

MCHIP Country Brief: Guyana

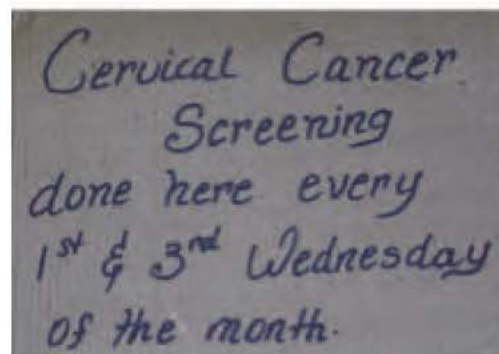


Health Areas:

- HIV/AIDS

Selected Health and Demographic Data for Guyana	
Maternal mortality ratio (deaths/100,000 live births)	270
Neonatal mortality rate (deaths/1,000 live births)	19
Under-5 mortality rate (deaths/1,000 live births)	40
Infant mortality rate (deaths/1,000 live births)	38
Contraceptive prevalence rate	43%
Total fertility rate	2.8
Skilled birth attendant coverage	92%
Antenatal care, 4+ visits	78.5%

Sources: UNICEF; Guyana Demographic and Health Survey; WHO; World Bank.



Program Dates	October 2010–September 2012					
Total Mission Funding	Redacted					
Geographic Coverage	No. (%) of provinces	N/A	No. of regions	9	No. (%) of facilities	N/A
Country and HQ Contacts	Patricia Singh, Consultant; Patricia Taylor; John Varallo; Maureen Reinsel; Laura Goodman					

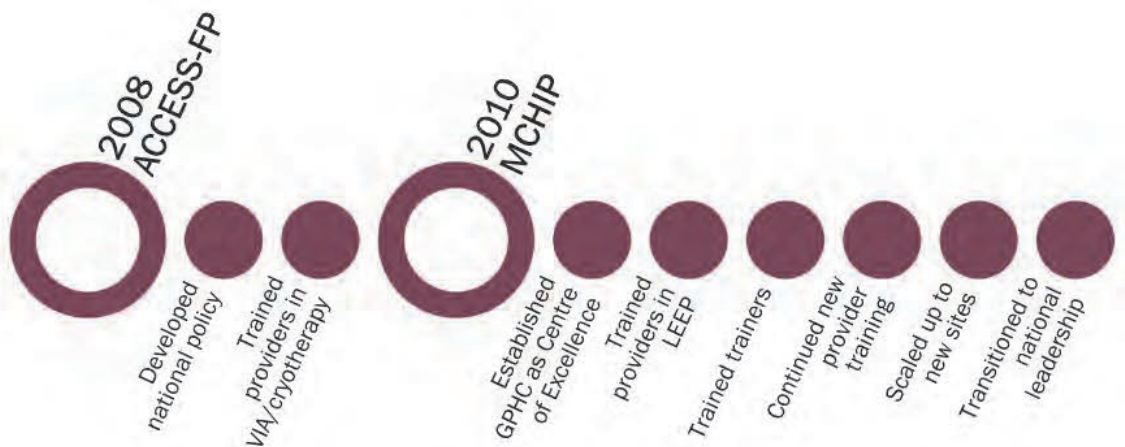
INTRODUCTION

The Maternal and Child Health Integrated Program (MCHIP) aims to assist in scaling up evidence-based, high-impact maternal, newborn, and child health interventions and thereby contribute to significant reductions in maternal and child mortality and hasten progress toward Millennium Development Goals (MDGs) 4 and 5. MCHIP is funded by the United States Agency for International Development (USAID).

In October of 2008, the ACCESS-FP Program, an Associate Award under USAID that preceded MCHIP, expanded and supported cervical cancer screening and treatment activities in Guyana. Building on the success of those efforts, MCHIP's program in Guyana began in October 2010 to scale up and strengthen cervical cancer prevention (CECAP) with a focus on HIV-positive women. MCHIP collaborated closely with the Georgetown Public Hospital Corporation (GPHC) and the Ministry of Health (MOH) to train providers in cervical cancer prevention, raise awareness of cervical cancer and preventative measures, and improve quality of CECAP care.

MCHIP established 18 CECAP service delivery sites across nine of 10 regions in Guyana, achieving nearly national geographic coverage. In addition, the MOH, in collaboration with MCHIP, developed and enacted a national cervical cancer prevention policy that dovetailed with MCHIP's strategy to reach all Guyanese women with cervical cancer prevention services. Following the passage of this national policy, MCHIP worked to rapidly expand CECAP service access. During the last year of the MCHIP program in Guyana, consolidation of gains, transfer of program responsibility to local stakeholders, and continued quality improvement became the priorities (see figure below).

Project Timeline and Major Milestones



Since the initiation of the MCHIP program in Guyana in 2010, MCHIP has arranged for the handover of project management to local partners. During the program, MCHIP provided technical assistance on the integration of CECAP into HIV/AIDS care and treatment and trained and updated providers in visual inspection with acetic acid (VIA) and cryotherapy.

KEY ACHIEVEMENTS

Integration of Guyana Cervical Prevention Project into National Program

The ultimate goal of the Guyana Cervical Cancer Prevention Project was to institutionalize a sustainable and effective national approach to cervical cancer prevention. MCHIP achieved this goal through its work with local partners to develop protocols for national CECAP implementation, which were formally adopted by the National AIDS Programme Secretariat.

Currently, new providers receive in-service training at GPHC, the established Centre of Excellence and Training Resource Centre. GPHC is working to incorporate VIA and cryotherapy into the curriculum of the new obstetrics and gynecology residency program and the pre-service medical education curriculum. MCHIP trained 11 master trainers, eight of whom will continue to provide training and supportive supervision through GPHC.

Integration of CECAP into HIV Treatment

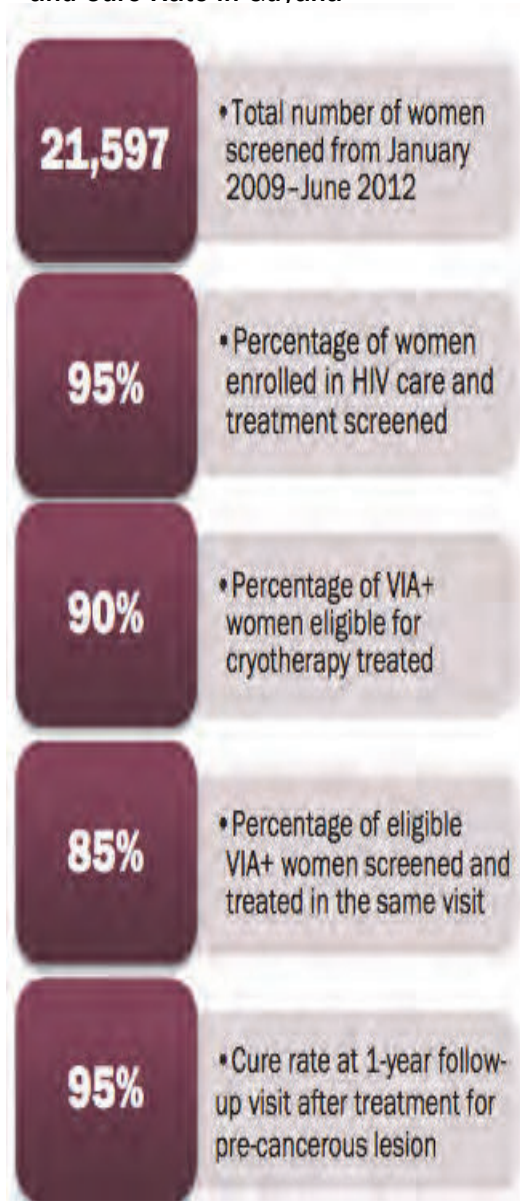
HIV-positive women are at the highest risk of developing cervical cancer. Between January of 2009 and June of 2012, the Guyana CECAP Project screened 95% of women enrolled in HIV care and treatment. In addition, the CECAP Project reached 17% of all women aged 25–49 countrywide with at least one cervical cancer screening. In total, the CECAP Project screened 21,597 women and helped identify 2,806 (13%) VIA-positive cases.

To document cure rates, the CECAP Project also tracked one-year follow-up results for women who received a VIA-positive diagnosis and had treatment. Most patients received a client card with follow-up instructions. The cure rate at one year was 95% (980); however, only 50% (1,027) of patients returned for this follow-up visit.

The Single Visit Approach (SVA)

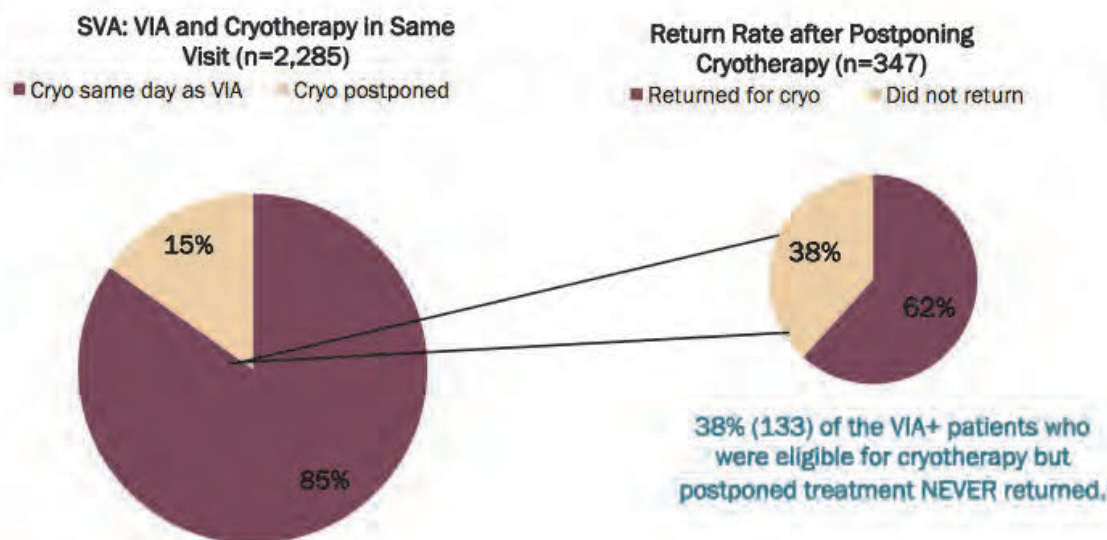
VIA provides immediate results, thus promoting the integration of screening and treatment. The SVA protocol for VIA testing followed by the immediate provision of cryotherapy for women with abnormal results mitigates loss to follow-up because no follow-up appointments are required. The SVA model increases program effectiveness, efficiency, and client satisfaction. Out of the 2,285 VIA-positive women found eligible for cryotherapy throughout the 42-month project period, 85% (1,938) were treated on the same day that they were screened (see figure below). At the GPHC VIA clinic, the flagship clinic in Guyana, the SVA rate was consistently near 100% throughout 2011 and 2012. Over the life of the project, of the 347 women who postponed cryotherapy, 214 (62%) returned for treatment. Improved counseling and tracking of women who postponed treatment increased the return rate from 49% in 2009 to 88% in 2012.

Cervical Cancer Screening, Treatment, and Cure Rate in Guyana



Over the life of the project, 64% of women referred for treatment of large lesions received loop electrosurgical excision procedure (LEEP) treatment. In Year 3, 71% of referred women received LEEP treatment. This increase was attributed to a rise in the number of trained LEEP providers, improved counseling and tracking, and better engagement with the GPHC Obstetrics and Gynecology Department. The overall treatment rate for VIA-positive women was 90% (2,405) over the life of the project. This rate improved from 83% in Year 2 to 98% in Year 3.

SVA and Return Rates



Increased Training and Improved Service Delivery

Beginning in 2010, MCHIP trained VIA and cryotherapy master trainers to ensure a sustainable source of quality education and supervision for new providers. The project also trained 71 providers in VIA, cryotherapy, and LEEP. At the end of the project, 69% of providers trained by MCHIP were still delivering services (see table).

Targeted provider selection was critical to provider retention. Although the sample size was relatively small, Medex, nurses, and midwives were more likely than doctors to continue to provide services once trained, as well as to remain in the country. Based on this evaluation, MCHIP recommended to the MOH that future in-service training focus primarily on increasing the number of Medex¹, nurses, and midwives trained.

Provider Retention: Guyana Providers Trained since 2009

PROVIDER TYPE	NUMBER TRAINED	NUMBER (%) STILL PROVIDING SERVICES AT END OF PROJECT
Doctor	30	16 (53%)
Medex	7	7 (100%)
Nurses/Midwives	34	26 (76%)
Total	71	49 (69%)
Trainers	11	8 (72%)

¹ Medex stands for medical extension workers, who are often trained midwives who receive additional training. Their role is to provide primary and secondary levels of care where doctors are not available.

Forty-seven percent of the screenings (10,127) were carried out at the GPHC VIA Clinic; other clinics screened between 24 and 2,159 women over the course of the project (average: 675 screenings/site). High-performance sites benefited from highly committed service providers, supportive facility leadership, consistent human resource availability, community awareness of services, and limited competing priorities. Sites that were unable to provide services consistently faced one or more of the following challenges: unexpected personnel changes, lower provider commitment, lack of support from facility leadership, inconsistent supplies, lack of consistently functioning equipment, and competing service delivery priorities.

Improving Facility-Level Use of Data

After each provider training session, clinicians were trained in data collection and use of data for decision-making. In 2010, each site was provided with a data tracking poster to facilitate visual performance tracking on key indicators. Providers used data to make decisions at the facility level to improve service delivery. Sites tracked their own results and were able to systematically brainstorm solutions to problems and improve their results.

The data collection tools MCHIP introduced at project sites built on the already prevalent use of log books and added client cards, a screening map to visually track the pre-cancerous lesions of VIA-positive women, a monthly summary form, and a collation and analysis tool in Microsoft Excel, along with the data tracking poster. Every month, data were reviewed by the project manager and Medex at GPHC and reported to MCHIP, which then provided feedback.

The availability of quality data allowed the project to track trends and contributed to program learning. Although not formally measured, the overall ability of providers to collect, analyze, and use data seemed to improve over the project period, which should have positively affected their service delivery activities.

During the course of the project, MCHIP staff collaborated on several efforts to expand knowledge about cervical cancer programming, using the lessons learned and results of the Guyana project. MCHIP also contributed to a multi-country analysis of CECAP among HIV-positive women.

In 2011, MCHIP conducted an evaluation of the project's implementation to determine its strengths and weaknesses and to identify any necessary course corrections for the project's final year. Results and recommendations for strengthening the national cervical cancer program were shared with USAID, the MOH, and GPHC.

WAY FORWARD

Although the trainers and providers voiced their commitment to continuing CECAP services, the maintenance of a truly national program requires national leadership. The MOH provided significant support during project implementation, but a change in the national government caused a leadership shift and administration changes in the MOH that may impact government priorities in the coming years.

MCHIP managed monitoring and evaluation (M&E) throughout the project. However, during the project's final two years, MCHIP encouraged the MOH to identify someone to take over responsibility for M&E to ensure that services continue to be delivered where and how they are needed. Unfortunately, the MOH plans for the national health information system to be changed. Consequently, M&E has not been fully integrated with the national M&E system.

A decline in the number of screenings in 2012 was noted and attributed to a combination of factors, including changes in administration at the MOH, the concurrent budget freeze, and a reduction in the number of short-term technical assistance visits from MCHIP headquarters. The MOH and GPHC also assumed a greater role in project management in Guyana, and their reduced budget and conflicting priorities may have contributed to the decline.

Based on the findings from the process evaluation conducted in 2011 as well as project monitoring in 2012, MCHIP presented the following recommendations to the MOH and GPHC at the project closeout presentation. These recommendations were also included in the final process evaluation report, copies of which were provided to the MOH and GPHC and are on file with MCHIP. Recommendations were as follows:

- In addition to the continued integration of CECAP into HIV counseling and testing services,
- look for opportunities to integrate CECAP into family planning and postpartum care
- Strengthen and coordinate awareness-raising efforts
- Consider modifying clinic schedules to meet client, provider, and facility needs
- Encourage individual sites to promote the program and conduct patient education
- Incorporate recommendations from remote sites and regions into communications plan
- Use monitoring and evaluation data to motivate providers and make informed programming decisions
- Monitor supplies more accurately to prevent shortages; quickly respond to equipment problems
- Strengthen the CECAP referral and treatment system
- Focus training on cadres with low rates of attrition
- Facilitate supportive supervision visits by trainers to ensure ongoing quality improvement.
- Integrate CECAP into pre-service education
- Develop a five-year CECAP strategy with an M&E plan

With the continued support of the Minister of Health and attention to the recommendations listed above, MCHIP believes that the national CECAP program will continue to be successful in reducing the incidence of cervical cancer in Guyana, especially among HIV+ women.