section 147 of the Constitution guarantees the right to freedom of association, and s. 149C the right to participate in the management and decision-making processes of the state. The right to freedom of association is fundamental for the establishment of all classes of civil organizations, defined as the right to "form or belong to political parties or trade unions or other associations for the protection of his or her interests." However, there is no specific legal or regulatory framework that addresses the formation, structure, reporting responsibilities, financing, or financial status of CSOs outside of existing legal frameworks related to the registration of companies, cooperatives, benevolent societies, or trusts. A CSO may assume corporate status through incorporation by an Act of Parliament—for example in the case of the *Chest Society (Incorporation) Act, Cap 35:10*.

Guyana meets the first criterion for establishing CSOs, in that there is nothing in its statutory framework that requires CSOs to be formed or prevents them from being formed. This criterion applies when the CSO represents the interests of, or where their members or staff comprise persons belonging to the following groups, or the CSO works on HIV or TB issues for these groups:

- Gay, bisexual, or other men who have sex with men
- Persons who use drugs
- Transgender people
- Sex workers
- Prisoners (except that prisoners may not be allowed to register a CSO, having lost the right to associate)
- Persons living with TB and/or HIV
- Migrants

The Companies Act, Cap 89:01

Companies register with the Deeds Registry Authority under the Ministry of Legal Affairs. Until 1991, the "Company Limited by Guarantee" allowed not-for-profit companies with a charitable or quasi-charitable character to register under the Act. Although not originally designed to do so, this form of incorporation was well suited to CSOs because such organizations do not have "shareholders" but allowed "members" to have limited liability (Morgan, 1997). This provision was eliminated in 1995 by the passage of the present Companies Act, Cap 89:01, leaving a "Private Limited Liability Company with No Share Capital" as the only corporate option for not-for-profit registration under the Act.[12]

The process: The procedure is the same as for a for-profit company, except that the Private Limited Liability Company with No Share Capital is achieved by specific inclusion in the Articles of Incorporation that the company is "not for profit" in place of the "classes and maximum number of shares" and inclusion of the purposes of the company (see Form 1 Companies Regulations, SI No. 2 of 1995). Thus, there are no legal provisions that specifically recognize the unique features of not-for-profit as compared to for-profit companies (Zaleski and Small, 2010). Many CSOs are registered under the Companies Act—for example, the National Coordinating Coalition Inc.

Tax exempt status: CSOs registered under the Companies Act do not enjoy tax exempt status and all income (including from service provision) is taxed at a regular rate, similar to a business.

The Friendly Societies Act, Cap 36:04

Although many CSOs have registered under the Friendly Societies Act, it is primarily designed to facilitate the legal registration of charitable or mutual benefit and relief organizations (particularly regarding sickness or mortality among its members), rather than NGOs that work programmatically to address the needs of external beneficiaries (Zaleski and Small, 2010). Groups of seven or more persons (s.11, ss. (1) and (2)) can register under one of four categories in the Act (s.3): (1) Friendly Society; (2) Benevolent Society; (3) Working Men's Club; or (4) Specially Authorized Society, defined in s.3(d) as "societies for any purpose to which the powers and facilities of this Act ought to be extended" as determined by the Minister (with responsibility for Friendly Societies).

Tax-exempt status: The Minister can exempt any society from the payment of income tax (s.68, ss. (1), (2), and (3)). Notwithstanding the lack of congruity with the structure of a CSO, the Friendly Societies Act does provide some advantages for organizations registering under its provisions. The power of the Minister is buttressed by the Corporation Tax Act, Cap 81:03 (s.7 (d)) and the Property Tax Act, Cap 81:21 (s. 6(j)), which exempt Friendly Societies from taxation, including on its income or property, as long as the income or property is not for business.

The Act, however, gives the Registrar and the Minister considerable discretionary powers. The Registrar can consider whether the application reflects the "intentions and objects" of those intending to form the society, and call a meeting with the named persons to determine that the objects of the society can be met. The Registrar also has the authority to refuse to register a society, and any appeal is directed to the Minister (s.15 ss. (2)).

[12] The Companies Act, Cap 89:01 was passed in 1991 by Act No. 29 of 1991; however, it came into effect on May 25, 1995 by SI 25 of 1995.

The process: Two copies of the society rules and two lists of the names of officers (if any) must be transmitted to the registrar, together with the application signed by the seven persons required.

The Trust Deed

The authorizing legislation under this option for registration of CSOs is not clear. However, this option has been utilized by some key population CSOs, including SASOD, Guyana Trans United (GTU), and the Guyana Rainbow Foundation.

The process: Perhaps the simplest form of registration, the process requires preparation of a trust deed and naming the trustees, responsibilities, and purposes of the trust. At least one trustee, with identification, must present the deed in person for filing at the Deeds Registry.

The Co-operative Societies Act, Cap 88:01

The Co-operative Societies Act (including co-operatives with limited and unlimited liability), although providing another option for CSOs, offers business forms that do not provide the flexibility and protection required by modern CSOs, and in fact are not intended for such organizations. This legislation understandably is used infrequently or not at all for CSOs seeking registration.

Tax Incentives for Legally Registered CSOs

In addition to the tax-exempt status of Friendly Societies under the Corporation Tax Act, Cap 81:03 (s.7 (d)) and the Property Tax Act, Cap 81:21 (s. 6(j)), the Value-Added Tax Act, Cap 81:05 at s.18 exempts from value-added tax "[those items] that, for social or difficult to tax reasons, are not taxed." Such items include "a supply of any goods or services by a charity where consideration for the goods and services is nominal in amount or not intended to recover the cost of such goods or services" (Value-Added Tax Act, Cap 81:05, p. 2 (e)).[13] Under the Customs Act, Cap 82:01 some CSOs may be exempt from paying custom duties on articles imported for the use of these organizations. Organizations to which these exemptions apply and are specifically named in the Act include the Guyana Red Cross, St. John's Ambulance Brigade, Guyana Society for the Blind, and the Salvation Army. There is also provision for "other approved charitable or non-profit organization in accordance with regulations and/or published guidelines" (Customs Act, Cap 82:01 First Schedule, Part III (1) B (2) s.10 (1) and (2)).

Donations to CSOs: Deductions on income tax liability may be made for donations to the Government of Guyana or any prescribed institution or organization of national character in accordance with s.35 of the Income Tax Act, Cap 81:01. However, this deduction applies solely to donations made to prescribed organizations listed in the Income Tax (Prescribed Organizations) Regulations 1974.[14]

Companies, not individuals, may claim a deduction on their contribution for the "benefit of any ecclesiastical, charitable, or educational institution, organisation or endowment of a public character within Guyana…" made over a period of two years. Individuals cannot claim a deduction for any charitable or public purpose (s.75 of the Income Tax Act, Cap 81:01).

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[13] In s. 2 of the Value-Added Tax Act, "charity" is defined as a "not-for-profit that is required to use any assets or income solely in furtherance of its aims and objectives."

[14] The prescribed organizations include Guyana National Steel Band, Guyana Cricket Board of Control, Guyana Society for the Blind, Institute of Small Enterprise Development Ltd., National Relief Committee, and the Cheddi Jagan Research Centre.

Registration with Government Line Ministries

Numerous CSOs and community-based organizations are listed or informally registered with a relevant government line ministry—for example, sports and youth clubs with the Ministry of Culture, Youth and Sport; agricultural groups with the Ministry of Agriculture; and women's groups with the Women's Affairs Bureau. It does not appear that this form of registration is governed by any legislation or policy defining its parameters and it does not ascribe corporate status to the organization (Zaleski and Small, 2010). The procedure for registration is not very clear and varies by ministry.

Findings

The Constitution of the Cooperative Republic of Guyana, Cap 1:01, s.147 guarantees the right to freedom of association; that is, the right to "form or belong to political parties or trade unions or other associations for the protection of his or her interests." CSOs can assume legal personality or be registered under various pieces of legislation, including The Companies Act, Cap 89:01; The Friendly Societies Act, Cap 36:04; Incorporation by Act of Parliament; and as a Trust Deed. There are no legal restrictions on the formation and registration of CSOs in Guyana, including CSOs comprising, managed, or staffed by the following:

- Gay, bisexual, and men who have sex with men
- Transgender people
- Sex workers
- People living with HIV or TB
    - Migrants (loggers and miners)

There are no legal or regulatory restrictions on forming legal entities to work on the following:

- HIV among gay, bisexual, and men who have sex with men
- HIV among transgender people
- HIV among sex workers
- HIV and/or TB among prisoners
- Services for people living with HIV or TB
    - Services for migrants

Notwithstanding the harmful legal environment, key population CSOs are registered and operate openly, including the Guyana Rainbow Foundation, GTU, Guyana Network of Persons Living with HIV, and Guyana Sex Work Coalition. Organizations like SASOD, the leading LGBTI rights organization in Guyana, have been registered and operating since 2003. However, the existing legal and regulatory frameworks were not originally designed to address the nature of a non-faith-based, non-private sector CSO and are inappropriate in their application to the structure and general purposes of CSOs. Other than incorporation by Act of Parliament, the Companies Act, Cap 89:01; Friendly Societies Act, Cap 36:04; and Trust Deed do not adequately address the formation, structure, reporting responsibilities, financing, or financial status of CSOs. Many stakeholders recommended the passage of new NGO-focused legislation similar to the Belize Non-Governmental Organisations Act, Chapter 315.

The legal environment is not conducive for CSOs to engage in income-generating activities or receive tax-free private or corporate contributions and thus become more sustainable. CSOs registered under the Friendly Societies Act may be granted tax-exempt status, however, registration under the Act does not automatically guarantee conferral of this status. CSOs registered under the Companies Act do not enjoy tax-exempt status, and all income (including from service provision) is taxed at a regular rate, similar to a business. However, regardless of

the source of incorporation, any CSO may apply to the Ministry of Finance for tax-exempt status.

By way of deed of covenant for a minimum period of two years, Section 75 of the Income Tax Act, Cap 81:01 allows only companies and not individuals to claim a tax deduction for donations to prescribed institutions, which excludes most CSOs.[15]

Stakeholder Comments

Unreasonable delays and denial of registration: The discretion of the Registrar of Friendly Societies to refuse to register an organization, or review after registration whether it is meeting its "intentions and objects" is subject to an arbitrary exercise of discretion on the part of the office holder. GTU reported that it took more than a year for it to be registered as a trust because time was lost attempting to register the organization under the Friendly Societies Act. Although legal counsel presented the application, there were multiple requests for unnecessary changes to the application, severely delaying the process and resulting in the effective denial of registration. However, as the Registrar made no "decision," it limited the right to file for judicial review of the Registrar's actions so as to require the office holder, by way of an order of "mandamus," to register the organization.

Stigma and discrimination: During the consultations with CSOs, they attributed the aforementioned actions of the Office of the Registrar of Friendly Societies to discriminatory attitudes. The registration process by GTU as a trust with the Deeds Registry was also subject to arbitrary requests for additional information or corrections to the trust deed every time a member of GTU attended in person at the Deeds Registry to facilitate the registration in accordance with the requirements. GTU overcame this problem and the trust was registered when a non-presenting transgender person was named as a trustee and a male in male attire attended at the Deeds Registry with proper identification. Only after that was the trust finally registered.

Lack of training of frontline staff at the various legislative bodies on the laws and procedures that allow for registration of CSOs: CSOs noted that the department within the Ministry of Social Protection responsible for registration of a Friendly Society is ill-equipped to manage the process for which they are responsible. This capacity deficit is evident in the conflicting, insufficient, or incorrect information that organizations receive when attempting to register, thus resulting in delays and making the process arduous. Some organizations "registered" or listed with various ministries mistakenly believed that the listing constituted registration and conferral of legal status. This administrative bottleneck was attributed to lack of knowledge of the legislation, the process, and requirements—or apathy—on the part of department staff.

There is no central point of information on the various forms of registration, their requirements and procedure, or the benefits and liabilities accessible by CSOs other than seeking and paying for legal advice. CSOs noted the lack of clarity on the various forms and the advantages and disadvantages of registration as administrative bottlenecks. A noted above, the government department responsible for registration appears to lack the relevant knowledge and thus is not in a position to advise CSOs.

[15] These include, in accordance with the Tax (Prescribed Organisations) Regulations 1974: Guyana National Steel Band, Guyana Cricket Board of Control, Guyana Society for the Blind, Institute of Small Enterprise Development Ltd., National Relief Committee, and the Cheddi Jagan Research Centre.

Legal Framework for HIV Service Provision by Civil Society Organizations

CSOs are recognized as the main providers of non-clinical HIV services, working in awareness, prevention, HIV counseling and testing, sexually transmitted infection (STI) screening (rapid testing to expand syphilis and Hepatitis B testing), referral, peer education, peer navigation, and linkage to services. HIV initiatives extend into prevention of mother-to-child transmission, nutrition, and TB referrals. Clinical services are provided by private hospitals for HIV treatment and care (NAPS, 2013). Legal restrictions on the provision of health services apply to all unqualified or unlicensed individuals or facilities under various pieces of legislation, including the Health Facilities Licensing Act 2007, Cap 33:03 and Regulations; the Allied Health Profession Act 2010, Cap 35:01; the Medical Practitioners Act, Cap 32:02 and Regulations; and the Pharmacy Practitioners Act, Cap 32:07, among others.

Legislation Reviewed:

- Health Facilities Licensing Act 2007, Cap 33:03 and Regulations
- Allied Health Professions Act 2010, Cap 35:01
- Medical Practitioners Act, Cap 32:02
    - Pharmacy Practitioners Act, Cap 32:07

Health Facilities Licensing Act 2007, Cap 33:03

The provision of clinical services is strictly regulated by various laws, including two key pieces of legislation—the Medical Practitioners Act, Cap 32:02 and the Health Facilities Licensing Act 2007, Cap 33:03. All health facilities as defined by the Act, whether public and private, are regulated by the Health Facilities Licensing Act 2007. Pursuant to Section 11, annual licenses are required. The Davis Memorial Hospital (Adventist) and St. Joseph Mercy Hospital (Catholic), which are involved in the PUSH Project funded by CDC, provide HIV and TB care and treatment and thus are regulated by the Act. In accordance with the requirements of the Act, the private hospitals can hire their own clinicians, provide treatment, prescribe and distribute ARVs, and distribute other health commodities.

The process: Establishing a treatment site or any site for the conduct of clinical services, with the exception of a "doctor's office," as defined in Section 2 of the Act, is made on application to the MOPH, supported by resumes of the key providers, a description of and plans for the premises, fee structure, and disclosure of guarantees of diversity to ensure non-discriminatory treatment in accordance with Section 13 of the Regulations to the Act. It is not required that the organization be a legal entity.

Pharmacy Practitioners Act, Cap 32:07 and Medical Practitioners Act, Cap 32:02

Section 2 (2) of the Pharmacy Practitioners Act defines the practice of pharmacy to include "compounding and dispensing of pharmaceuticals … and information related to the use of pharmaceuticals in response to prescriptions given by a duly registered medical practitioner, dental practitioner, medex or veterinarian." The Medex Act, Cap 32:04, which recognizes a person trained in an approved University of Guyana program as an auxiliary primary healthcare provider employed in government service as a medex, does not provide for or give power to a medex to prescribe pharmaceuticals. Therefore, only a duly registered medical practitioner, dental practitioner, or veterinarian may prescribe pharmaceuticals. This provision would limit the ability of CSOs (including from the private sector) that may not have a licensed health facility or be staffed with a clinician from engaging in the distribution of ARVs. The distribution

of other commodities by CSOs—for example, condoms and lubricants—does not appear to be restricted under the Act or by any other law.

Allied Health Professions Act 2010, Cap 35:01

HIV counseling and testing, STI screening, referrals, peer education, and peer navigation, whether conducted by service providers within the government health structure or CSOs funded by donor resources (e.g., the organizations involved in the USAID Advancing Partners and Communities project, who provide counseling and testing, peer navigation, and linkages to services for key populations) are all required to be trained in and follow the Guyana National HIV Prevention Principles, Standards, and Guidelines; Most-at-Risk Population Guidelines; and HIV Counselling and Testing Guidelines 2016, with modifications and amendments.[16] Where applicable, all providers are also required to follow the HIV Treatment Guidelines and apply the unique identifier code developed by the MOPH.

Counselors and testers fall within the definition of "community health worker" defined in the Regulations to the Health Facilities Licensing Act, Cap 33:03, s.2 as "a person who is selected by the community to provide basic healthcare in the community, and who has completed a community health worker program approved by the Minister" (Health Facilities Licensing Act 2007, Cap 33:03, s.2). CSO service providers who provide counseling and testing services, STI screening and testing, referrals, peer education, and peer navigation, and whose staff are required to be trained in and adhere to the MOPH guidelines thus fall within the definition of community health worker. Remuneration levels may differ based on the source of funding—that is, government as opposed to donor resources—and the times and location of the community in which they work.

"Community health worker" is not included in the list of professions under the Allied Health Professions Act, Cap 35.01 (s.2 (a) and (c), First Schedule). However, in the interview with the Chief Medical Officer, he indicated that CSO service providers should be monitored and regulated as allied health professionals, and that once the administrative arrangements are in place, they should also be subject to annual licensing in accordance with the Act for quality assurance of service provision standards.

The process: Licensees require formal medical training or, in the case of counselors and testers, training in the approved guidelines developed by the MOPH. Licensees thereafter require a six-month internship and four hours of continuing education credits for their annual license. Although the Act establishes an Allied Health Professions Council (s.3), it does not appear that this council is functional or that the licensing process is ongoing. Notwithstanding, all service providers are trained in accordance with the national guidelines and monitored by the MOPH National AIDS Programme.

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[16] The National AIDS Programme, HIV Counselling and Testing Guidelines 2016 are intended to provide direction to all sites and providers of HIV counseling and testing, whether they are providing voluntary counseling and testing services for clients who self-refer or HIV counseling and testing as part of routine medical care for STIs and TB, antenatal care, and maternity care. These guidelines apply to all HIV counseling and testing in Guyana, both in public and private settings. The National AIDS Programme, Most-at-Risk Population Guidelines provide standards for HIV prevention program implementation for NGOs and CSOs against which services provided to the target populations can be monitored and evaluated to ensure quality and client satisfaction. The guidelines describe the elements of a comprehensive prevention program for most-at-risk populations, including behavioral, biomedical, and structural activities, and include standard operating procedures and relevant screening and data collection tools.

Findings

There are no specific legal or regulatory restrictions applicable to CSOs working on HIV or TB outside of relevant health regulations applicable to all service providers under existing laws. For clinical services, health service providers, including government and CSOs (and those in the private sector), require training and the issue of licenses in accordance with the Health Facilities Licensing Act 2007, Cap 33:03 and the Medical Practitioners Act, Cap 32:02 among others.

The provision of ARVs and other pharmaceuticals are restricted by the Pharmacy Practitioners Act, Cap 32:07 to licensed medical practitioners. Only a doctor/physician or clinician (also a dentist or veterinarian) may prescribe medication. There do not appear to be any restrictions on the distribution of commodities employed in prevention initiatives, including condoms and lubricants.

CSOs providing prevention services are required to be trained in and adhere to the guidelines developed by the MOPH National AIDS Programme, including the Guyana National HIV Prevention Principles, Standards and Guidelines; Most-at-Risk Population Guidelines; HIV Counselling and Testing Guidelines 2016; and the HIV Treatment Guidelines, where applicable.

Counselors and testers fall within the definition of "community health worker" defined in the Regulations to the Health Facilities Licensing Act, Cap 33:03. Although "community health worker" is not included in the list of professions under the Allied Health Professions Act, Cap 35:01 (s.2 (a) and (c), First Schedule), the Chief Medical Officer recommended that CSO service providers should be monitored and regulated as allied health professionals and be subject to annual licensing in accordance with the Act once the administrative arrangements to give effect to this provision are in place, so as to maintain quality assurance of service provision standards.

A review of all applicable laws revealed no legal or regulatory restrictions or policies related to hiring practices within CSOs directly related to a person's status or sexual identity. Like every other employer, CSOs are subject to the labor laws and other relevant legislation in the hiring of personnel and their conditions of work. For example, CSOs are subject to the Occupational Health and Safety Act, Cap. 99:01, (HIV and AIDS) Regulations 2013, which prevent employers from discriminating against persons living with HIV in their hiring, promotion, transfer, training, remuneration and working conditions, or any other terms or conditions of employment. With respect to migrant populations, hiring practices must conform to the relevant immigration laws.

Stakeholder Comments

GTU reported that it had received external funding to establish a clinic addressing the needs of transgender populations—in particular, linking them to HIV services by using the clinic as a point of collection for ARVs and conducting screening for STIs and Pap smears. GTU identified a doctor who agreed to provide pro bono services to the clinic; however, the doctor was not allowed to fill ARV prescriptions. Services at the clinic are still ongoing and include testing, support group meetings with doctors and nurses, and referrals to the Guyana Responsible Parenthood Association for cancer screening.

The assessment team's attempts to verify the reason given for not allowing the doctor to fill prescriptions were unsuccessful. In view of the strict requirements of the Medical Practitioners Act, Cap 32:02 and the requirements of the Pharmacy Practitioners Act 2003, Cap 32:07, this practice may be considered a breach, as the law assigns the functions of prescribing and dispensing medication to doctors and pharmacists, respectively.

3.3 Legal and Regulatory Framework Related to Funding of Civil Society Organizations

Objective: Determine the legal and other mechanisms to facilitate direct funding of CSOs by the Government of Guyana.

Legislation reviewed:

- The Fiscal Management and Accountability Act, Cap 73:02
  - The Ministry of Health Act, Cap 32:01

Government Budget Formulation Process

It is important to have a basic understanding of the Government of Guyana's budget formulation process. Each agent (the MOPH, Guyana Public Hospital Corporation, and the 10 Regional Democratic Councils) submits a budget annually in August. The Ministry of Finance then vets these submissions and finalizes them after Parliament approves the national budget in January of the following year. The typical timeline and process for budget development in the health sector in Guyana is described in Table 4.

Table 4. Budget Formulation Process

Period	Budget Formulation Process
Jan	In Nov to Dec of the preparation year a new budget is voted on. After passage, agencies are expected to adjust their workplans to match the approved budget and is executed from January.
Jan-July	If needed, agencies review their program structure and narrative (objectives, etc.) and make changes or adjustments through the agency's budgeting committee. These changes are then submitted to the MOF for approval before July 30.
July	MOF issues a circular for budgeting agents to submit budgets by a specified date.
Aug	The Minister of Health approves all health sector budgets prepared by MOPH programs, Guyana Public Hospital Corporation, and the regional health services and submit to MOF.
Sept	The MOF holds sector-wide and agency-specific (MOPH, Guyana Public Hospital Corporation, and the Regional Democratic Councils) review meetings to vet budgets and submit final versions.
Sept - Oct	Agencies may submit all necessary adjustments to the MOF. The Ministry of Finance conducts an internal review of numbers and makes adjustments. The budget is finalized in Oct/Nov of the preparation year.
Nov-Dec	Parliament votes on the current year's budget.

Source: Planning Unit, MOPH, 2017

Existing Funding Options

The Fiscal Management and Accountability Act, Cap 73:02

This Act governs the regulation of the preparation and execution of the annual budget; the receipt, control, and disbursement of public funds; the accounting of public monies; and any other matters related to or incidental to the transparent and efficient management of finances in Guyana. This Act makes provision for three classes of direct government funding in the

estimates of expenditure for each Ministry to external organizations, including CSOs. These are as are follows:

1. Chart of Accounts 6321: "Subsidies and contributions to local organizations" creates a budget line item for funding CSOs and various other organizations, including state agencies, commissions, orphanages, convalescent homes, legal aid clinics, and women's shelters, among others.
2. Chart of Accounts 6301: "Education subventions and grants" directs funding mainly to educational institutions under the Ministry of Education.
3. Chart of Accounts 6322: "Subsidies and contributions to international organisations" includes Government of Guyana contributions to regional and international agencies, including CARICOM (Ministry of Finance, 2016a).

Of relevance to this report is government funding directly from the Consolidated Fund or domestic sources to CSOs by way of a financial contribution, frequently referred to as a subvention under Chart of Accounts 6321. Although subventions are expressly excluded from the definition of "social contracting," it is the sole instance in Guyana in which domestic resources fund CSO work, and there are lessons to be learned or adapted from the subvention model that are relevant when considering social contracting in Guyana.[17]

Subventions

A subvention may be defined as a contribution or subsidy, usually by a state or government, to aid or support CSOs and other social organizations, made at the sole discretion of the state. In 2016, the Government of Guyana, through various ministries, supported 68 CSOs with a subvention (excluding state agencies and commissions at various levels). Under the Ministry of Social Protection alone, excluding state entities, 44 CSOs, including trade unions, were allocated subventions under the Chart of Accounts "Subsidies and contributions to local organizations." Table 5 provides a list of the major contributions made in 2015 and 2016 as well as other contributions to select CSOs. The highest level of support went to the National Trust in the sum of GY$65 million; at the lower end, various organizations, such as Red Thread (women's rights organization), were allocated GY$25,000.

Regional (local) governments also provide support to CSOs, including the East Berbice/Corentyne Program in Region 6, which provides additional funding to organizations, including two convalescent homes and the Guyana Legion (Ministry of Finance, 2016a). The process described next applies to subventions initiated at the level of line ministries and local government.

Table 5. Government of Guyana Subventions to Select CSOs (GY$)

	2015	2016
Total support to CSOs	231,532,000	251,918,000

[17] The Social Contracting Diagnostic Tool does *not* consider core funding for the operation of CSOs, including *subventions,* social contracting. Because these funding arrangements do not outline any specific services or outcomes to be delivered in exchange for financial support, they do not fall under the concept of social contracting. In addition, loose agreements or memoranda of understanding between government agencies and CSOs that do not specify specific compensation for service arrangements (e.g., in which a CSO commits to collaborating with government services but is using outside/donor resources to do its work) do not qualify as social contracting for the purposes of this document.

Select CSOs receiving support		
National Trust	56,620,000	65,000,000
Legal Aid Clinic	49,087,000	49,087,000
Castellani House	37,331,000	47,000,000
Ptolemy Reid Rehabilitation Centre*	27,452,000	28,632,000
Help and Shelter	10,000,000	10,000,000
Salvation Army (Drug Rehabilitation Program)*	10,000,000	10,000,000
Red Cross Convalescent Home for Children*	6,991,000	6,992,000
Linden Legal Aid Clinic	0.00	6,351,000
Guyana Responsible Parenthood Association*	6,251,000	6,251,000
Guyana Chest Society*	200,000	250,000
Guyana Cancer Society*	3,150,000	3,150,000
David Rose Centre*	200,000	200,000
St. John's Ambulance Brigade*	200,000	200,000
Red Thread	25,000	25,000

* Indicates CSOs receiving MOPH subventions
Source: Ministry of Finance, 2016a, pp. 575–583

The process:

Who is qualified? An application for a subvention may be made by any legally registered CSO with a history or track record of success in engaging in the work for which the organization is seeking funding.

What is required? Requests for a subvention by each local organization must be supported by the following:

- A written proposal detailing the nature of the activities, which should align with government priorities and not duplicate or compete with existing government programs, and expected outcomes with performance indicators, if possible.
- A full financial breakdown of how the funds will be applied. There are no restrictions on funding core costs. Many of the organizations that presently receive a subvention apply these funds to salaries and other core costs.
- Information on the latest year of audited accounts available for that organization, as well as the financial statement from the end of the preceding year of the application.
- The request should consider the organization's ability to generate revenue internally and its projected cash balances at the end of the preceding year of the application.
- Background of the organization, including aims and objectives.
- Organizations that receive an annual subvention still need to submit a full proposal but must submit audited financial statements, a detailed project report of the previous year's support, and financial and programmatic details of the new request.

- Applications for funding can also be made directly to the Regional Executive Officer in each of the regions.

What is the procedure?

- Requests for subvention for new a local organization—that is, an organization that has not received a subvention in the previous financial year—will be considered only if it is supported by a Cabinet decision.
- An applicant ideally should communicate directly with the applicable ministry to determine alignment of the proposed activities with government priorities before presenting the proposal.
- Following submission of the proposal, it is reviewed internally in the ministry and approved by the Permanent Secretary and the Minister. A Cabinet Memorandum is prepared and presented by the minister of the supporting ministry.
- The Cabinet will review and make recommendations to (a) support the request as presented, (b) approve a higher or lower amount, or (c) deny the request. The Cabinet is not required to give reasons for its decision. When funding is approved, the Cabinet decision authorizes the Minister of Finance, who in accordance with the Fiscal Management and Accountability Act, Cap 73:02 will make an allocation in the annual budget.
- The respective ministry will inform the organization of the Cabinet's decision.
- If approved following the budget approval process, the funds are allocated to the respective ministry.
    - The applying organization then submits a request for disbursement of funds, which may be annually, quarterly, or as otherwise agreed by the ministry.

Timeline: Keeping in mind the budget formulation process presented above, proposals for the subvention should be submitted between January and July of the previous year. By July, all ministries must submit their sector budgets and plans to the Ministry of Finance, so any proposal must have been received, vetted, and approved by a ministry beforehand. The first disbursement of funds will be in January after passage of the Annual Estimates of Expenditure in Parliament. For recurring recipients, the timeline is more flexible if the allocation already exists and is approved within the ministry's budget (Ministry of Finance, 2016b).

The Ministry of Health Act, Cap 35:01

Further to the provisions in the Fiscal Management and Accountability Act, section 8 of the Ministry of Health Act states:

> *"The Government through the Minister [of Health] may make grants or other financial arrangements for the enhancement of health care to such persons and organisations and on such terms and conditions as may be determined."*

This statement establishes clear legislative authority by the Ministry of Health through the Minister to direct funding for "the enhancement of healthcare" to individuals and organizations. Although the Act does not specify the source of these funds, it is reasonable that any allocation from domestic sources would still be subject to the Fiscal Management and Accountability Act. However, donor resources managed by the Ministry are subject to less strict rules.

Cooperative Agreements—Malaria and TB Programs

The MOPH, through the national TB and malaria programs funded by the Global Fund have entered into cooperative agreements with mining companies and associations for testing; distribution of commodities, including mosquito nets; and linkages to care for TB and malaria in mining and hinterland regions for loggers and miners. Funding for the TB program is US$500,000 for April 1, 2019 to March 31, 2022; funding for the malaria program is US$1,062,021 for January 1, 2020 to December 31, 2022.

Partnership or cooperative agreements have been established with the miner's associations (Guyana Gold and Diamond Miners Association, Guyana Women's Miners Association, Guyana Forest Producer's Association) and mining companies (the Mining Commission and Guyana Gold Fields) using Global Fund resources. Through these agreements, the mining industry engages in the distribution of commodities and testing and treatment for TB and malaria in collaboration with the regional health structures, and the MOPH provides the commodities and guidelines for treatment.

The process: These partnerships are strategic and cultivated by the MOPH to increase coverage and efficiency in prevention, testing, and treatment for malaria and TB. They are examples of public-private partnerships in that the ministry provides the commodities, nets, and testing kits, and the companies distribute commodities, benefiting by securing a healthier workforce. Some aspects that are not clear include monitoring and evaluation, collection of surveillance data, and contributions from or payment to the companies under these arrangements.

Direct Funding Requests—HIV Program

The Health Sector Development Unit and the National AIDS Programme in the MOPH, with funding from the Global Fund, have provided mini-grant support to CSOs working in HIV, including key population organizations. These support grants are for transportation stipends and other meeting costs, among other things. This support does not allow for funding a major program or project by civil society. The source for this assistance is the Global Fund, which provides substantial support to the National AIDS Programme, rather than direct government resources.

The process: Organizations make their requests directly to NAPS. There are no specific guidelines other than that the assistance must align with the objectives and goals of HIVision 2020, which guides the national HIV response. NAPS then submits the proposal through the Health Sector Development Unit to the Permanent Secretary of the Ministry for approval. There is no clear procedure or timeline for submitting requests.

Direct Funding Requests—Other Ministries

Government ministries can direct grant funds to CSOs for various projects. These opportunities are either advertised or pursued by CSOs through inquiries, solicitations, and submission of a proposal to the respective ministry, following discussions with officials. SASOD, for example, has received funding from the Ministry of Social Protection for a youth-focused project as part of a wider United Nations-funded initiative being implemented by the Ministry. In all cases reviewed, the funds came from donors, not from government resources.

Findings

There is clear authority in legislation in both the Fiscal Management and Accountability Act, Cap 73:02 and the Ministry of Health Act, Cap 35:01 for government funding of CSOs from the

Consolidated Fund. Under the Chart of Accounts 6321, "Subsidies and contributions to local organizations," subventions to CSOs are made on an annual basis. The subvention model is the only instance of government-generated revenue as opposed to donor funds being directed to CSOs to provide services or cover core costs.

The Government of Guyana is willing to support CSOs, as demonstrated by the scope of support it presently provides. In 2016, the government supported 68 CSOs, excluding state agencies and commissions, with subventions totaling approximately GY$251,918,000. Notwithstanding this fact, it is notable that of the 68 organizations that received a subvention, only one focused on TB (the Chest Society). There were no HIV or key population-focused organizations. However, many organizations that received a subvention provide services to key populations, including the Guyana Planned Parenthood Association, which provides voluntary counseling and testing, services for STIs, screening for cervical cancer, and hormonal treatments.

The process for subventions is highly subjective and political, given that Cabinet approval is required. There are no published guidelines; CSOs must engage in "a fishing expedition" to receive information on government priorities, the process, and timelines for submission. For example:

- The process is not preceded by the publication and advertising of terms of reference for the work to be conducted and any eligibility criteria for applicants.
- The Cabinet of Ministers selects awardees following support/approval of a particular ministry; selection is not done by an independent body, so the process is not transparent and may be politicized.
- The range of services funded through the subvention would make it difficult to compare or utilize price control mechanisms.
- No published criteria exist for review by the receiving ministry or the Cabinet in assessing the request.
    - The subvention model does require a detailed programmatic report and annual audited financial statements to be eligible for renewed funding, which is not guaranteed because the Cabinet may, without giving reasons, deny, approve, or vary the sum requested.

The lack of procedural transparency in granting a subvention and the inherent politicization are two reasons that subventions are not considered to be a social contracting model. Notwithstanding this fact, there are opportunities to modify this model and address the issues of transparency and politicization, thus transforming it into an objective and responsive social contracting model.

There do not appear to be any restrictions in law or policy preventing or limiting CSOs from working on HIV or TB with key populations, or government funding going directly to groups comprising key populations. Alternatively, there are some CSOs that may never seek direct government assistance so as not to compromise their ability to advocate on human rights and other issues challenging key populations.

There do not appear to be any legal or regulatory restrictions on activities that can be conducted by CSOs that may be funded from government budgets. Other than service delivery activities, which require training and licensing under existing legislation, and ensuring that activities address government priorities, such as for HIV and TB, and ensuring that they are consistent

with and designed to achieve the outcome indicators of the TB Strategic Plan and HIVision 2020, CSOs are not subject to legal or policy restrictions.

Stakeholder Comments

Since 2004, the organization Help and Shelter (women's shelter) has received a substantial subvention from the Ministry of Social Protection. A 2004 U.S. State Department study on trafficking in persons showed that human trafficking was occurring in Guyana, and in 2005, the Trafficking in Persons Act was passed. The Government of Guyana identified Help and Shelter, at that time the only shelter providing a safe space and other services to victims of gender-based violence, as a safe space, and gave it responsibility for housing victims of human trafficking. Consequently, the subvention that was GY$50,000/year prior to 2004, increased to GY$10 million as of 2006. Under the present government, it is estimated to have increased to GY$31 million as of 2017 at the request of the new board at Help and Shelter. This increase primarily targets funding for its crisis service center.

The Executive Director of Help and Shelter stated that the reason provided by the government for approval of the increase was due to Help and Shelter's good work in helping victims of trafficking in persons. The Executive Director firmly believes that the reason the organization has received so much attention is due to its transparency; the organization can account for every penny of funds it receives from the government. Although commending the excellent work of Help and Shelter and citing its level of accountability, other CSO stakeholders indicated a clear bias toward non-controversial issues or those enjoying wide national support, like domestic violence, protection of the environment, and shelters and homes, which attract direct government assistance through subventions.

Some CSOs admitted that many organizations involved primarily in HIV work had not applied for this type of assistance due to the following issues:

- Lack of information available on the process, who or what department to approach for information, requirements and timelines, reporting procedures, etc.
- Fear of being stigmatized or discriminated against by public officers when seeking information
- The politicization of the process, which requires independent ministry and Cabinet approval without needing to provide a reason if the decision is not favorable or the criteria that will be considered to arrive at a decision; this concern was critical for key population organizations
- The need to avoid any specter of conflict of interest by organizations that focus on or engage in advocacy on issues of human rights abuses, and lack of a supporting environment

3.4 Actual Funding of Civil Society Organizations from Government Budgets, Areas of Practice, and Procurement Practices

Objectives:

1. Determine the level of HIV funding to CSOs or key populations
2. Determine the procurement practices of the government when funding of CSOs occurs, as well as service provision standards

Sources reviewed:

- National AIDS Spending Assessment 2011–2012
- Health Policy Project, 2014, Supporting PEPFAR Guyana Transition Planning for HIV Prevention, Care, and Support Services in the NGO Sector
- UNAIDS, National Composite Policy Index, 2014
    - Guyana Presidential Commission on HIV/AIDS, Guyana 2015, AIDS Response Progress Report
    - The Procurement Act 2003, Cap 73:05 and Regulations
    - Allied Health Professions Act 2010, Cap 35:01

Funding to Civil Society Organizations

As discussed in the introduction, 25% of funding for HIV in 2015 came from government sources, with the government absorbing support for donor-funded ARVs and laboratory supplies as well as costs for the TB program. The question is thus whether any part of the 25% of government spending was allocated to civil society.

The latest National HIV and AIDS Spending Assessment in Guyana was conducted for the period of 2011–2012 (NAPS, 2012). Although the date of the information must be considered, the assessment found that the majority of CSOs working in or providing HIV services were funded by international agencies. The U.S. Government, through PEPFAR, USAID, and the Global Fund, is the main funder of NGOs in Guyana.[18] The U.S. Government provided more than GY$1 billion to CSOs in 2011, reduced to GY$9.3 million in 2012. The Global Fund also reduced its level of support, providing funding of GY$18.1 million in 2011 and GY$8.7 million in 2012. The overall availability of resources changed significantly for CSOs between 2011 and 2012, from GY$1 billion to GY$983 million (NAPS, 2012).

In 2014, the Health Policy Project conducted a study to document Guyana's capacity gaps and needs to support the transition of financial responsibility for HIV services from donors to the country. The study assessed NGOs, the private sector, and the Ministry of Health, and found that PEPFAR funding supported, at a minimum, 80 percent of expenditures for 10 of the 15 NGOs included in the assessment.[19] The remaining funding sources were identified as not coming from the Government of Guyana but from other sources, including the Global Fund, United Nations partners, and the private sector. Of the organizations included in the study, the Guyana Planned Parenthood Association and Help and Shelter received subventions from the Government for non-HIV related work (Health Policy Project, 2014).

A cost-effectiveness and allocative efficiency study (AP Study, 2017) was conducted in 2016–2017, and presented in a March 2017 report; however, this report is in draft and the findings have yet to be released for dissemination. The study did not include an analysis of funding sources for service provision by CSOs, however. It is also unclear whether the MOPH will conduct another National HIV and AIDS Spending Assessment.

Stakeholder Comments

One of the gaps identified during the stakeholder interviews was the lack of accounting for the government's contribution to the provision of ARVs, test kits, and TB treatment to two PUSH

[18] Other sources of funding included United Nations organizations, multilateral and development funds, and for-profit and not-for-profit institutions and corporations.
[19] PEPFAR supported at least 80 percent of HIV expenditures for the Hope Foundation, Youth Challenge, Fact, and Guyana Business Coalition on HIV and AIDS, and supported more than 90 percent of HIV expenditures for Help and Shelter, Comforting Hearts, Agape, Lifeline Counseling, United Bricklayers, and Linden Care Foundation.

hospital sites; HIV test kits to other testing sites, including those of CSOs; and treatment for the TB and malaria programs working with mining associations. For example, the PUSH sites—two faith-based hospitals, the Davis Memorial Hospital and St. Josephs Mercy Hospital, primarily funded by PEPFAR—offer a holistic package that includes counseling; ARVs; STI, TB, and lab services; and screening for cervical cancer. They use a multidisciplinary approach involving nurses, social workers, doctors, and others. As of December 2016, they had 2,038 patients between the two sites, with 1,500+ active in care and 1,258, or 62%, virally suppressed. Since 2013, they have adopted the "treat all" approach as part of the PEPFAR program, including patients who are virally suppressed and not on treatment. ARVs and test kits are furnished by MOPH, but staff, the prevention of mother-to-child transmission program, labs, and medicines for opportunistic infections are covered by PEPFAR. Viral load tests are done at the MOPH reference laboratory, with the government covering the cost. The project is thus substantially funded by PEPFAR, with support from the Government of Guyana for ARVs, test kits, and viral load. In the absence of confirmatory financial analysis, it cannot be shown that the government's support is included in the 25% of government direct expenditure for the HIV program, although it may be inferred.

Civil Society Organization Areas of Service Delivery

Of the five priority areas identified in HIVision 2020—coordination, prevention, treatment and support, integration, and strategic information—CSOs have been identified as lead agencies for all strategic objectives and interventions under prevention, and three of the strategic objectives under treatment and support targeting key populations. This identification recognizes the critical support and direct provision of services that CSOs provide as part of the national HIV response. CSOs provide direct services in the following areas:

- *Treatment and care*—PUSH sites to 2,038 persons living with HIV and/or TB
- *Care and support*—Home-based care, activities for orphans and vulnerable children (i.e., after-school sessions), monthly support groups, life skills sessions (e.g., parenting training and hygiene sessions), psychosocial support, and nutrition enhancement/support
    - *Prevention*—Peer education outreach, prevention with positives (e.g., adherence counseling, disclosure counseling), voluntary counseling and testing, prevention activities with men who have sex with men and sex workers, in- and out-of-school youth sessions, stigma and discrimination reduction, prevention sessions with other vulnerable groups (i.e., miners, loggers), and workplace programs (Health Policy Project, 2014)

The 2012 National HIV and AIDS Spending Assessment also underscores the vast range of services provided by CSOs (NAPS, 2012).

According to UNAIDS' 2014 National Composite Policy Index for Guyana, CSOs have played a key role in the HIV response, particularly in helping to reach key populations. In 2014, the National Composite Policy Index estimated that more than 75% of programming for people living with HIV, men having sex with men, sex workers, transgender people, and orphans and vulnerable children is provided by CSOs—specifically 51–75% of testing and counseling services and programming to reduce stigma and discrimination; 25–50% of home-based care and palliative care; 25–50% of know-your-rights/legal services; and just under 25% of clinical services (antiretroviral therapy/opportunistic infections) and prevention programs for persons who use drugs.

Table 6. Organizations that Provided Services to Key Affected Populations in 2014

Organization	Key Population
Cicatelli Associates Incorporated	Female sex workers, men who have sex with men
International Organization for Migration	Miners and loggers
Guyana Business Coalition	Female sex workers, men who have sex with men, miners and loggers
Youth Challenge Guyana	Female sex workers, miners and loggers
Guyana Network of Persons Living with HIV	People living with HIV, female sex workers, men who have sex with men
Artistes in Direct Support	Female sex workers, men who have sex with men, transgender persons
Hope for All	Men who have sex with men, miners and loggers
SASOD	Men who have sex with men
Guyana Sex Work Coalition	Sex workers
Guyana Trans United	Transgender persons, men who have sex with men
Hope Foundation	Men who have sex with men, miners and loggers
FACT	Female sex workers, men who have sex with men
United Bricklayers	Female sex workers, men who have sex with men
Linden Care Foundation	Female sex workers, men who have sex with men, miners and loggers
Merundoi	General population

Source: UNAIDS, 2014a, p. 60

Government of Guyana Procurement Practices

Other than the unaccounted contributions of ARVs, testing kits, viral load testing, and other commodities provided to CSOs involved in the HIV, TB, and malaria responses, and the subventions under Chart of Accounts 6321 of the Fiscal Management and Accountability Act to organizations like the Chest Society, Guyana Responsible Parenthood Association, and Help and Shelter (discussed in section 3.3), there does not appear to be any direct government funding of CSOs working in TB, HIV, and malaria. There are no procurement practices to facilitate this kind of assistance. Procurement of goods, services, and infrastructural and other works by the Government of Guyana under existing laws are thus considered here to assess their applicability to a social contracting model.

A significant function of every government is the public procurement of goods, services, and infrastructural development. Government of Guyana procurement practices were established by the Procurement Act 2003, Cap 73:05 and Regulations, which provide for the regulation of the procurement of goods, services, and the execution of works to promote competition among suppliers and contractors, and fairness and transparency in the procurement process. *Procurement* is defined as "the acquisition of goods by any means, including purchase, rental, lease or hire-purchase, and the acquisition of construction, consulting, and other services" (s.2). The Act establishes authority limits and levels, the composition of the various tender boards, eligibility requirements for suppliers/contractors, prequalification procedures, specifications of

goods/services, prohibition of contract splitting, restricted tendering, sole source procurement, two-stage tendering, tender security, tender evaluation, and tender award, among other things.

The hierarchy of tender boards includes, at the lowest level, the head of the budget agency (accounting officer) and national, regional, ministerial, and district tender boards (Part III, s.16–s.24 Procurement Act 2003, Cap 73:05). At the highest level, the Cabinet approves all contracts above G$15 million. Five forms of tendering are allowed by the Act: (1) open tendering (s.25), (2) restricted tendering (s.26), (3) a request for quotations (s.27), (4) single-source procurement (s.28), and (5) procurement through community participation (s.29).

Procurement Law through community participation occurs in those "circumstances where procurement is conducted in poor, remote communities where the competitive procedures described in this Act are not feasible, goods, works and services the value of which does not exceed such an amount as may be prescribed by regulations" (s.29). Procurement thus may be done using either of the following methods:

a. In accordance with procedures that promote efficiency through participation of community organizations
b. Through single-source procurement via direct contracting of suppliers or contractors located near the community

Requests for tenders are routinely advertised with substantial detail on the form, quality, requirements, and criteria for potential contractors. Notices are published in the government-owned *Guyana Chronicle* and other local newspapers. Additionally, they are posted on the National Procurement and Tender Administration website.

The procurement process is complex and, contrary to the stated objectives of the Act, has been criticized as being anything but transparent or fair (Khatoon, 2017). This criticism was acknowledged by the head of the National Procurement and Tender Administration, an agency established by Section 16 of the Act to manage public procurement under the direction of the Public Procurement Commission, which was established by a 2001 amendment to the Constitution. However, the Public Procurement Commission was only appointed in 2016, some 13 years after the passage of the Procurement Act.

In a presentation during the celebration of the 50th Anniversary of Guyana's independence, the Chairman of the National Procurement and Tender Administration noted that there may be credible allegations of corrupt behavior in public procurement in Guyana due to a series of failings, including sole sourcing of drug contracts, contract splitting, inflated engineering estimates, evaluation bias in favor of certain contractors, use of inexperienced contractors, the absence of competitive bidding in some cases, overpayment to contractors, absence of district tender boards, limited publications on the website, failure of members of the various tender boards to file financial returns with the Integrity Commission, lack of a formal Bid Protest Committee, lack of expertise among evaluators, discrimination against particular suppliers and contractors, and award of contracts to the lowest bidder versus the lowest evaluated bid (Wickham, 2016).

An Inter-American Development Bank-funded project for public procurement modernization and financial management strengthening in Guyana is currently underway to address the challenges and strengthen the system, and may consider amendments to the legislation.

Service Provision Standards

The legal and regulatory framework related to service provision standards include the Health Facilities Licensing Act, Cap 33:03; laws regulating health professionals and professional standards, including medical practitioners, nurses, and pharmacists, among others; and the Allied Health Professions Act 2010, Cap 35:01. The policy framework is directed by national guidelines established by the MOPH for service providers of prevention, treatment and care, and support services, including the Guyana National HIV Prevention Principles, Standards, and Guidelines; Most-at-Risk Population Guidelines; HIV Counselling and Testing Guidelines 2016; and the HIV Treatment Guidelines.

Regardless of the source of funding, service provision standards by those CSOs providing care and support, treatment and care, and prevention are maintained by training, licensing, and adherence to the national guidelines established by the MOPH as referenced above and monitored by the National AIDS Program. A more detailed consideration of this issue is addressed in section 3.2 under Legal Framework for HIV Service Provision by CSOs.

Findings

A National HIV and AIDS Spending Assessment has not been conducted since 2012, so little relevant analysis of funding to CSOs is available (including for in-kind and commodities, training, accommodation, utilities, etc.) nor of funding of key population programs disaggregated by population. The majority of CSOs working in or providing HIV services are funded by international agencies—principally the U.S. Government under PEPFAR and the Global Fund.

A gap exists in capturing data on the level of funding provided by the government in direct contributions of ARVs, test kits, and TB treatment to PUSH hospital sites; HIV test kits to other testing sites, including CSOs; and treatment for the TB and malaria programs and other commodities to mining associations. Other than these unaccounted contributions and the subventions under Chart of Accounts 6321 of the Fiscal Management and Accountability Act to organizations like the Chest Society, Guyana Responsible Parenthood Association, and Help and Shelter (discussed in section 3.3), there does not appear to be any government funding of CSOs working in TB, HIV, and malaria, and thus no consideration of procurement practices other than what is in place to access a subvention.

CSOs have been identified as lead agencies for strategic objectives in HIVision 2020. This identification recognizes the critical support and direct provision of services provided by CSOs as part of the national response to HIV. CSOs make a significant contribution to the national HIV response, particularly in the area of reaching key populations and linking them to care and treatment. Addressing the human rights barriers acting on access to services by key populations is also critical. The range of services provided by CSOs, whether they are NGOs or from the private sector, offers a significant portion of care and support and prevention activities to move toward achievement of the 90-90-90 treatment targets.

In general, public procurement in Guyana, in accordance with the Procurement Act 2003 has been widely criticized as being unfair and fostering inequality. Although the Act sets restrictive and onerous requirements to guarantee transparency and fairness, the administrative mechanisms to safeguard them are not enforced or are, in some cases, not in place. The Act and the process in general are currently being reviewed as part of an Inter-American Development Bank-funded project.

The various levels of approval of contracts for goods and services established by the Procurement Act do not allow for community participation except in circumstances where procurement is conducted in poor, remote communities. Otherwise, the selection and approval process is government controlled, with little opportunity for civil society engagement. Given the politicization of the process, opportunities to stigmatize and discriminate against potential contractors, particularly key population organizations, is possible within the existing structure.

3.5 Planning Service Provision by Civil Society Organizations

Objective: Determine mechanisms for CSO participation in the budget development process for costed action plans.

Sources reviewed:

- National Health Policy 2013–2020 – Health Vision 2020
- National HIV Strategic Plan 2013–2020 – HIVision 2020
    - National TB Strategy

The major strategic policies, including the national health policy (Health Vision 2020), the national HIV strategic plan (HIVision 2020), and the National TB Strategic Plan, have not been costed, and there are no defined budgets for CSO activities in these plans.

PEPFAR has conducted a cost analysis of test and treat, but it was not available at the time of writing this report. There does not appear to be a formal modality for the inclusion of CSOs in a budget development exercise within the existing framework of engagement between CSOs and the national programs for HIV, TB, or malaria through the TWGs within the MOPH, the Key Population Working Group, Monitoring and Evaluation Reference Group, or the Care and Treatment Working Group within the National AIDS Programme. However, there are clearly stated policy objectives in support of CSO-funded delivery of services.

Health Vision 2020

Health Vision 2020 acknowledges and expresses in clear terms the Government of Guyana's commitment to health systems strengthening in expanding service delivery—one of the Pan American Health Organization (PAHO) building blocks for health—by engaging in strategic partnerships to achieve universal health coverage. There is recognition of the following:

> *"partners represent a potential for broadening the resource envelope, extending the influence and reach of health promotions and other services and strategically addressing gaps in access and coverage which contribute to the social exclusion of certain population groups" (p. 66).*

With respect to civil society, Health Vision 2020 proposes the following as a strategic objective: "Develop capacity within civil society to deliver critical, complementary services, address determinants of health and reduce health equalities" (p. 67). Activities to achieve this objective include the following, among others:

- Establish a grant mechanism to provide financial assistance to community-based organizations in implementing proposals in support of Health Vision 2020
- Support and enable the functioning of forums that give voice to civil society, including national commissions and regional health management committees, and facilitate their participation in relevant National Health Policy Committee discussions

- Provide opportunities for CSOs partnering in health to benefit from national and external training

With respect to the private sector, Health Vision 2020 proposes as a strategic objective the following: "Establish an incentive framework to stimulate private sector participation in the provision of quality health services" (p. 69). Activities to achieve this objective include the following, among others:

- Review the ministry's organizational and functional structure to identify services that can be outsourced to the private sector for reasons of efficiency and effectiveness
- Develop and implement an incentives framework to encourage private service providers to extend services to vulnerable populations or establish services in interior and under-served rural locations

Monitoring and Evaluation Mechanisms

The Monitoring and Evaluation Reference Group plays a critical role in monitoring and evaluation through establishment of standardized reporting formats for government and CSO service providers; these reports are received, reviewed, and processed by the Monitoring and Evaluation Reference Group to inform national reports and the achievement of targets by the national HIV program. In support of HIVision 2020, a revised monitoring and evaluation framework was drafted to support effective implementation by including additional indicators on the HIV cascade, the continuum of care, and targets for 90-90-90 projections after 2015.

In the 2014 UNAIDS National Composite Policy Index for Guyana, participation of CSOs in the development of monitoring and evaluation plans was described as weak. However, CSOs are actively engaged on the oversight subcommittee of the CCM and are represented on the Monitoring and Evaluation Reference Group, although representation could be strengthened (UNAIDS, 2014b).

Findings

The major strategic policies, including Health Vision 2020, HIVision 2020, and the National TB Strategic Plan have not been costed, and there are no defined budgets for CSO activities in these plans. There does not appear to be a formal modality for including CSOs in a budget development exercise within the existing framework of engagement between CSOs and the national programs for HIV, TB, or malaria through the TWGs within the MOPH or the working groups and reference groups within the National AIDS Programme.

Despite the critical role of CSOs in providing services to key populations and care, support, and prevention services, their role in the National HIV, TB, and malaria responses have largely focused on implementation, with limited capacity to influence national policies and budgets and contribute to monitoring and evaluation frameworks. Although the major strategic policies have not been costed, the contemplation of strategic partnerships with civil society as articulated in Health Vision 2020 is a progressive concept and establishes a clear policy basis for the social contracting of CSOs.

4. Recommendations From Analysis and Stakeholder Interviews

The essential structural elements recommended for the implementation and sustainability of a social contracting model are as follows:

1. A legal framework that facilitates CSOs' work on the targeted diseases
2. A funded mechanism that facilitates community monitoring of the disease response
3. A clearly defined role for CSOs (with targets and budgets) in disease-specific strategic plans and costed action plans
4. An existing contracting mechanism or system to provide both governments and CSOs with the tools needed for the work to be done effectively, and that can be reported on (both programmatically and financially) to all parties' satisfaction

As Guyana is assessed against each of these scenarios, from a legal and structural perspective, it appears to be in an excellent position to implement social contracting as a means of increasing sustainability of HIV, TB, or malaria programs. The findings highlight the structures that are currently working. Gaps exist in relation to a clearly defined role for CSOs containing targets and budgets in disease-strategic and costed action plans, and the absence of a contracting mechanism or system to provide both government and CSOs with the tools needed to work effectively and provide programmatic and financial reports. The following recommendations are provided to address these gaps and draw on the existing legal and institutional structures to provide practical options for consideration by stakeholders.

1. **Determine the fiscal space for the government to engage in social contracting through:**
    - **Conducting a cost/benefit analysis**. The reports required to assess this issue at the time of this review either have not been conducted or were not available. The reality of reductions in donor funding will require information on the cost of service delivery against the cost of impact, even when it is determined that this space is limited. A cost-benefit analysis is a recommended next step in moving this process forward. It will allow for the allocation of resources to the most cost-effective, high-impact strategies and organizations.
        - **Updating and continuing the National HIV and AIDS Spending Assessment.** Also, in the current economic climate, tracking resource flows becomes paramount, as does directing expenditures toward those areas most in need.
2. **Define the scope of work for CSO direct engagement** by costing HIVision 2020, and the TB and Malaria Strategic Plans with defined budgets and targets for CSO activities. HIVision 2020 has already identified CSOs as lead agencies for all strategic objectives and interventions under prevention and three of the strategic objectives under treatment and support targeting key populations. This can serve to guide the points of entry for or scope of work that can be funded directly by the government for CSO implementation and reporting.
3. **Develop contracting mechanisms.** Various options may be considered in developing a contracting mechanism. These recommendations focus on utilizing the existing legal, financial, and CSO engagement structures.

- **Develop a modified subvention model using an open, competitive process.** The assessment identified that ministries have budget lines to support CSOs, and precedence exists because some CSOs already receive funding. What is missing is a transparent, simple process accessible to all. Under the subvention model, applicants are required to submit a detailed programmatic report and audited financial statements. The process is also synced to the government's budget formulation process. However, the lack of a transparent procurement process and politicization of the decision to fund may be modified by consideration of the following:
  - This system should be supported by the present legal framework—the Financial Accountability and Transparency Act.
  - Applicants should be required to follow the same submittal schedule employed under the existing subvention model, as it complies with the government budgeting formulation process.
  - Before publicizing a request for expression of interest or funding applications, a full term of reference, including a budget envelope, proposed activities, and targets, should be circulated as widely as possible to give sufficient time for CSOs to prepare a proposal. This could be guided by the priorities and scope of engagement for CSOs stated in HIVision 2020.
  - It is advisable that standard application forms be included that list the details of all criteria and necessary information in support of the application. All forms should be standardized to increase efficiency and allow for more effective training by CSOs and the government in processing the documents. Timelines for each stage of the process should be established.
  - Drawing from the subvention model, applicants should be incorporated bodies and required to submit a detailed programmatic report and audited financial statements.
  - Reformulate the CCM as an approval committee to establish an independent approval process. Approval of the applications could move from the ministerial and cabinet system to the CCM through a select grant committee. As many of the organizations that would be eligible and interested in applying are also represented on the CCM, a rigorous conflict of interest policy for this circumstance should be developed. There is sufficient diverse representation from the private sector, academia, etc. on the CCM to avoid an over-representation of either CSOs or government agencies on the grant approval committee.
  - The criteria for review should be published as part of the terms of reference.
  - **Pre-qualify CSOs based on external evaluation** using a model similar to that of the Global Fund, which selects sub-recipients based on technical criteria assessed by an independent Local Fund Agent. In Guyana, selection of CSOs for social contracting can be done utilizing a similar process using the Auditing Unit that resides within ministries to conduct the assessment. There should be a multisectoral committee to help decide on selection of projects. Using the Global Fund model was strongly recommended by in-country stakeholders. Part of this system would be the safeguarding against smaller, less qualified CSOs, based on experience and capacity, for example GTU, competing with stronger CSOs. Therefore, a tiered system or setting limits based on selection criteria could be developed.

4. **Assist stakeholders in Guyana** to determine and develop the social contracting/procurement mechanism/model to set up for planning, procuring,

implementing, and accounting for CSO/NGO contracting of HIV-related services and programs. Implementation of pilot project is recommended, once a mechanism has been agreed. It was recommended that CSO partners are uniquely positioned to support the first of the 90-90-90 targets, which is getting persons linked to services once they find out they are HIV positive. A pilot focusing on peer navigation and linkage to services would be an effective project for reaching the final target of viral suppression.

5. **Capacity building and training for government and CSOs.** Following the development of the model, training and capacity building will be needed for: government officials to implement and account for contracts/grants to NGOs/CSOs; CSOs to implement, monitor, and maintain adequate financial and programmatic reporting structures in alignment with the national HIV strategic objectives and indicators; and the CCM on developing robust conflict of interest policies and objective criteria for assessing proposals.

6. **Secure meaningful engagement of CSOs.** Bringing more voices into health policy from service delivery organizations, like CSOs, in an expanded, formalized, and sustained manner has been recognized as a gap and an area to be addressed by the state. The government needs to:

   - Strengthen the engagement of CSOs to contribute to policy and budget development, monitoring and evaluation, and health systems strengthening initiatives by including permanent CSO representation on all MOPH and NAPS TWGs and reference groups.

     - Ensure that selection of CSO representatives are made by CSOs acting in caucus at the level of the CCM CSO committee or National Coordination Coalition, utilizing a similar election process as that required for population representatives on the CCM.

7. **Adopt appropriate, responsive, and progressive NGO incorporation legislation** and address bottlenecks under existing processes, including:

   - Passage of new NGO legislative framework along the lines of the Belize Non-Governmental Organisations Act, Chapter 315.

   - Train frontline staff with responsibility for incorporation of entities at the various legislative bodies in human rights and non-discrimination, customer service, and the laws that allow for registration of CSOs.

   - Resource the National Coordination Coalition to advise CSOs and develop their capacity on, and access to relevant information on, the various forms of registration, the requirements and procedures, and benefits and liabilities.

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Annex 1. Methodology

Key Steps in Implementing the Social Contracting Diagnostic Tool

Step 1: Approval among government, donor partners, and CSO stakeholders to conduct the diagnosis and follow up on proposed recommendations/solutions.

Step 2: Adaptation of the tool to the country context. Following the approval for the conduct of the assessment the tool was adapted by:

- Identifying key populations in Guyana and adapting the questions in the tool to assess the situation in relation to the identified populations, which include: men who have sex with men, sex workers, transgender people, persons living with HIV, miners, loggers, and prisoners.
    - Developing sector specific questionnaires, dissecting the relevant sections of the tool to facilitate a fluid process during the interview stage with the various organizations and key informants. Specific questionnaires were developed for: CSOs; development partners; key informants; lawyers, legal experts, and Registrar of Friendly Societies, medical regulatory authorities; Ministry of Finance; Ministry of Finance, Budget Office; and National AIDS Programme Secretariat, Ministry of Public Health, and Country Coordinating Mechanism.

Step 3: Desk review. In preparation for the desk review an outline of the legal and regulatory issues for social contracting, specifically related to the Social Contracting Diagnostic Tool, was developed. This document distilled the objectives to be achieved under each of the sections of the tool and identified under each section, and listed the relevant legislative and/or policy sources to be reviewed. This served as a guide for conducting the desk review to ensure that all relevant sources were considered. The document is generic in the sense that it is applicable to any country context in guiding a desk review for the Social Contracting Diagnostic Tool.

A detailed desk review was conducted to determine the legal and regulatory framework related to participation of CSOs in the national HIV response, the status and registration of CSOs, restrictions on hiring practices and licensing requirements for service provision by CSOs, whether CSOs can be funded from domestic sources, existing modalities for funding of CSOs, the level of HIV funding to CSOs or HIV funding to key populations, procurement practices of government where funding of CSOs occurs, service provision standards and monitoring and evaluation mechanisms, and mechanisms for CSO participation in the budget development process for costed action plans.

Some 33 pieces of legislation were reviewed together with key documents including Health Vision 2020, HIVision 2020, the Guyana 2015 AIDS Response Progress Report, the TB Strategy, health system assessment reports, key population and HIV counseling and testing guidelines, spending and transition assessments conducted in Guyana, country and CSO human rights reports, government estimates of expenditure for 2016, and donor cooperation strategies, among others.

Step 4: Country Mission and stakeholder interviews. Seventeen interviews (16 in-country and one virtual), one CSO consultation, and one validation meeting on the findings of the mission were conducted. Interviews were conducted with:

- Government—Ministry of Public Health, Health Sector Development Unit; Planning Unit, Chief Medical Officer; NAPS; Guyana Public Hospital Corporation; and TB Unit

- Civil society organizations—Guyana Trans United; Artistes in Direct Support; Lifeline Counselling Services; Volunteer Youth Corps; Youth Challenge Guyana; Help and Shelter; Family Awareness Consciousness Togetherness; Society Against Sexual Orientation Discrimination; CPIC Moniques Caring Hands; Davis Memorial Hospital/ Positively United to Support Humanity; and Guyana Civil Society Leadership Project
- Private sector—Guyana Business Coalition on Health Awareness and Private Sector Commission of Guyana
- Development partners—Inter-American Development Bank, USAID Mission; Advancing Partners & Communities; PEPFAR; CDC; UNAIDS; and UNICEF
- Key informants—Former head of the National AIDS Programme and Guyanese lawyer
    - Country Coordinating Mechanism

A complete list of the organizations interviewed follows in Annex 2.

Next Steps

Step 5: Validation workshop to identify priority actions. This report analyses the findings from the desk review and in-country stakeholder interviews. It will be subjected to validation through an in-country meeting to determine, based on the recommendations presented, the most useful funding mechanism and, thereafter, what activities will be required to implement the recommended changes. This exercise will further determine the activities to be prioritized, the time lines for implementation, and how progress will be monitored and evaluated. Participation will be drawn from the CSOs, government, development partners, private sector, and CCM representatives who participated in the interview process.

Step 6: Final Report. This report will thereafter be finalized and shared with the Government of Guyana, Country Coordinating Mechanism, civil society organizations, and other stakeholders to be incorporated into the country transition and sustainability strategies and mechanisms.

Limitations

Taking into consideration the human resource constraints of many government departments, not all potential key informants were interviewed, in particular, those from the Ministry of Finance, Budget Office, despite numerous attempts.

Annex 2. Organizations and Individuals Interviewed

Date of Interview	Name of Interviewee and Organization	Type of Activity
April 3, 2017	Edris George, USAID; Preeta Jagan, PEPFAR; Colin Roach, CDC; Ron McInnis, HP+	In briefing and out briefing
April 3, 2017	Paola Marechi, Sylvie Fouet, and Jewell Crosse, UNICEF	Key informant interview
April 3, 2017	Kesaundra Alves, Guyana Public Hospital Corporation, Chairman of the Board, Attorney at Law	Key informant interview
April 3, 2017	Morris Edwards, Ministry of Public Health Guyana	Key informant interview
April 4, 2017	Amalita Abrams, Artistes in Direct Support; Sheridan Bacchus, Lifeline Counselling Services; Simone Sills, Volunteer Youth Corps; Dimitri Nicholson, Youth Challenge Guyana; Magaret Kertxions, Help and Shelter; Tricia Teekah, Volunteer Youth Corps; Annette Jaundoo, Family Awareness Consciousness Togetherness; Devanand Milton, GTU; Lindon Welch, Davis Memorial Hospital – HIV; Dawn Stewart, CPIC Moniques Caring Hands; Jairo J. Rodriquez, SASOD	CSO consultation
April 4, 2017	Rhonda Moore, NAPS	Key informant interview
April 5, 2017	Shamdeo Persaud, Chief Medical Officer, Ministry of Public Health Guyana	Key informant interview
April 5, 2017	Enid Thom-Alleyne and Suanne French, Guyana Business Coalition on HIV and AIDS	Key informant interview
April 5, 2017	Adele Mack, Principal Investigator, Davis Memorial Hospital, PUSH Project	Key informant interview
April 5, 2017	Simone Sills and Tricia Teekah, Guyana Civil Society Leadership Project	Key informant interview
April 6, 2017	Elizabeth Alleyne, Private Sector Commission Guyana	Key informant interview
April 6, 2017	Lisa Thompson, Advancing Partners & Communities	Key informant interview
April 6, 2017	Devanand Milton, Quincy McEwan, Marlon Taylor, and Twinkle Rissoon, GTU	Key informant interview
April 6, 2017	Magaret Kertxious, Help and Shelter	Key informant interview
April 6, 2017	Joel Simpson, SASOD	Key informant interview
April 7, 2017	Brian Peters, CDC; Preeta Jagan, PEPFAR; Edris George, USAID; Julia Henn, ASC	Debriefing
April 7, 2017	Jeetendra Mohanlall, National Tuberculosis Programme/MOPH	Key informant interview
April 7, 2017	Dr. Martin Odit, UNAIDS	Key informant interview
April 7, 2017	Jewell Crosse, UNICEF; Martin Odit, UNAIDS; Lisa Thompson, Advancing Partners & Communities; Devanand Milton, GTU; Rhonda Moore, NAPS; Maria Wiles, Global Fund CCM	Validation meeting
April 7, 2017	Maria Niles, Global Fund CCM	Key informant interview

For more information, contact:

Health Policy Plus
Palladium
1331 Pennsylvania Ave NW, Suite 600
Washington, DC 20004
Tel: (202) 775-9680
Fax: (202) 775-9694
Email: policyinfo@thepalladiumgroup.com
www.healthpolicyplus.com