National Health Sector Strategy 2008-12

MINISTRY OF HEALTH, GUYANA

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Contents

Health and development are intrinsically linked and having recognized this crucial fact, the Ministry of Health, through the National Health Sector Strategy (NHSS) 2008 – 12 purposefully and continuously seeks to address critical health issues to enable sustainable development. This will require a coordinated and an inter-sectoral approach in the process to ensure greater harmonization of efforts.

On this basis, the NHSS was formulated to further strengthen the efforts of the previous National Health Plan (NHP) in achieving harmonization, impact and reform in the health sector. This reform, while a process, is driven by and will be centred on a number of significant elements, resulting in improved health of the population. These include equity, consumer-oriented and quality service and accountability.

Key among the priority issues to be addressed in this NHSS are those related to primary heath care such as maternal and child health and, extend to the management and treatment of communicable (among them, HIV/AIDS and tuberculosis) and non-communicable diseases, including mental health and substance abuse and disability.

To achieve these, the Ministry of Health will diligently continue its drive to allow for greater autonomy among the regional health entities, responsive to the needs of the population such as the Regional Health Authority in Region 6 (RHA 6). Consequently, the ministry will assume a leadership role with a key function of monitoring and evaluation. Accompanying capacity development of the human resource base also plays a crucial aspect in the plan with the provision of the necessary supportive physical infrastructure.

Pivotal to the NHSS will be the presence of the following Acts – Ministry of Health Act; Health Facilities Licensing Act and the Regional Health Authorities Act – to guide its implementation and preserve the integrity of the health sector and, in particular, health care delivery system. Coupled with this will be an established monitoring and evaluation framework to ensure accountability to the citizens of Guyana. This framework will guarantee a health care system that is of high quality, maintaining internationally recognized standards while preserving the health of the population.

The ministry has already begun initiatives to this end with the support of its key partners, among them, the Pan American Health Organization/World Health Organization (PAHO/WHO), Inter-American Development bank (IDB), World Bank, Global Fund, Canadian International Development Agency (CIDA), United Nations Children Fund (UNICEF), United Nations Development Programme (UNDP), Centre for Disease Control (CDC), United States Agency for International Development (USAID) and the United States Embassy. Efforts will be continued to achieve an even greater level of coordination/harmonization in related sectors particularly in view of the health indicators as stated in the National Development Strategy (NDS), the Poverty Reduction Strategy Paper (PRSP) and the Millennium Development Goals.

Cognizant of the tremendous challenges with which the health sector is faced with, not least among them emerging diseases, the ministry is confident that, along with the support of partners, the objectives of increased harmonization in the health sector and the delivery of equitable, consumer-friendly and quality health care will realize improved health for all.

SUMMARY

This National Health Sector Strategy 2008-12 (NHSS 2008-12) sets out government's plans for providing equitable access to high quality and 'consumer-friendly' health services. The strategy covers all health care provided in the country by public, private and voluntary services and is guided by the values and principles outlined in the National Development Plan and the Poverty Alleviation Strategy ie. to protect the most vulnerable and assure sustainability, accountability and transparency in government-led processes.

Goals guiding sector development:

1. Equity in distribution of health knowledge, opportunities and services

2. Consumer-oriented services: people focused and user friendly

3. High quality services (and good value for money)

4. Accountable providers and government.

To achieve these broad sector goals, the NHSS 2008-12 focuses on achieving strong organisations with built-in incentives to drive change. The sector strategy is divided into five main components:

Components of the NHSS 2008-12 to achieve those goals:

1. Decentralization of health services providers
The decentralisation process will be completed: authority over health services will be transferred to semi-autonomous Regional Health Authorities (RHA) operating under service agreements (contractual relationships) with the Ministry of Health, following the model of the Georgetown Public Hospital Corporation. Management will be stronger at all levels of RHAs down to services in clinics and hospitals, and services will be more responsive to local needs. Service agreements will be guided by the Package of Publicly Guaranteed Health Services, and other national policies and required standards.

2. Strengthening the skilled workforce and HR systems
Retention of skilled staff will be improved by the higher remuneration possible under the employment of autonomous RHAs in return for enhanced productivity. RHAs will introduce modern HRM systems including performance management. The MOH will support capacity building of RHA and GPHC staff, and will work with education and training institutions to improve programmes and to introduce new ones to alleviate shortages in key clinical skills.

3. Strengthening government capacity for sector leadership and regulation
The MOH will be restructured and strengthened to provide leadership in governance, policy and contracting providers of services (through service agreements), improving services and facilities standards through licensing, inspection and assessment programmes, promoting the use of national treatment guidelines and professional codes of ethics, requiring licensing and registration for all health care professionals, enshrining a patient charter, ensuring that national level functions like media-based health education are delivered to high standards, accelerating investment in new health services, buildings and equipment, and ensuring the availability of drugs and supplies.

4. Strengthening sector financing and performance management systems
Government and donor funding will be consolidated into a single funding arrangement, and a new planning, budgeting and sector performance management process institutionalised that ensures all funding is coordinated and put to the best possible use in meeting the NHSS 2008-12. New sources of financing will be explored to allow expansion of services to meet the Package of Publicly Guaranteed Health Services.

5. Strengthening strategic information
A strategic information capacity will be developed to lead relevant data collection, analysis and use in planning, management and evaluation at all levels.

The Ministry of Health has already implemented initiatives or lines of action within these components of the NHSS 2008-12 and aimed at making progress towards the sector goals of improving equity of access, user friendliness, and quality of services, and accountability in those providing those services. These specific initiatives are outlined in Annex 1.

1. National HIV and AIDS Monitoring and Evaluation, Situational Analysis, NAPS 2006
2. Developing RHA Information Systems, HSDU 2007

Improved health by 2012:

In terms of improved health impact and outcomes, it is expected that the NHSS 2008-12 will result in:

- increasing life expectancy to 68 years for both men and women and achieving progress in meeting the Millennium Development Goals through reduction in maternal mortality to 80 per 100,000 live births, in infant mortality to 16 per 1,000 live births, in child mortality to 25 per 1,000 live births, and reducing HIV prevalence to 1%, tuberculosis prevalence to 75 per 100,000 and malaria to 5,000 cases per year
- improving access to priority services of the Publicly Guaranteed Package of Services by all citizens measured by attaining 90% immunisation coverage for all antigens; 95% access to health services within one hour of where people live; 95% of births attended by skilled attendants; adequate provision of medicines with 95% consistent availability for drugs and health-related commodities on the Essential Drug List; an increasing percentage of persons on antiretroviral treatment still alive 12 months after commencing treatment; and increasing knowledge of healthy behaviour for priority risks
- preventing and reducing disease, disability and premature death associated with chronic non-communicable conditions, including diabetes, cardiovascular diseases, cancer, mental health (including suicide and depression), violence and injuries, including work-related and road traffic accidents
- preventing and reducing health, social and economic burdens associated with communicable diseases, including HIV, TB, malaria, and neglected and emerging diseases
- improving capacity to respond to emergencies, disasters, climate change and environmental health risks
- reducing numbers of people exposed to six major risk factors: tobacco, alcohol, other psychoactive substances including cocaine and ganga, harmful diet, physical inactivity, and unsafe sex
- increasing patient satisfaction in terms of shorter waiting times, courtesy and responsiveness of staff to patients' concerns and complaints, and availability of essential medicines and commodities, as measured by routine consumer surveys of consumers
- raising numbers and quality of technical staff, including doctors, dentists, pharmacists, medical technologist, nurses etc., and professional staff working in management in key disciplines of human resources, finance, facilities, and information, communication and technology (ICT)
- improving collaboration with other sectors with important roles in securing a healthy environment, including education, housing, water and sanitation, transportation and food safety
- increasing community participation in monitoring and influencing provision of health services
- intensifying efforts by the Ministry of Health (MOH) to deploy modern legislation, regulations and licensing, using professional codes of ethics, patient charters, standards and guidelines.

Priority health services to be driven by the sector strategy:

In order to achieve the desired health outcomes and achieve the MDGs, the NHSS 2008-12 will implement the 2nd Edition of the Package of Publicly Guaranteed Health Services, with the following as priority areas:

- **Family health (formerly maternal and child health)**

Maternal and child health (MCH) will be transformed into an integrated family health programme, including women's health (encompassing safer motherhood initiatives), neonatal and child care, expanded programme of immunisation, integrated management of common childhood illnesses (IMCI) and integrated management of adolescent and adult illnesses (IMAI), and adolescent health, including school health and family planning.

- **Chronic non-communicable diseases**

There will be an intensified programme to promote prevention and self care through knowledge, attitude and behaviour change, supported by health professionals, aimed at reducing heart disease, hypertension leading to stroke and kidney failure, diabetes, cancers, and respiratory conditions including asthma. The chronic disease programme will address the common risk factors of poor diet, physical inactivity, smoking and alcoholism, and seek to promote activities in other sectors that impact on these risk factors and on accidents. Health services will provide earlier detection, diagnosis, treatment and management, employing evidence based care and involving patients in their own care.

- **Accidents, injuries and disabilities**

Increasingly, injuries related to road traffic accidents, other forms of accidents and violence are contributing to disabilities and premature deaths. In addition, disabilities related to various pre-birth and acquired factors, and visual and hearing impairments have become important. The NHSS 2008-2012 identifies these as priorities and seeks to ensure that appropriate interventions prevent and reduce disabilities and premature deaths.

- **Communicable diseases: HIV, STIs, tuberculosis and malaria**

In collaboration with Civil Society, prevention efforts will be intensified to reduce HIV, tuberculosis and malaria that remain leading causes of death and ill health in our younger populations. Treatment, care and support services will be further integrated into the health and social services offered by government and non-government providers.

- **Other communicable diseases**

Guyana has developed an impressive immunisation programme and generally does not face a problem with vaccine-preventable diseases. However, government must remain keen in its determination to avoid the emergence of any vaccine-preventable disease, must deal with other communicable diseases including dengue, leptospirosis and the neglected diseases of filariasis and Hansen's Disease, and must be vigilant in ensuring that emerging diseases, including SARS and avian influenza, do not become a public health challenge.

- **Mental health**

There will be a significant shift in mental health services from institutional to community and primary care. Improvements will be achieved through prevention and management of suicide, depression and substance abuse in first contact clinical care. Acute services will be enlarged at GPHC, and the National Psychiatric Hospital will be reconstructed and re-organised.

- **Health promotion and risk reduction**

A national 'public education and behavioural change for health' strategy and programme will be developed and implemented in support of the NHSS 2008-12. It will utilise mass media and modern marketing methods to achieve reductions in the priority health problems outlined above including the growing problem of injuries and accidents on the road, in the home and at work. Radio and TV will be utilized on a daily basis to support education and awareness of the population. The programme will target health promotion and risk reduction in six risk factors and determinants of health: tobacco, alcohol, psychoactive substances including cocaine and marijuana, harmful diet, physical inactivity, and unsafe sex.

How the strategy will be financed

The health sector has achieved significant increases in allocation over the years and now receives 10% of total government expenditure, higher than most countries. In 2006, government allocated approximately G$ 6,400 million (US$32m) in recurrent expenditure to fund primary care, hospital services, other services and the administrative costs of the ministry and regions. Consumers spent an additional G$ 1,600 million out of pocket in the private sector. Also, Guyana received approximately $G 5,097 million in external aid for health although almost all of this is for one-off capital expenditure rather than annual recurrent expenditure (salaries, drugs etc) and dedicated to specific diseases, mostly HIV. Crucially, we do not know for how long such external financial assistance will continue, and we cannot plan on it always being available.

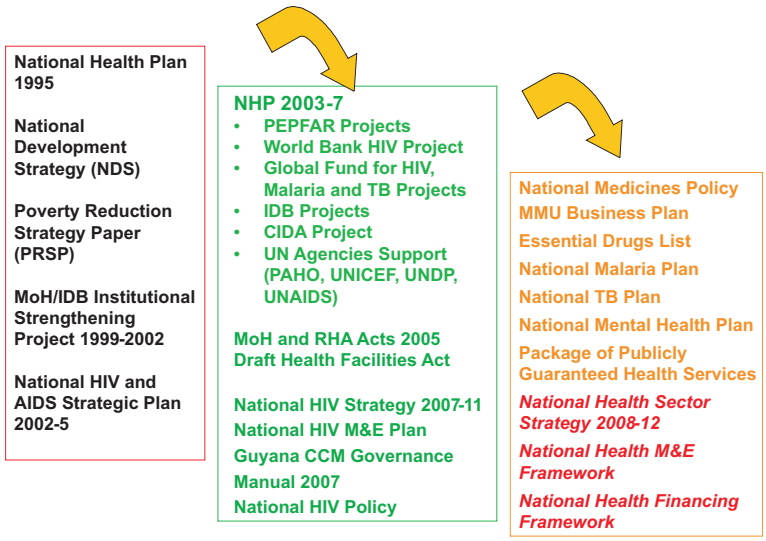
It is estimated that, to deliver the Public Package of Guaranteed Services and to achieve the objectives of the NHSS 2008-12, the 2006 recurrent budget of G$ 6,400 million would have to have been at least G$ 10,968 million (71% more), to pay our health workers salaries sufficient to retain skilled staff, and depending on the extent to which we are able to improve efficiencies in our delivery system. But health must compete with other important needs like education, law enforcement, roads and coastal protection for its share of government expenditure, and it is unrealistic to expect that the government allocation for health can increase significantly.

Funding of the sector remains uncertain and consequently, government will now embark on a national consultation process looking at options for financing health care in the future. Any future financing arrangements will aim to ensure protection of the poorest from all costs, and protection of all from the catastrophic costs of major illness.

1. INTRODUCTION

Significant achievements have been made in recent years in modernising the health sector, and in forming a solid base on which the National Health Sector Strategy (NHSS) 2008–12 can build.[1] The NHSS 2008–12 is a continuation of the national health planning process that produced the National Health Plan (NHP) 2003–07 and that has been based on extensive consultation and technical analysis. Figure 1 outlines the key steps in this process.

Figure 1: Road map for NHSS 2008-12, building on the NHP 2003-07



The NHSS 2008-12 marks another break with traditional public services planning: whilst the NHP 2003-07 focused on development and piloting of improvements in the public sector, the NHSS 2008–12 places greater emphasis on strategic changes for the entire sector, public, private and voluntary.

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Components of the NHSS 2008-12 to achieve those goals:

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2. Strengthening the skilled workforce and HR systems
3. Strengthening government capacity for sector leadership and regulation
4. Strengthening sector financing and performance management systems
5. Strengthening strategic information

2. COMPONENTS OF THE SECTOR STRATEGY

2.1. Decentralisation of health services providers

Problems and issues to be addressed

Experience from Guyana and, indeed, from all over the world indicates that the complex functions of funding, planning, regulating, and providing health services cannot be undertaken efficiently by a single public service agency like a ministry of health. The traditional public sector lacks incentives to deliver high quality, consumer oriented services, and suffers from bureaucratic management unable to take dynamic and responsive decisions close to the point of services being delivered. Sensible policy is often not translated into actions, and services typically respond more to the demands of powerful middle classes and the interests of those providing the services, than to the health needs and preferences of the public.

Guyana's policy to overcome these problems has been to separate the functions of funding and regulation from those of providing services. Our initial step was to devolve the function of providing local health care services to local government, the Regional Democratic Councils (RDCs). However, this step has not been able to overcome the lack of accountability for poor performance, and lack of reward for good performance. RDCs lack the degree of autonomy required to manage staff and services efficiently.

Strategy Component: decentralisation of health services providers

The Government of Guyana remains committed to completion of the decentralisation agenda in health. Responsibility for health services is being devolved to Regional Health Authorities (RHA), and to Georgetown Public Hospital Corporation (GPHC). These are statutory authorities created under the RHA Act 2005 (and the Public Corporations Act in the case of GPHC). They will operate under contract to MOH, and their contracts will specify the level and quality of services they should provide in return for the funding they receive. Their funding will be based on a combination of the regional population they each serve, and any services they provide to other regions or nationally.

It is planned to establish four or five RHAs to cover health care delivery across the country, to justify full management teams and to achieve economies of scale in clinical services. The RHAs will be operationalised in phases over 2008-10, covering one or more RDC geographic area. The Berbice RHA has been established covering Region 6 and, later, will incorporate Region 5. It is already operational, with a Board and Executive Team. The Authority has developed its RHA Strategic Plan 2006-10, its Business Plan 2007-9 and Annual Workplans. These are now part of the annual budgeting and workplan process led by the Ministry of Finance. The process is illustrated in the figure.

The RHAs and GPHC will introduce performance management systems in which planning targets are converted into directorate and personal workplans that define roles and responsibilities down through the organisation, and for the basis for staff achievement goals, performance incentives and personal development.

The RHAs will employ their own staff, combining direct recruitment and transfer from traditional civil service employment. They will have full managerial control over staff and resources with which to meet their contractual obligations, avoiding the delays of the public service. They will be charged with managing the improvement of: regional primary care services, regional hospital services, logistical systems including transportation, diagnostic and clinical monitoring. Their performance will be assessed on how well they meet their contractual targets based on national policy priorities. To optimise resources nationally, investment and development plans involving infrastructure and services development will be led and coordinated by the Ministry of Health but implemented by the RHAs and GPHC. A Package of Publicly Guaranteed Services (PPGS) has been produced to guide the development of services, subject to sector financing.

Expected results
Combined with contracting, the increased local autonomy of the RHAs and GPHC is expected to improve the quality and cost effectiveness of services, and to ensure that they are more consumer oriented. Professional and allied staff will have a clearer work context and performance targets that will include specifically quality and consumer satisfaction measures.

Contracting will require the RHAs to make the best use of their resources, to rationalise services to achieve critical mass of skilled staff and raise quality, and to refer patients to the most appropriate facility. Combined with the development of a national single payer mechanism through pooled funding of government and external sources, contracting will direct resources to priority health services. As contractor, the MOH will provide the targets for services linked to funding.

Results in achieving this strategy component will be measured with the following indicators:

- Services delivered by RHA and GPHC will be reported against regional and facility based targets and trends

- Organisational development targets will include:

    - RHAs operationalised in phases, with targets for each RHA of:
        - RHA Board and Executive Team appointed
        - Regional strategic plans, business plans, services agreements produced and operational
        - Transfer of staff from Regional Democratic Council (RDC) and MoH to RHA employment by RHA
        - RHA performance management systems in place

    - Regional development plans designed and implemented in accordance with the PPGS and national strategy in the respective areas, covering:
        - Primary care services development plan
        - Hospital services development plan
        - Logistics and communication systems
        - Diagnostics development plan.

2.2 Strengthening the skilled workforce and HR systems

Problems and issues to be addressed

The shortage of health care professionals and their continued loss, the inappropriate mix of skilled professionals, and the low levels of training output, remain major underlying causes of sector problems. To address this, Guyana has introduced new cadres of health workers but, whilst this maximises coverage, it also brings issues of maintaining quality. Further, decentralisation to RHAs and GPHC, and the availability of new sources of external health funding for HIV, are introducing problems of staff working on different employment contracts, terms, conditions, and reporting arrangements. Increased autonomy for providers brings the need for significant changes in work place culture and behaviour, and these must be developed before full benefits can be realised. Capacity building is needed in all aspects of human resources management in the RHAs, GPHC, private providers, and the MOH itself.

Strategy Component: strengthening the skilled health workforce

The Publicly Guaranteed Package of Health Services establishes minimum staffing requirements. These will achievable until the Human Resource Plan is implemented, but are being used to establish human resource needs for the sector. A Human Resources Unit has been established in the MOH to take on the roles of workforce planning and development, and providing HR advice to policy development and decision making. Consistent with plans for the modernisation of this function in line ministries, the HR Unit will coordinate development of the current personnel function, the training unit and the organisational change agenda for the RHAs, including critical industrial relations aspects. This will be coordinated with the Public Services Ministry, the Public Services Commission and the Ministry of Local Government.

The RHAs will establish workforce development and human resource management systems based on staff appraisal, training opportunities and performance-based incentives and promotion, in accordance with agreed national policy.

The role for the MOH in human resources will comprise:

- national workforce planning to establish professional career development, education and training needs
- monitoring the distribution of skilled staff based on revised staffing norms of the Package of Publicly Guaranteed Services

- organising support for RHAs in developing HRM systems including staff appraisal systems (and in introducing these within MOH) and designing compensation packages and incentive systems
- implementing a management development programme to increase numbers and raise quality of managers.

The MOH will work with the University of Guyana to improve the existing health-related training programmes in medicine, dentistry, pharmacy, nursing and medical technology and assist the university in introducing new programmes, including rehabilitation medicine and optometry. The Health Sciences Department of the MOH will be integrated into GPHC, and expanded programmes implemented for community health workers, medex, dentex, multi-purpose technicians, radiographers, laboratory technicians, operating room technicians, refractionist technicians, and patient care assistants. Some of the GPHC training programmes will continue as associated programmes with the University of Guyana. The GPHC will expand its post graduate programme for physicians to include surgery, medicine, obstetric and gynaecology, and anaesthesia and will also develop post-graduate programmes for nurses in anaesthesia, mental health and paediatrics. A new programme to train mental health professionals and emergency medical technicians (EMT) for ambulances will be introduced.

Expected results

The combination of improved remuneration and opportunities, stronger HR planning and management, and enhanced training is expected to assist in achieving the sector goals of more equity, more response to consumers, and higher quality of services. Results in achieving this strategy component will be measured with the following indicators:

- MoH, RHA and GPHC costed HR plans, including recruitment and training intentions, and within realistic financial allocations

- HRM systems in place at both MoH and RHA levels able to monitor:

  - numbers of staff by type employed or contracted in relation to new norms
  - staff performance management processes and outcomes
  - trainee needs as determined by both job and personal development goals

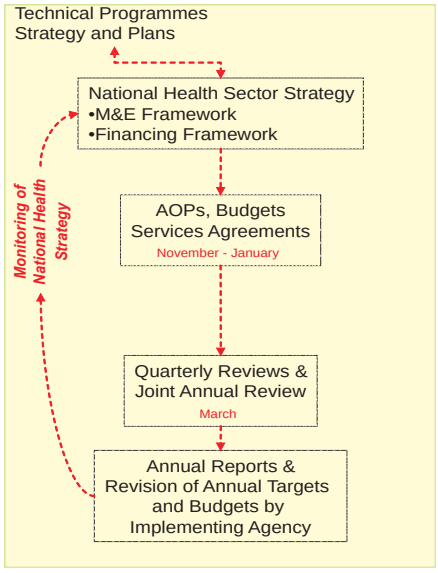
- adequate number of managers in place who have successfully completed management development training

- expansion of the number of training programmes to include post-graduate programmes in surgery, medicine, obstetric and gynaecology, orthopaedics, mental health, EMT, and Public Health.

Strengthening government capacity for sector leadership and regulation

Problems and issues to be addressed

Whilst much progress is being made in decentralisation to RHAs and GPHC, much remains to be done at central level where old and new functions and cultures still exist in parallel, constraining organisational effectiveness. Governance structures are weak, and managers maintain separate processes and reporting systems which result in increased transaction costs and less than optimal use of available staff. Combined with shortages of skilled staff, this has resulted in little coordinated effort to integrate work, complete the devolution of services provision to the new provider agencies, and assume the new contracting role of the MOH.



Strategy component: strengthening government capacity for sector leadership and regulation

As services are contracted to RHAs, GPHC, private and voluntary providers, the structure and capacity of the MOH will be developed to fulfil its new role, which includes policymaking, regulation and performance management of the sector (see figure). These fall under:

1. to align regional targets and budgets

2. Directly providing or contracting for the national activities and services necessary to support those health care services, including:

   - developing quality standards and guidelines
   - intensifying media-based health education aimed at behavioural change
   - ensuring medicines supplies and distribution.

Much of this work is already underway, particularly those health systems strengthening activities that were required for assuring HIV targets, with support from USG/PEPFAR, World Bank, Global Fund and the Canadian Government and direct support from PAHO, UNICEF, and the Inter-American Development Bank, eg. in improving national procurement and supply, health information and management information, and clinical education and training.

Expected results

Divested of the functions of directly managing personal health care services, the MOH will focus on raising standards, raising and sustaining funding, and achieving good value for money across the sector, including improving the private sector through regulation and purchasing services of defined standards. The MOH will undergo reorganisation to develop the skills to assume this new role of orchestrating the functioning of the whole sector to achieve strategic goals.

Expected results in achieving this strategy component will be measured with the following indicators:

- MOH Organisational Development Plan and Business Plan prepared and implemented to agreed timetable
- National quality standards, guidelines and regulatory system completed, and employed in contracting
- A national 'public education and behavioural change for health' strategy developed (see 3.8)
- Equitable availability of high quality and effective medicines and related commodities
- An effective strategic health information system implemented
- Adequate sector financing secured and managed through a transparent sector planning and budgeting process (see 2.4).
- Supporting health services buildings design and construction.

2.4 Strengthening sector financing and performance management systems

Problems and issues to be addressed

Achievement of sector goals is hindered by the earmarking of much external funding for specific diseases and activities (mostly HIV), and by the stipulation of donors for separate reporting along lines that suit the their needs rather than conforming with and strengthening national systems. A process is needed to combine government and external funding and to direct this to the providers of services in ways that ensure their activities are aligned with and maximising achievement of the overall sector strategy and priorities.

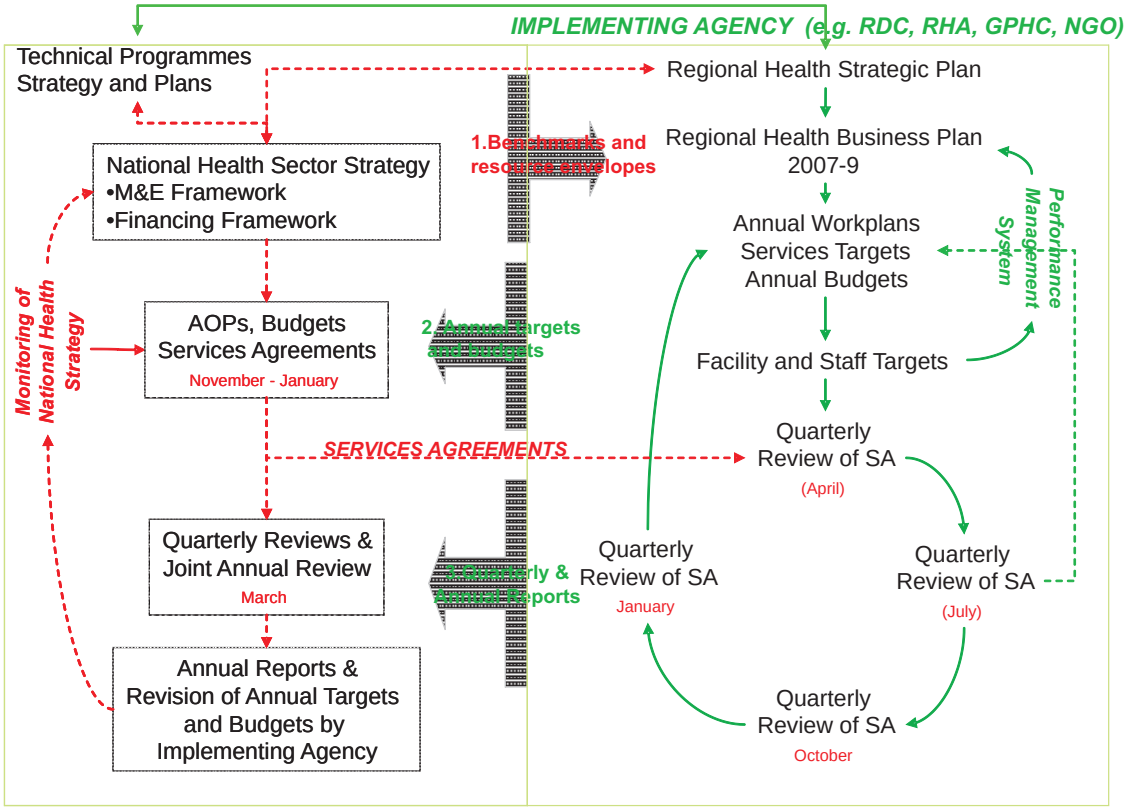
Strategy component: strengthening sector financing and performance management systems

Government and donor funding for the sector is being consolidated into a single fund, a National Health Fund (NHF) that will combine finance from all sources into a single payer mechanism. A single fund will ensure that fund disbursement is aligned to the priorities of the NHSS 2008-12, and create a single forum for GOG and its Development Partners (DPs) to ensure that they are harmonised in their support efforts. The Fund will help to smooth variations in donor (and domestic) financing so as to create more predictable sector funding and facilitate longer term planning. It will maximise the use of international disease-dedicated funding (for HIV particularly), to strengthen the health system and sustain the delivery of all health services.

A single-payer NHF will minimise the significant administrative burden of providing different reporting to different DPs. It will allow a single performance monitoring mechanism relating all support to achievement of an explicit national strategy and priorities. This is reflected in a new process of performance management for the health sector that guides annual planning, budgeting and contracting arrangements. The process provides annual targets and financial estimates for the RHAs, GPHC, and other service providers or 'implementing

agencies' contracted. Based on these, the implementing agencies prepare their business plans covering the following two years, and their annual workplans, service targets and budget requests for the following year.

These are submitted to MOH for review and consolidation into a draft national sector budget and draft contracts for the implementing agencies. Following this, MOH holds a joint annual review process involving implementing agencies and external funders. This reviews progress and problems nationally based on various inputs including the annual reports of implementing agencies. MOH then revises annual targets and budgets for the implementing agencies, and prepares final submissions for the health sector budget. Throughout the year, MOH engages with the implementing agencies in quarterly reviews of progress and problems in implementing their contracts. The whole process is illustrated in the figure.



Expected results

Consolidating government and donor funding into a single pool, and introducing a new planning, budgeting and sector performance management process will achieve:

- Increased harmonisation of external and government funding and support, and alignment with sector processes and priorities
- More efficient use of resources available
- More transparency and accountability
- Reduced transaction costs for government in dealing with multiple DPs.

Expected results in achieving this strategy component will be measured with the following indicators:

1. Sector performance management system in operation (annual cycle)

2. National health fund (basket) established, and funding allocated through contracting mechanism.

2.5. Strengthening strategic information

Problems and issues to be addressed

Numerous studies at both national and regional level are consistent in concluding that the main issue is not the paucity of data collected but rather the lack of strategic use of information[1]. Data needs are dictated vertically from the various technical and operational programmes, and the horizontal linkages and usefulness of the information at national and regional levels are grossly underdeveloped. As a result, there are complex information flows with poorly defined and supervised data validation processes and little concern for the integrity or use of the data at the user level.[2] This 'territorial' information culture pervades health, economic, social, demographic, human resources and finance data, and technical knowledge.

Strategy component: strengthening strategic information

A strategic information capacity will be developed to lead data collection, analysis and use throughout the sector, thus ensuring that the requirements of individual programmes are coordinated and provide relevant information for strategic decision making. Significant resources are available through the HIV support of the United States Government (USG), Global Fund (GFATM) and World Bank for strengthening monitoring and evaluation capacity. A joint approach has been agreed to meet HIV M&E requirements through strengthening of the health sector M&E function, and work has begun on the development and implementation of an operational plan to this end.[1] This requires improvement of the Central MOH Statistical Unit and related technical programmes for disease surveillance, statistical analysis and reporting, and survey methodology.

Work is required also at regional and facility levels to reduce the amount of time spent on multiple reporting lines and thus allow a focus on improving data quality by ensuring that data sets address regional information requirements, are consistent at different sites, validated, and useful for decision making. There are currently several parallel initiatives in this area which will be aligned better to the needs of the regions as RHAs are established, and their contracts specify data collection and reporting requirements.[2,3,4]

Whilst invaluable to achieve efficiencies in information flows and sharing, computerisation is not sufficient in itself to overcome the structural issues described above. Appropriate introduction and management of technology as an enabler to improving functionality of providers and technical programmes will be a critical tool for this component. The MoH has recently established the Management Information Systems Unit (MISU) to lead development in this area. MISU has developed a draft ICT Policy outlining the standards for ICT procured for the sector so as to ensure compatibility and sustainability of investment in this area.

Expected Results

This component of the NHSS 2008-12 will result in more coordinated data across the sector, and in data more useable for decision making at all levels.

Results in achieving this strategy component will be measured with the following indicators:

- National Health Sector M&E Framework for the NHSS 2008-12 developed and implemented in collaboration with other sectors initiatives to strengthen M&E capacity[2]
- National MIS Strategy agreed and first phases implemented, incorporating the ICT policy for procurement and management of related assets in the sector
- Annual reports of implementing agencies produced according to format and schedule required by legal and policy framework
- Knowledge management systems operational.

1. Operational Plan for strengthening M&E for HIV, National AIDS Programme Secretariat (NAPS), 2007
2. The Guyana Health Information System (GHIS) developed by the CIDA funded Strengthening Public Health through HIV, Tb and STIs programme, currently being implemented as a pilot in GPHC and Region 6.
3. RHA Management Information Systems to include financial management, HR management and facilities management as priority areas under the MoH/IDB Health Sector Programme and links to the Warehouse Management Systems under SCMS in the USG HIV Programme.
4. Draft Operational Plan for the National HIV M&E Plan, 2007; Strengthening M&E for the Poverty Reduction Strategy, M&E Unit, Office of the President

3. SERVICES PRIORITIES TO BE DRIVEN BY THE SECTOR STRATEGY

The significant changes in organisations and systems driven by the NHSS 2008-12 aim ultimately to improve the equity, user-friendliness, quality (and value for money) of services, and the accountability of those providing them. Whilst improvement is sought across the whole range of services, the process of contracting the organisations providing services will focus on certain priorities, selected to have maximum impact on improving the health of the nation. They are outlined below.

3.1. Maternal, child and family health

The NHSS 2008-12 focuses on reducing morbidity and mortality by ensuring universal access to effective interventions for the newborn, children, adolescents, and young adults. This priority area is vital to improve national health status, and for Guyana's effort to attain the Millennium Development Goals (MDG) 4 and 5. Over the last five years, significant improvements in statistical reporting have been achieved, and more reliable baselines are available with which to compare and measure progress. By 2005, morbidity and mortality rates stabilised, and the Multi-cluster Indicator Survey (MICS) 2006 shows a significant reduction over the MICS 2001.

Up to 2001, Maternal and Child Health (MCH) services provided mainly traditional antenatal and child immunisation programmes, forming the foundation for expansion and transformation into a comprehensive **Family Health Programme**[1] that is now being developed. During 2003-07, other preventive and curative services for mothers and children were integrated into the MCH platform, including HIV services through the PMTCT, safer labour and delivery initiatives, nutrition services, adolescent services and the Integrated Management of Childhood Illnesses (IMCI). Integrating new initiatives into the MCH programme has allowed a rapid scale up to meet new services targets while maintaining performance in traditional outcome indicators such as immunisation rates and attendance at delivery by skilled attendants.

The Family Health Programme Policy and Procedures Manual 2006[2] provides guidelines for the programme. Emphasis is placed on the family including the supportive role of men in family planning, safe sex, voluntary counselling and testing (VCT) for HIV, and in bringing their children to MCH clinics for immunisation and other services. Family planning will be further strengthened by community orientation and sensitization, and the improving information system will allow better forecasting, stock control, and distribution of contraceptives. High vaccination coverage will be maintained, and improved in areas of low coverage with outreach and 'mop up' activities. Surveillance of vaccine-preventable diseases will be intensified, and monitoring and evaluation of vaccination coverage undertaken tri-annually.

Maternal health will be enhanced with a full **Women's Health Programme**, introducing services for pre-conception, safer motherhood, and early detection of breast and cervical cancer, whilst continuing to integrate other vertically delivered services into the IMCI. Obstetric care is to be improved with an enhanced package of services standardised at all hospitals, and C-section capacity developed for all Regional Hospitals.

Safer motherhood will be strengthened through inter-sectoral and inter-agency collaboration, and through promotion of community support groups in, for example, breastfeeding and HIV counselling. Maternity services will be stratified further to improve quality at the various levels from basic care to comprehensive obstetric services, to simplify provision of the right equipment and supplies, to ensure equity in the distribution of trained skilled staff, to reinforce management of high risk cases, and to develop a functional referral system. Training in emergency obstetric care will be done at all levels of the health care system. Provision of mosquito nets for mothers and children will greatly reduce malaria morbidity.

The **Adolescent and Young Adult Health and Wellness Programme** will improve the health and well-being of adolescents (age 10-19 years) and youth (age 15-24 years) by increasing access to youth-friendly services, and promoting knowledge, skills and healthy behaviours, thereby enabling adolescents and young adults to make healthy choices. The Adolescent and Young Adult Health and Wellness Unit was created to meet the developmental needs of young people, and this unit will be strengthened to lead the national programme.

Key impact and outcome indicators and targets for this priority area are to:

1. maintain 90% immunisation national coverage for all routine antigens, with 95% for Regions 2,3,4,5,6 and 10 and with no region under 85%, and to introduce selected new vaccines into routine immunisation

2. ensure 95% attendance of births by skilled attendants and better access to emergency obstetric care, including C-section surgery in Regions 2,3,4,5,6,7 and 10

1. Strategy for the Reduction of Maternal and Infant Mortality 2005-10
2. Family Health Programme Policy and Procedures Manual, 2006 edition

1. achieve 90% coverage of HIV positive pregnant women with PMTCT prophylaxis
2. reduce maternal mortality to 100 per 100,000 live births, with no more than 5 maternal deaths at the GPHC in any year
3. reduce the percentage of deliveries by under-19 year olds to 18% of the total
4. reduce infant mortality to 16 per 1,000 live births and under-five mortality to 25 per 1,000
5. increase the use of contraceptives to 60%
6. attain exclusive breastfeeding for 75% for all infants under 6 months
7. increase the use of insecticide treated mosquito nets to 95% of pregnant women and children in Regions 1,7,8 and 9
8. reduce the proportion of underweight children under five years old to 5% by 2010
9. ensure that 60% of health centres are youth-friendly by 2012, with at least two YFS in each region
10. establish a mobile YFS to serve those areas without YFS in Regions 1,7,8 and 9
11. develop a School Health Plan in 2008 and ensure that 25% of the programme is operational by the end of 2009.

3.2. Chronic non-communicable diseases

Like other countries, Guyana is experiencing an increase in illness, premature deaths and disability from chronic non-communicable diseases: heart disease, hypertension leading to stroke and kidney failure, diabetes and cancers. Containing the increase requires lifestyle changes by individuals, environmental change led by government, plus earlier diagnosis, treatment and rehabilitation services. Otherwise, premature deaths and disabilities will rise, and costs will spiral.

In the recently held CARICOM Heads of Government Conference on Chronic Non-Communicable Diseases[1], countries agreed to work together to address the growing health problems resulting from obesity, poor dietary choices, lack of physical activity, smoking and alcohol abuse. *"Both in the Caribbean and in Latin America, chronic diseases are now the leading cause of premature mortality, accounting for nearly half the deaths of persons under 70, and for two out of three deaths overall. In the current decade, cardiovascular diseases are expected to claim 20.7 million lives in the Americas, and predictions for the next 20 years include a tripling of heart disease and stroke mortality in Latin America."*[2]

Guyana has developed a draft programme to address the problem of chronic diseases that include a combination of:

- nationally led efforts to inform individuals about how they can reduce the risks of these chronic diseases, and to promote environmental change through actions in other sectors: taxation of harmful products, promotion of physical activity in schools and communities, policies and regulations about smoking and alcohol
- using the contracting mechanism (see section 3.4), to encourage public and private service providers to strengthen integrated primary care, encourage early reporting of chronic diseases, and offer more effective treatment and management.

Indicators and targets for progress in containing chronic non communicable diseases have been identified to measure (i). inputs and activities aimed at changing relevant behaviour, and (ii). the reduction in morbidity and mortality being achieved compared with the projected increase without a programme of containment.

1. *"Stemming the Tide of Non-communicable Diseases in the Caribbean"* CARICOM Heads of Government and Ministers of Health, September 2007, supported by the Pan American Health Organisation (PAHO) and the Americas Bureau of the World Health Organisation (WHO).
2. CARICOM statistics suggest that between 2001 and 2002, chronic diseases cost Jamaica, Trinidad and Tobago, Barbados and The Bahamas more than $1.063 billion.

Key impact and outcome indicators and targets for this priority area include[1]:

observing the CARICOM Health Day on the second Saturday of September beginning in 2008

introducing the Chronic Disease Register at all health care facilities between January and June 2008 and improving the Cancer Registry

implementing the comprehensive plan for prevention, screening and management of chronic diseases by June 2008, with:

100% of persons coming into contact with the health sector for non-emergency care routinely screened for diabetes and hypertension by the end of 2008

establishing routine screening in the health system for breast, cervical and prostate cancers by the end of 2008

80% of people having access to preventive education based on regional guidelines, and 80% of chronic diseases being diagnosed on a timely basis, and receiving quality care by 2012

introducing a programme to promote self care for persons with chronic diseases by March 2008, and ensuring that 100% of persons living with chronic diseases have been trained in self care by 2012

100% of persons living with diabetes, hypertension and cardiovascular diseases receiving annual lipid investigation, eye examination and foot care by the end of 2008

reducing amputation rates caused by diabetes by 25% by 2012

100% of health care facilities using national guidelines for prevention and treatment of diabetes and hypertension by June 2009, and 100% of health facilities implementing the Integrated Management of Adult Illnesses (IMAI) by 2012

employing public revenue derived from tobacco, alcohol or harmful products for preventing chronic diseases
offering a smoking cessation programme in public health system by the end of 2008

reducing the proportion of school aged children who smoke to less than 10%

immunising more than 50% of adolescent females with HPV vaccine

establishing mechanisms for collaborative working with other sectors including education, agriculture, and finance in the development and implementation of policies and programmes to achieve the NHSS 2008-12.

3.3. Accidents, injuries and disabilities

Injuries related to road traffic accidents, other forms of accidents and violence increasingly contribute to disabilities and premature deaths in the Guyanese population. Domestic violence and violence related to criminal activities have increased, and homicide has become a major cause of death among the 15-44 age group. Road accidents have emerged as one of the major causes of physical disabilities and death among young people. In addition, disabilities due to various pre-birth and acquired factors also have become important.

The NHSS 2008-2012 seeks to prevent and reduce disabilities and premature deaths from violence and injuries, and to reduce physical disabilities and visual and hearing impairment. Strengthened health promotion will raise awareness and prevention at primary health care level, and development of a network within the health care system will scale up rehabilitation from levels 2 to 5.

Key indicators and targets for this priority area are:

1. implementing comprehensive policies and legislation to allow safer road use through speed limits, alcohol consumption, seat belt and helmet use, standards for road engineering, and driver education and testing

2. developing an inter-programmatic approach to address violence and unintentional injuries

3. developing a programme to address visual and hearing impairment

4. ensuring a nation-wide network of rehabilitative services and developing a national register.

1. Declaration of Port of Spain, CARICOM Heads of Government and Ministers of Health Meeting, 2007.

3.4. Communicable diseases: HIV, STIs, tuberculosis and malaria

While non-communicable diseases and accidents are increasing, Guyana still experiences high levels of communicable diseases. This priority area of the NHSS 2008-12 seeks to reduce the morbidity and mortality and the social and economic consequences of HIV, TB and malaria by strengthening prevention, early diagnosis, treatment and control of these diseases. Particular attention will be paid to the needs of vulnerable and most-at-risk populations.

Over the last five years, Guyana has surpassed the targets set for HIV, tuberculosis and malaria. To a large extent, this results from unprecedented amounts of external development funding and technical inputs mobilised specifically for these three diseases. But this disease-specific funding has created parallel management and activities that by-pass the country's health delivery system, and has frustrated efforts to strengthen budgeting, planning and managing across the sector. As a result, we have not made as much progress in reducing infant and under-five morbidity and mortality, for example. In addition, it has created big additional administrative burdens in dealing with the individual requirements of the external funders. Guyana is now seeking to rectify this situation by:

- working to integrate all disease-specific activities into the country's general health care services, public and private, thus ensuring that all external support is used to build capacity across the board
- working with our external development partners to streamline the processes in which their funding assistance is integrated into the country's planning and budgeting systems and used to deliver services.

These objectives are particularly important for Guyana as it is essential to make the best use of our scarce workforce and maximise the synergies available through integrated service provision. At the inaugural Joint Annual Health Sector Review 2007, we sought agreement from our Development Partners to work with us on implementing a sector approach which will build on the successes of the last few years, implement the strategies 2007-11 for HIV, tuberculosis and malaria within the parameters of our NHSS 2008-2012 and, at the same time, work more efficiently and effectively on systems strengthening to ensure sustainability.[2]

Under the NHSS 2008-12 we will now work actively and energetically to:

- entrench the achievements in these three diseases within a sustainable health system
- fully integrate HIV, tuberculosis and malaria services into our health services delivery system eg. integrating HIV treatment, care and support into the comprehensive package of publicly guaranteed health services
- complete reforms to our health services delivery system that will achieve this integration and ensure that all funding supports directly our strategic goals and priorities (these are further elaborated in Section 3).

Key impact and outcome indicators and targets for this priority area include:

HIV

1. increasing the percentage of persons on ART who are still on ART 12 months after initiating treatment[3]
2. reducing mortality rates associated with HIV
3. reducing prevalence of HIV to 1.5% for all age groups
4. 25% of the adult population knowing their status by testing within the last 12 months.
5. covering 90% of pregnancies/deliveries with PMTCT services, and reducing the number of children born HIV+ to 10 per year
6. 4,500 persons on ART by 2012
7. 90% detection rate and treatment for STIs.

1. National HIV Strategy 2007-11, National Malaria Strategy 2007-11, Draft National Tuberculosis Plan 2007-09.
2. This is consistent with the international agreements on harmonisation and alignment: Paris Declaration on Harmonisation and Alignment 2004, International Health Partnership 2007, UNAIDS Three Ones Principles 2005.
3. Universal Access Targets for National HIV Strategy 2007-11.

Tuberculosis

1. reducing mortality rates associated with tuberculosis to 1.5% by 2012
2. reducing prevalence rate of TB from 185 per 100,000 to 75 per 100,000 by 2012
3. increasing case detection rates to 80% by 2010 and 85% by 2012
4. achieving DOTS coverage of 80% by 2010
5. reducing the treatment default rate to 2% by 2012
6. testing 95% of tuberculosis patients for HIV on their first visit to a health facility.

Malaria

7. reducing prevalence and mortality rates associated with malaria, and reducing the number of malaria cases to 5,000 by 2012
8. 90% of households in Regions 1,7,8 and 9 having at least one insecticide treated bed net.

3.5 Other communicable diseases

Communicable diseases other than HIV, tuberculosis and malaria still represent major public health concerns. These include the vaccine-preventable diseases, dengue, worm infestation, and the neglected diseases of Bancroftian Filariasis and Hansen's Disease. Thus, this priority area focuses on prevention, early detection and diagnosis, treatment, control, elimination and eradication measures to combat these diseases. While Guyana has achieved impressive immunisation coverage, recent imported and indigenous outbreaks of whooping cough are a stark reminder that some vaccine-preventable diseases still pose serious threats. Flood prone areas are at risk from dengue and leptospirosis.

Key indicators and targets for this priority area include:

- ensuring continued high coverage for all vaccines, but that pockets of low coverage are detected and immunisation completed, and that there are no cases of whooping cough by 2012
- reducing the number of dengue cases to 100 per year by 2009 and 50 per year by 2012, with no case of dengue hemorrhagic fever
- reducing intestinal worm infections by implementing an albendozole-based de-worming programme for all communities by the end of 2008, reaching 25,000 children per year
- reducing leptospirosis cases to 15 per year
- reducing filariasis prevalence to 1% by continued mass treatment with DEC and albendazole
- reducing prevalence of Hansen's Disease to 1 case per 100,000
- verifying the absence of Chagas Disease and maintaining rigorous surveillance
- reducing the prevalence of leishmaniasis by 90% to 2 cases per 100,000
- reducing water-borne diseases by promotion of safe water in 100 % of communities by 2010.

3.6. Mental health

Globally, mental disorders affect more than 25% of people at some time during their lives, affecting one in ten people at any one time, and placing great demands on health and social services. The common conditions of depression, anxiety and substance abuse are associated with academic and vocational under-achievement, family and relationship disruption, financial loss, social failure, poor physical health, and premature death by suicide, and are predicted by WHO to become the second leading cause of disability in the world by 2020. Although there are no epidemiological surveys upon which to quantify the problem in Guyana, depression, anxiety, suicide and substance use disorders are recognized as serious public health concerns. Suicide is the leading cause of death for 15-24 year olds and the third leading cause of death among persons aged 25-44. The prevalence of completed suicides (24-26/100,000 population) is more than double the global average. Much clinical depression and anxiety can be treated effectively with inexpensive medicines and simple

psychosocial interventions, and the majority of patients respond well. Early detection and appropriate treatment will promote better outcomes, reduce health care costs, and minimize personal disability.

The recently completed Draft Mental Health Strategic Plan[1] sets the directions for addressing population mental health needs: integrating mental health services within general health care, and replacing custodial and institution-based care with therapeutic and community based care with a focus on rehabilitation and recovery. Successful implementation of the strategy requires:

- creation of an appropriately resourced mental health authority responsible for planning, standards setting, budgeting, and monitoring and evaluation of mental health and substance abuse services
- development and implementation of modern mental health legislation
- building of mental health care capacity within the five levels of the health care system with a focus on prevention, early detection and treatment in primary care.

The NHSS 2008-12 will develop a national suicide prevention strategy focusing on restriction of access to lethal means, training of first contact care providers in the early identification and appropriate referral and management of persons at risk for suicide, and training of health providers in suicide risk mitigation and the early identification and management of depression and other common mental disorders. Training will target both in-service health care providers and health profession s students, emphasising building capacity in primary care. The NHSS 2008-12 will also develop a comprehensive strategy for the prevention, treatment and rehabilitation of persons with substance use disorders.

Key indicators and targets for this priority area include:

- 10% of primary health care facilities offering services for the identification and treatment of common mental disorders including substance use disorders by 2010
- 10% of primary care providers receiving mental health care competencies training appropriate to their health care role by the end of 2008, and 100% receiving such training by 2012
- 100% of health care professional students receiving training in mental health competencies appropriate to their health care role by 2012
- implementing a comprehensive national suicide prevention strategy leading to a detectable reduction in mortality rates associated with suicide by 2009
- 100% of in-service health workers at community and primary care levels receiving training in suicide risk identification and risk mitigation by 2012
- implementing a referral system for suicidal patients by 2009
- ensuring that a community support system for persons at risk for suicide is operational by 2009
- reconstructing the National Psychiatric Hospital, starting in 2009
- developing a national substance abuse plan for treatment and rehabilitation, and for an expansion of the treatment programme by NGOs by September 2008.

3.7 Emerging diseases, environmental health and health consequences of emergencies, disasters and climate change

As Guyana tries to control current infectious diseases, it recognises that new ones can arise, and that preparations must be made. SARS and avian influenza may pose real threats, and preparations must be made to control these and other possible diseases.

The NHSS 2008-12 aims to achieve safe, sustainable and health enhancing environments, protected from social, occupational, biological, chemical and physical hazards, and to promote security to mitigate the adverse effects of climate change and industry. Recent experience of heavy rainfall and flooding has emphasised Guyana's vulnerability. The Environmental Health Unit of the Ministry of Health will be upgraded and will host the coordination unit for health disasters. It will be re-organized to fulfil its traditional and its new roles. An urgent need is to upgrade policies, legislation and technical norms. Emphasis will be placed on solid waste, health and safety in the work environment, and exploring the linkages between health and the environment.

1. Draft National Mental Health Strategy, Ministry of Health, 2007

Key indicators and targets for this priority area include:

- establishing an early warning system, and achieving full compliance with the IHR by the end of 2008
- expanding the national surveillance system to all regions, and monitoring all ports of entry
- establishing a working rapid response team
- ensuring the health sector disaster preparedness plan is familiar to all stakeholders by 2009
- conducting national simulation disaster preparedness exercises in 2008 and 2010 and regional simulation exercises in 2009 and 2011
- strengthening the mass-casualty management plan and simulating its readiness in 2008 and 2010 as part of the national disaster preparedness exercise
- establishing a unit at the Ministry of Health to coordinate disaster preparedness by 2009
- improving environmental health surveillance by 2009
- evaluating the existing public health laws and policies, environmental standards and guidelines and upgrading where necessary by 2009
- developing a medical waste disposal policy by 2009
- ensuring 90% access to improved water sources, by working with other stakeholders
- ensuring that 90% of the urban and 60% of rural populations have improved sanitation
- improving worker safety in collaboration with the Ministry of Labour by 2010.

3.8. Health promotion and risk reduction

Many of the priority needs identified in sections above indicate that major impact on our disease burden requires not only improved personal health care services, but a significant increase in consumer knowledge and changes in lifestyle and behaviour. Without behavioural change resulting in the prevention, early reporting and self management of disease, health services will never be able to afford to treat rising levels of lifestyle-related diseases including chronic non-communicable disease, HIV, suicides, accidents and injuries, and treatment outcomes will be worse in terms of premature deaths and disabilities.

This NHSS 2008-12 priority area seeks to promote health by reducing harmful behaviour and consumption including tobacco, alcohol, substance abuse, unhealthy diets, physical inactivity and unsafe sex. It seeks to do this through a combination of health promotion and disease prevention measures and development of social and public health policies. It also seeks to inform consumers of their potential as patients to improve their own outcomes and quality of life.

> "The nature of chronic diseases means that they cannot be fixed through episodic treatment in an acute hospital. To be sure, the expertise of specialists has an essential contribution to make to the effective management of chronic diseases, but this has to be harnessed in support of the care provided by primary care teams. It is these teams that will be the first port of call for most people with a chronic condition and that will then provide the continuity of care for conditions that can neither be cured nor are life threatening. Moreover, people with chronic diseases also have a major part to play in managing their conditions. Understanding that the main primary care providers are people with chronic diseases, rather than health professionals, is the first step on the road to reshaping health services so that they are appropriate for societies that live in the time of chronic diseases. From this simple but profound insight, three important implications follow.
>
> The first is that much more needs to be done to enable people to become effective primary care providers. Compared with the massive investment of resources in the training of health-care professionals, paltry sums are spent supporting patients to be expert in their own care. . . The second implication is that people with chronic diseases need care that is integrated rather than fragmented. In the course of their illness, this may entail continuing contact with a trusted primary care physician able to call on nursing and other expertise within the immediate team. In turn, the primary care team will need to have rapid and easy access to specialist advice when additional expertise is required. Support from social care and other professionals must be part of this approach. . . The third implication is that the way in which health care is funded needs to reward good quality care for people with chronic diseases while also ensuring continuity of care over time. "
> Chris Ham, *Lancet* **367**, May 6, 2006

Guyana has mounted health promotion campaigns with some noteworthy successes in the Expanded Programme on Immunisation, and more recently in HIV. These require combinations of advocacy and clear communication objectives eg. promotion of National Immunisation Days (NIDS), and participation in VCT as part of PMTCT. However, health promotion activities have generally been *ad hoc* in nature, with discreet,

uncoordinated inputs, duplicative interventions, and limitations in scope and duration, and thus have had limited impact[1].

It is clear that we now need a significant change of gear in our approach to public education and behavioural change, and that much more funding is needed to achieve this. In the short term we shall look to employ some of our external funding for HIV to build our capacity to plan, design and commission media-based communications. While disease-specific information and behaviour change programmes have their own specific messages, themes and target groups, there are common approaches and delivery mechanisms that can be coordinated to ensure that messages are reinforcing and complementary. Examples of this include breastfeeding and HIV, and use of condoms in HIV prevention and for family planning.

We will now develop a national 'public education and behavioural change for health' programme as a foundation for achieving the objectives of the NHSS 2008-12. This will ensure that resources are coordinated to reduce duplication across programmes, employ modern media methods and effectiveness, increase consistency of messages to targeted population groups, improve the scope and duration of campaigns, and measure results continually. It will be supported by providing incentives for primary care services and health workers to support consumers in prevention and self care.

Key indicators and targets for this priority area include:

1. adapting the CARMEN Strategy for Guyana, and beginning implementation by mid 2008

2. developing a national 'public education and behavioural change for health' programme by mid 2008, including agreed national health promotion and behavioural change indicators and targets

3. developing a costed and budgeted three year communication plan (2008-10) by mid 2008, targeting knowledge and behavioural change relevant to the services priorities 2.1 - 2.8 above

4. educating 60% of the population about healthy lifestyle methods by 2012, intensifying awareness on the ill-effects of tobacco, alcohol and all addictive substances, and with 60% of all target groups receiving materials created specifically for them

5. increasing positive health behaviours, including health seeking behaviour, as measured by knowledge, attitude and behaviour surveys

6. revising the National Guidelines of Nutrition by 2009, addressing the needs of specific groups, eg. children, adolescents, diabetics etc.

7. introducing physical activity as an examinable subject in all schools by 2010

8. continuing the implementation of the FCTC and meeting all requirements on a timely basis

9. establishing smoke-free zones and places by law by 2010

10. increasing taxes on tobacco products

11. expanding programmes for the development of healthy settings, including schools, markets, communities, workplaces.

1. Draft National Behaviour Change Communication Strategy for HIV and AIDS 2006-10, 2006

4. FINANCING THE SECTOR STRATEGY

Sector expenditure 2000-2006

The health sector has achieved significant increases in allocation over the years and now receives 10% of the total recurrent government budget. This is higher than most countries. The chart below shows the pattern of recurrent government expenditure for the period 2000-2006[1].

Year	2000	2001	2002	2003	2004	2005	2006
Health expenditure, (recurrent, G$m)	4,150	4,392	5,017	5,269	5,548	5,935	6,400
Government health expenditure per capita (G$000)	5.72	6.08	7.07	8.51	8.66	9.11	11.15
Recurrent Health expenditure as % of total govt recurrent expenditure	8.57	9.31	11.18	10.28	10.42	10.37	9.99

Current total sector expenditure 2005-7

Estimated percentage of GDP spent on health is also estimated to have increased to about 5.5% in 2006.

The chart below shows estimated annual total expenditure in the sector 2005-07 where assumptions have been made about out-of-pocket household expenditure, and capital expenditure has been broadly allocated to the various programmes. This illustrates the estimated total financial envelope of the health sector and highlights the unprecedented amount of external funding mobilised over the period of the NHP 2003-7. This level of funding is estimated to continue to 2008-9.

1. Public Sector Estimates, 2006

Sector expenditure by source: G$m

Current prices

	2005		2006		2007	
PHC, hospital services and administration[1]						
GOG	5,935	52%	6,400	49%	7,061	40%
MOH	1,577		1,700		1,876	
RHAs / RDCs	2,177		2,451		2,758	
GPHC	2,182		2,249		2,427	
private out of pocket	1,484	13%	1,600	12%	2,189	12%
Vertical programmes[2]	4,005	35%	5,097	39%	8,554	48%
GFATM HIV	428		503		736	
GFATM Malaria	57		95		95	
GFATM Tb	0		17		100	
World Bank	68		230		982	
USG/PEPFAR (discounted by 20%)	3,200		3,520		4,631	
USG/PEPFAR budget before discount	4,000		4,400		5,788	
IADB	251		732		1,637	
nutrition	139		182		407	
hsp	112		543		1,150	
app	0		6		80	
Other DPs	0		0		373	
total	**11,424**	100%	**13,097**	100%	**17,803**	100%

1 annual recurrent expenditure

2 combined capital and recurrent support

In 2006, government allocated approximately G$ 6,400 million (US$32m) to the sector to fund primary care and hospital services, other services and the administrative costs of the ministry and regions. An additional G$ 1,600 million was spend by consumers out of packet in the private sector. Also, Guyana received approximately $G 5,097 million in external aid to the sector although almost all of this is for one-off capital expenditure rather than annual recurrent expenditure (for salaries, drugs etc) and dedicated to specific diseases, mostly HIV. This all constitutes a significant increase in sector funding in recent years, both by government and by external aid.

Costs of improved services

Whilst G$ 6,400 million was available for personal health care services, more than this is needed to run current services satisfactorily. The chart below shows what it would cost if adequate numbers of staff were in place, and drugs and supplies available, removing the shortages that exist now. At 2006 prices, this would cost about:

- G$ 8,209 million to properly staff and run all health centres and hospitals as they currently exist, or
- G$ 7,398 million if health centres and hospitals were re-configured into a more efficient pattern (closing under-used facilities and concentrating resources in fewer centres then able to offer more staff, equipment and higher quality services).

These are respectively 28% and 16% more than current expenditure.

Annual recurrent costs of services, G$millions, 2006

	Actual expenditure	Needed with current beds and HCs	% change from actual	Needed with rationalised beds and HCs	% change from actual
PHC, hospital services and administration					
MOH	1,700	1,700	0%	1,700	0%
Regions	2,451	4,161	70%	3,276	34%
GPHC	2,249	2,348	4%	2,422	8%
Total	**6,400**	**8,209**	**28%**	**7,398**	**16%**

This highlights the fact that the current distribution of health care facilities is very inefficient. It results from historical reasons and is not optimal for the current distribution of the population or for modern clinical practice which demands more concentration of staff and equipment and which requires larger numbers of patients to ensure staff are busy and gaining maximum experience, and that expensive equipment is fully utilised. Yet it is very difficult to change, as proposed closures of under-used facilities are resisted by constituencies and their political representatives.

Over and above the costs shown in the chart above, however, significant additional expenditure would be required to make the health system adequate to meet the objectives of the NHSS 2008-12. In practice, skilled health workers will not be attracted or retained unless they are able to earn considerably more than they can now (see 3.2). The chart below shows the impact of this and other needs on the cost of providing services. It illustrates the consequences of a 50% increase in salaries and wages which, in practice would be achieved incrementally and negotiated by the RHAs and GHPC in return for productivity and quality gains.

The chart indicates the need for a 71% increase in total public sector expenditure on health assuming that, under pressure of contracting, RHAs and GPHC can reconfigure the services they provide to become more efficient.

It should also be noted that the external aid available to the sector does not help this situation very much since it is dedicated for specific diseases and is not available to fund the annual costs of running basic health and hospital services. The chart assumes only that external aid will fund excess HIV services costs including drugs, and new vaccines. Moreover, we do not know for how long such external financial assistance will continue, and we cannot plan on it always being available. In the future there may be more calls on our domestic health budget to fund HIV and other vertical programmes unless relevant services can become fully integrated into general health care services.

Further reduction in costs would be possible if external HIV aid were employed to fund the major increases needed in public education under the NHSS 2008-12, and for some decentralisation and M&E costs.

Annual recurrent costs of services, G$millions, 2006 to meet NHSS 2008-12 objectives

	Actual expenditure	Needed with current beds and HCs	% change from actual	Needed with rationalised beds and HCs	% change from actual
PHC, hospital services and administration					
MOH	1,700	1,700	0%	1,700	0%
Regions	2,451	4,161	70%	3,276	34%
GPHC	2,249	2,348	4%	2,422	8%
Total	**6,400**	**8,209**	**28%**	**7,398**	**16%**
Health system improvements					
productivity linked salary increase					
50% of salary/wages		3,078		2,774	
decentralisation and M&E					
5% of total services costs		410		277	
HIV drugs, laboratory, VCT					
0% funded by external aid		-		-	
excess HIV and TB case management					
1% of total services costs		82		74	
public education . . . behavioural change					
5% of total services costs		410		370	
new vaccines introduction					
0% funded by external aid		-		-	
community mental health					
1% of total services costs		82		74	
Total	**6,400**	**12,272**	**92%**	**10,968**	**71%**

Future financing strategy

No significant increase in government budget can be relied upon. Health must compete with other important needs like education, law enforcement, roads and coastal protection for its share of government expenditure. Any growth in government allocation to the sector is likely to come only from growth in the total government budget resulting from national economic growth.

If health services are to meet the needs and expectations of consumers, and contribute maximally to economic growth and poverty reduction, two things need to happen:

- more money must be found
- that money must be spent more effectively, with the proposed national health fund contracting service providers.

There appear to be two possible sources for additional financing in the sector. One will be to convince our Development Partners (who support us with external aid) that some of the money they provide us with should no longer be earmarked for their favourite diseases, mainly HIV, but must be spent to improve our general health services so that we can handle all diseases better and according to our actual disease priorities.

The second will be to raise additional domestic funding through new fiscal measures which may include:

- a dedicated health tax (for example on harmful consumer products like cigarettes, or a small percentage increase in sales tax on other selected items)

- user charges at health facilities
- introduction of a social insurance like contribution from income

or some combination of these directed into the national health fund and disbursed through the contracting mechanism described earlier.

Government will now embark on a sustained consultation process looking at options for financing health care in the future. Any financing arrangements will aim to ensure protection of the poorest from all costs, and protection of all from the catastrophic costs of major illness.

Annex 1: Ministry of Health lines of action to improve service delivery

The Ministry of Health has already implemented initiatives or lines of action within the five main components of the NHSS 2008-12 (section 2) and aimed at making progress towards the sector goals of improving equity of access, user friendliness, and quality of services, and accountability in those providing those services. Examples of these specific initiatives are outlined below.
These will be further articulated in the MoH Business Plan 2008-9.

Principle	Activity	Current Status
Equitable distribution of health services	1. Implementation of the **Package of Publicly Guaranteed Health Care Services**, ensuring it is fully in place by 2012, with at least 20% of facilities meeting the goal by the end of 2008 and 50% by 2010	This is to ensure that all citizens have access to basic health care services. The package is already available and is being distributed
	2. Development of (and agreed by Cabinet) a human resource training programme and a distribution plan in keeping with the staffing formulation guideline for Levels 1 to 5 facilities in the public sector by March 2008	A Health Workforce Strategic Plan has been developed as part of the NHSS 2008-2012. This is to be finalized by end of February 2008
	3. Continuing education for health care providers in the hinterland areas, particularly in the areas of MCH, IMCI, chronic diseases and malaria, HIV, TB and other infectious diseases	Continuous monitoring and enhancement of the skills of providers for MCH, HIV, TB and malaria in place
	4. Promoting development of **public private partnership**, including voluntary organizations, in developing new services and in bringing services to under-served areas	Already providing radiotherapy, dialysis, cardiac surgery, MRI and CT in Georgetown
	5. Improve the **national referral system** to ensure that patients receive services unavailable where they live	Weak system in place. Reorganized referral system to be in place by June 2008
	6. Further expand the medical transportation of patients from Regions 1,7,8 and 9 to Georgetown and within these Regions by combining the resources of Government and those of voluntary organizations such as Wings For Humanity and Remote Area Medical	Wings for Humanity has been assisting in Regions 1,7 and 8 and Remote Medical in Region 9. These have been mostly in intra-regional transport, but MOH will seek to engage them more in med-evacuation to city
	7. Expand further medical outreach programmes by integrating those organized by government (including those delivered by the Guyana Defence Force) with those organized by local and international organizations, and ensure the latter focus more in Regions 1,7,8 and 9 and parts of Regions 2,3,4,5,6 and 10.	Already being done, but arrangements are ad hoc. The MOH will formalize a medical outreach unit to mobilize local and international groups to extend services to under-served areas. thus addressing a major weakness in the sector, particularly in the hinterland regions.
		Improvement of transportation (vehicles and boats) and radio communication capacity planned for 2008 and 2009

Principle	Activity	Current Status
	8. Improve transportation capacity, particularly in Regions 1,7,8 and 9, ensuring availability of land and water transport	Already started and will be in place by end of 2008
	9. Ensure all health care facilities are equipped with communication capabilities, including telephones or radio sets and computers, as far as possible, by end of 2009	Already started and would be in place by end of 2008
	10. Create a **facility-specific essential medicine and commodity list** and	
Making services people focused and user friendly	1. Formalize **Guyana's Patient Charter**, establish it as a Regulation under the Ministry of Health Act by March 2008 and implement in all health facilities	Draft for Cabinet-subcommittee's consideration in January 2008
	2. Develop and implement a **patient unique identifier** system by January 2008 and make it compulsory by establishing it as a regulation under the Ministry of Health Act	For Cabinet subcommittee's consideration December 18, 2007
	3. Create **Patient Advocate** Position (both voluntary and paid) for all health care facilities. Paid and voluntary positions are to be located at the GPHC and all Regional Hospitals for all shifts, and voluntary positions are to be located at each community hospital and at large health centres	Already in place at GPHC A&E Department. GPHC to extend to MOPD, other clinics and wards incrementally January - June 2008. New Amsterdam to begin in January 2008 and MOH will ensure others throughout 2008.
	4. Develop and implement patient satisfaction survey tool for both out-patient and in-patient services, at both public and private health care facilities. This must be a continuous exercise at the GPHC and conducted periodically at all hospitals and at health centres throughout Guyana.	Survey tools are being finalized and use will begin in March 2008. This is informally in place at GPHC, but will formally be introduced at GPHC and New Amsterdam Hospitals by March 2008 and in all hospitals by the end of 2008
	5. GPHC and all Regional Hospitals to have a Hospital Information Desk to assist clients and visitors for the 8.00am to 4.00pm shift by end of 2008	Already exists at GPHC Exist presently at Skeldon Hospital
	6. Establish **Community Oversight Committees** to work with health care facilities to mobilize community support, effect liaison between care providers and the community, and provide feedback to the providers etc.	Already exists in ten communities.

Principle	Activity	Current Status
	7. Expand the **Health Facilitator** Programme to cover 50% of the communities in the ten regions by 2012. This is a person who has been chosen by the community and trained by the MOH to provide testing for pregnancy, glucose and blood pressure in a home setting. These persons do not receive a salary, but the cost of consumables and a small additional amount are paid by a mechanism agreed to by the community.	Already exists in ten communities.
	8. Facilitate formation of **patient support groups** for HIV, cancer, diabetes, hypertension	Ten support groups exist for HIV at this time
	9. Expand Youth (Adolescent)-Friendly Health Centre Initiative to cover at least 60 health centres and hospitals and a minimum of two per region by 2012	Twelve such centres have been established and MOH hopes to establish six more in 2008
	10. Ensure availability of TV and DVDs at health care facilities to provide patent information and education and awareness in all facilities, with at least 25% in place by end of 2008	An inventory is being completed, and the 2008 budget has catered for provision of TV and DVDs for some health facilities
	11. Introduce weekly and then daily TV, radio and periodic newspaper health information services by January 2008	The team has already been assembled and will begin immediately in January 2008
Improving quality of services	1. Licensing requirement for health care facilities, establishing minimum standards for physical, technological and human resources, requirement for standard operating manuals and establishment of inspectorate and assessment pre-requisites, to start in March 2008	The Health Facilities Licensing Bill has been passed by Parliament. The Regulations will be introduced as soon as Presidential assent is obtained. Inspections for 2007 have been completed
	2. Development and implementation of **standard treatment guidelines** for major diseases by the end of 2008	Already exists for HIV, TB, malaria, diabetes and hypertension Training has been completed. Guyana's proficiency testing is in place and its use

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	2. Development and implementation of **standard treatment guidelines** for major diseases by the end of 2008	Already exists for HIV, TB, malaria, diabetes and hypertension
	3. Formalization of ISO standards as minimum standard for laboratories in Guyana by June 2008. Introduction of proficiency testing is part of this requirement	Training has been completed. Guyana's proficiency testing is in place and its use will be promoted in 2008

Principle	Activity	Current Status
	4. Formal adoption of a Guyana Minimum Standard for the operation of a Blood Bank by March 2008	Already approved by National Oversight Committee for Blood Transfusion
	5. Establishment of the Guyana Quality Council to promote quality control and quality assurance in health facilities and services in Guyana by March 2008	To be formally established in January 2008
	6. Formalization of codes of conduct for all health care professionals in Guyana by June 2008	Already at AG's Office
	7. Enhancing the national surveillance system, computerizing its operation and ensuring timely flow of information	A national surveillance system has been producing weekly reports for malaria and daily reports for dengue and influenza
Enhancing accountability by service providers and by government	1. Annual review of the State of Health by broad stakeholder grouping, including the civil society within two months after the end of the year, beginning in 2008, particularly the State of Health pertaining to HIV, TB, malaria, cancer and chronic diseases	This is to be a public review
	2. Weekly epidemiological reporting in place at MOH for all major conditions, and release of annual surveillance reports for various conditions in Guyana	Already in place for malaria, TB and HIV and influenza and dengue. Improved surveillance for chronic diseases in place
	3. National Disability, Cancer and Chronic Diseases Register to be in place by end of 2008	Cancer Register functioning. Others have started
	4. Strengthening the National Oversight Committees for the review, monitoring and evaluation of programmes of national interest, such as blood transfusion, HIV, TB, malaria, chronic diseases, immunisation, PMTCT, cancer, mental health	MOH and PAHO have collaborated to establish focal points for the strengthening of these oversight groups and to assist in preparing reports for discussion
	5. Quarterly review of budget status at Ministry of Health and in all Regions by end of June 2008	This has been done on an ad hoc manner outside of the MOH
	6. Complete **service agreements** with GPHC, Region 6 Regional Health Authority and all the RDCs and institute quarterly reviews of the compliance with the service agreements by end of 2008	Completed with Region 6 and GPHC and in place for 2008. Now adapting for RDCs
	7. Make mandatory the provision of consumption reports for medicine and commodities within one week of the end of each month, starting in March 2008	In place, but not implemented as mandatory. Most regions are in non-compliance
	8. Implementation and rigid compliance with **Motor Vehicle Policy** starting in January 2008	Approved by MOH Policy Committee
	Computerization of the warehouse management system in the MOH and greater accounting for stocks at local level	Already in place at MOH. To be put in place at GPHC in 2008