GUYANA

COUNTRY COOPERATION STRATEGY

2010 - 2015

Renewed commitment to Primary Health Care

Pan American Health Organization

Regional Office of the World Health Organization

TABLE OF CONTENTS

GLOSSARY

AMRO/PAHO	Americas Regional Office of WHO/Pan American Health Organization
ARVs	Anti-Retrovirals
BBSS	Biological Behavioural Surveillance Survey
BPB	Biennial Program Budget
BWP	Biennial Work Plan
CAREC	Caribbean Epidemiology Centre
CARICOM	Caribbean Community
CBR	Crude Birth Rate
CCA	Common Country Assessment
CCH	Caribbean Cooperation in Health
CCS	Country Cooperation Strategy
CDC	Centers for Disease Control and Prevention (USA)
CDR	Crude Death Rate
CDs	Communicable Diseases
CFNI	Caribbean Food and Nutrition Institute
CHRC	Caribbean Health Research Council
CIDA	Canadian International Development Agency
CNCDs	Chronic non-communicable diseases
CO	Country Office (PAHO/WHO)
Coartem	Artemether-lumefantrine combination
CROSQ	CARICOM Regional Organization for Standards and Quality
CRS	Congenital Rubella Syndrome
CSWs	Commercial Sex Workers
DEC Salt	Salt fortified with diethylcarbamazine
DOTS	Directly Observed Treatment, short-term
DWSS	Drinking Water Surveillance Systems (Regional)
EAR	Epidemic Alert and Response
EB	Extra-budgetary
ECLAC	Economic Commission for Latin America and the Caribbean
EMT	Emergency Medical Technicians
ENSO	El Nino Southern Oscillation
EPHFs	Essential Public Health Functions
EPI	Expanded Program for Immunization
EU	European Union
FCTC	Framework Convention on Tobacco Control
FAO	Food and Agriculture Organization
GAVI	Global Alliance for Vaccines and Immunization
GDP	Gross Domestic Product
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GOG	Government of Guyana
GPHC	Georgetown Public Hospital Corporation
GSHS	Global School Health Survey
HCV	Hepatitis C Virus
HDI	Human Development Index
HIPC	Highly Indebted Poor Country
HIV/AIDS	Human Immunodeficiency Virus / Acquired Immunodeficiency Syndrome
HTLV	Human T-cell Lymphotropic Virus
IDB	Inter-American Development Bank
IHR	International Health Regulations (2005)
IICA	Inter American Institute for Cooperation in Agriculture
ILO	International Labour Organization
IMAN	Integrated Management of Adolescent Needs
IMCI	Integrated Management of Childhood Illnesses
IMR	Infant Mortality Rate
IUD	Intrauterine Device
JICA	Japan International Cooperation Agency

JMP	Joint Monitoring Programme for Water Supply and Sanitation (WHO/UNICEF)
M&E	Monitoring & Evaluation
MDGs	Millennium Development Goals
MDR	Multiple Drug Resistant
MICS	Multiple Indicator Cluster Survey
MMR	Maternal Mortality Ratio
MOE	Ministry of Education
MOH	Ministry of Health
MOSS	Minimum Operating Security Standards (UN)
MSM	Men who have Sex with Men
NBTS	National Blood Transfusion Services
NCDs	Non-Communicable Diseases
NDC	Neighbourhood Democratic Councils
NGOs	Non-governmental Organizations
NMR	Neonatal Mortality Rate
NHSS	National Health Sector Strategy
NPA	National Plan of Action
NRSC	National Road Safety Council
OAS	Organization of American States
ODA	Official Development Assistance
OS	Other Sources
OSH	Occupational Safety and Health
PAHO/WHO	Pan American Health Organization/World Health Organization
PEPFAR	President's Emergency Plan for AIDS Relief (USA)
PHCO	PAHO HIV Caribbean Office
PPES	Performance Planning and Evaluation System
PPGHS	Package of Publicly Guaranteed Health Services
PPP	People's Progressive Party
PRSP	Poverty Reduction Strategy Paper
PWR	PAHO/WHO Representative
RAVREDA	Amazon Network for the Surveillance of Antimalarial Drug Resistance
RB	Regular Budget
RDC	Regional Democratic Councils
RHAs	Regional Health Authorities
RTAs	Road Traffic Accidents
SBA	Skilled Birth Attendant
SSA	Special Service Agreement
STEPS	STEPwise Approach to Surveillance of NCD and Risk Factors
STI	Sexually Transmitted Infections
TB	Tuberculosis
TC	Technical Cooperation
TCC	Technical Cooperation among Countries
UG	University of Guyana
UN	United Nations
UNCT	UN Country Team
UNDAF	UN Development Assistance Framework
UNDP	United Nations Development Programme
UNDSS	United Nations Department of Safety and Security
UNICEF	United Nations Children's Fund
UNIFEM	United Nations Development Fund for Women
USAID	United States Agency for International Development
UWI	University of the West Indies
VC	Voluntary Contributions
VHL	Virtual Health Library
WB	World Bank
WHO	World Health Organization
WSP	Water Safety Plan

EXECUTIVE SUMMARY

The first Country Cooperation Strategy (CCS) between the Pan American Health Organization / World Health Organization (PAHO/WHO) and the Democratic Republic of Guyana covered the period 2003-2007 in line with the 2003-2007 National Health Plan. The implementation of the CCS was reviewed in March 2006. This CCS expired in August 2007 and this occasioned the need to revise the previous strategy.

Initially the intention was to update the recently expired CCS, given the changes in the national socio-economic environment over the last five years. However, the challenges of the on-going institutional arrangements for health systems and services development in Guyana pointed to the need to articulate a completely new strategy for the period 2010-2015. This also allowed for the utilization of the new CCS guidelines.

To address the gap between the end of the previous CCS (2007) and the commencement date for the new one (2010), a review of the health situation was undertaken to determine if there were any changes to the national health priorities. This review was necessary so as to have a sound strategic base for the development of the 2008-2009 BWP in the absence of an approved CCS. The Ministry of Health participated in this review and it was agreed that the health issues and challenges which guided the previous CCS still held true and should be used for the development of the 2008-2009 BWP.

The process for the current CCS was highly participatory, involving extensive strategic consultations with the Ministry of Health (MOH), other relevant Ministries, bilateral, multilateral and United Nations (UN) agencies supporting health development in Guyana. The CCS team, consisting of members from the three levels of the Organization (national, regional, and global), was led by the PAHO/WHO Representative (PWR) in Guyana.

Guyana, a country with an approximate population of 750,000 and 215,000 sq. km land mass, extends along the north–eastern coast of South America and shares borders with Venezuela, Brazil, and Suriname. It has the distinction of being the only English-speaking country in the South American continent, having been a former British territory. Consequently, Guyana is very closely linked to the English-speaking Caribbean, and the Caribbean Community (CARICOM) Secretariat is located in Georgetown, the capital city, in which 20% of the population resides. The country, with a sparsely populated hinterland, is divided into 10 administrative regions and the local government structure consists of 10 Regional Democratic Councils (RDC), 65 Neighbourhood Democratic Councils (NDC), six municipalities and 76 Amerindian Village Councils.

Since 1997, Guyana was classified as a Highly Indebted Poor Country (HIPC) and benefitted considerably from reduction of external debt from 122% of the GDP at the end of 2002 to 38% in 2008. The HIPC status has also facilitated the flow of a significant amount of resources into the country from many bilateral, multilateral, and international partners. The main multilateral agencies supporting the Guyana Health Sector Reform through infrastructural development and institutional strengthening include the Inter American Development Bank (IDB), World Bank (WB), the Global Fund to Fight against AIDS, TB and Malaria (GFATM), the Global Alliance for Vaccines and Immunization (GAVI), the Canadian International Development Agency (CIDA), China, Cuba, the European Union (EU), the United States Agency for International Development (USAID), Japan International Cooperation Agency (JICA), the President's Emergency Plan for AIDS Relief (PEPFAR), the USA Centers for Disease Control and Prevention (CDC), and UN agencies such as PAH/WHO; UNICEF, UNDP, and UNFPA.

The key challenges of aid flow and effectiveness include: multiplicity of international development and donor agencies operating in Guyana with different project management requirements and high transaction costs; weak mechanism for coordinating and harmonizing the aid flows into the country; limited efficiency of international cooperation programs, with need for better allocation of resources in accordance with the established priorities; concerns about sustainability of the health and related programs once donor funds are no longer available; weak mechanisms to

bring about real intersectoral partnerships; weak private-public partnerships for health development; and the country's limited capacity to effectively absorb the considerable amounts of donor funds.

Guyana's health care system is based on the primary health care principles, but there is a major challenge in ensuring equitable access to health care for populations in the hinterland (interior) due to limited infrastructure. Hence, the recent major paradigm-shift in the traditional role and function of the MOH from that of being the main provider of health care to regulator. In this new arrangement, the Regional Health Authorities (RHAs) are responsible for the provision of health care services.

The recent (2007) assessment of the Millennium Development Goals (MDGs), affirmed the likelihood of Guyana achieving the goals of eradicating hunger (Goal 1), universal primary education (Goal 2), gender equality (Goal 3) and environmental sustainability (Goal 7). The country, however, faces challenges in its efforts to achieve the goals of reducing child mortality (Goal 4) and improving maternal health (Goal 5), by 2015, despite spite high immunization coverage, improvement in the level of skilled attendance at birth, and improved access to health care.

Notwithstanding advances made by the Government in addressing the health situation, the public health challenges in Guyana remain considerable. While communicable diseases, including HIV/AIDS, malaria, tuberculosis and vector-borne diseases such as dengue continue to be challenging, chronic non-communicable diseases (CNCDs), as is the case with may many other Caribbean countries, represent a significant social and economic burden. Other life-style related problems such as substance abuse, injuries, and violence also present major public health challenges. Mental health issues, including suicide, are also areas of concern. Complicating the public health landscape are the so-called neglected diseases such as filariasis and geohelminthiasis.

Other key challenges that impact on quality, availability, and accessibility of health services, particularly in the more under-served hinterland regions, include inadequate health workforce, weak strategic planning and management processes, incomplete decentralization of health services, limited use of clinical protocols to support patient management, fragmented health information system, and limited use of available data for evidence-based decision making and policy formulation.

The Government of Guyana, in responding to these health challenges, has put in place the National Health Sector Strategy 2008-2012, which has four clear goals:

- Equity in distribution of health knowledge, opportunities and services
- Consumer-oriented services: people focused and user-friendly
- High quality services (and good value for money)
- Accountable providers and government

Taking into consideration the foregoing, and in line with national, subregional, regional, and global mandates, the PAHO/WHO's CCS for Guyana for 2010-2015, based on the Organization's core functions and comparative advantage, will support the government in addressing the identified five strategic priorities:

1. Strengthening health systems governance, organization and management based on the primary health care approach
2. Addressing the social and environmental determinants for improved health outcomes
3. Reducing the burden of diseases
4. Enhancing family and community health
5. Leadership and management for results

In support of these goals a number of legislative changes were introduced and a Package of Publicly Guaranteed Health Services was approved.

PAHO/WHO will, during the period of this CCS, support the Government of Guyana towards achieving the national health objectives. This will be done through the respective Biennial Work Plans (BWP) and by applying the six core functions of the Organization. Strategic approaches such as

strengthening alliances and partnerships, increasing resource mobilization (both internally and externally), applying innovative technologies, using strategic information for decision making, and facilitating technical cooperation among countries (TCC), will be employed in a mannerthat will promote the sustainability of health programs while maximizing the resources within the three levels of the Organization to better respond to the country's priority health needs.

MAP OF GUYANA

FOREWORD

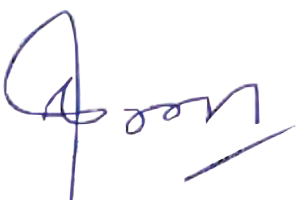
The Country Cooperation Strategy (CCS) represents a medium-term strategy for the technical cooperation of PAHO/WHO for and with its member countries. It is designed to respond to broad organizational strategic priorities and objectives as well as to national public health priorities as set out in the country's National Strategic Plan for Health.

This 2010-2015 CCS for Guyana is the second such framework and was developed after broad-based consultation with the national health authorities, other public sector entities and relevant national and international stakeholders. It was enriched by the involvement of all levels of the Organization. In so doing, the Organization is confident that it reflects the major public health issues in Guyana as well as the factors which predispose to those issues - the determinants of health. In addition, the in-depth analysis and consultation ensured that the strategic priorities and main areas of focus identified in the document along with the specific areas for action and the approaches to be used in addressing them, are tailored to the needs of Guyana. The findings from the evaluation of the first CCS also served to inform the substance and approaches set out in this current CCS.

The peculiar geographic and cultural make up of Guyana pose certain challenges for access to health care and considering this, the CCS is designed to address health systems strengthening based on primary health care. This is critical since the vast majority of the indigenous population live in the hard to reach hinterland areas - a consideration that was taken into account as the CCS sought to address issues of equity and social inclusion. For the same reason, the needs of other vulnerable and disadvantaged groups were also taken into account when developing the Strategy.

This CCS ends at a crucial time (2015), which represents the date for the countries to report on achievements in relation to the Millennium Development Goals (MDGs). The areas of focus identified in the Strategy as well as the emphasis placed on strengthening the country's ability to report on the health related MDGs should stand Guyana in good stead by the due date for delivering on those goals and targets.

Guyana is one of the priority countries identified by PAHO/WHO for particular attention and as such, no effort will be spared in ensuring that the resources necessary to achieve the stated outcomes defined in the CCS are made available from what ever source those resources could be found in the different levels of the Organization -global, regional, sub-regional and national. At the same time, bearing in mind the challenges which continue to confront public health globally and in the countries, special attention will be paid to mobilizing additional resources to ensure the successful implementation of the CCS.



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1. INTRODUCTION

The regional arm of the WHO for the Americas (AMRO/PAHO), has a long history of developing work programs for the countries based on the strategic directions of the Organization and an analytical process at the country level to determine the national health priorities in general and the specific ones to be addressed by PAHO/WHO in any given time period. The analysis of the situation, the identification of the national health priorities, and the technical cooperation initiatives and activities to address them are arrived at through a participatory process of all the partners (governmental and non-governmental) with which PAHO/WHO collaborates in the course of its operations at country level. This process, which is conducted every two years, saw improvements over time and was generally felt to be an effective approach on which to base PAHO/WHO's technical cooperation in the countries. The main limitation was that it was done on a short-term rather than a medium-term basis and was therefore not as strategic as it could have been. In addition, it did not include the synergistic approaches to be employed by different levels of the Organization in responding to the public health needs of the countries.

In 2000, WHO introduced the CCS approach to shaping and strengthening its response to countries in the medium term, usually 4-6 years. AMRO/PAHO, along with other WHO regions, embraced this new approach to framing and defining the response to all countries. The CCS therefore constitutes a critical part of the Organization's Country Focus as reflected in the WHO Country Focus Policy. The main tenets of this Policy are: core competencies and capacities of country teams; coherent programmatic and technical support from regional offices and headquarters; effective functioning of country offices; information and knowledge management to and from countries; and working with agencies of the United Nations (UN) system and other development partners. The CCS is also critical to the achievement of the Strategic Objectives of PAHO/WHO and will ensure greater alignment of the Organization's technical cooperation (TC) with the national agenda, and harmonization with the UNDAF and other major international commitments in health.

The articulation of the CCS is done at the country level, with the involvement of a multi-disciplinary team representing WHO Geneva, PAHO Washington DC, PAHO/WHO Country Office (CO), and a wide cross-section of national stakeholders and partners. The process allows for the identification of national priorities in health; the contribution of other partners, including UN agencies, in responding to the identified priorities; the ability of the national health system to address the priorities with its own resources; and most importantly, the comparative advantage of PAHO/WHO to support the country in addressing the critical health priorities identified.

Within this strategic framework, the first CCS for Guyana for the period 2003-2007 was developed using a participatory methodology involving the UN agencies, the national authorities, civil society groups, and non-governmental organizations (NGOs). This CCS was evaluated in March 2006 by the WHO Office of Internal Oversight Services to determine to what extent it was on track and whether the country's then Biennial Program Budget (BPB) was aligned with the Strategic Directions and Core Functions of the Organization. One of the main findings was that there was need for greater alignment of the BWP with the priorities identified in the CCS. This and other findings, as well as the corresponding recommendations, among other things, were taken into consideration in the articulation of this second iteration of the CCS.

There was a time lag between the end date of the first CCS and the development of the second one (December 2007 and December 2009). The Biennial Work Plan (BWP) for the Guyana Country Office for the period 2008-2009, developed during that time with the agreement of the national authorities, was based on the broad priority areas identified for the period 2003-2007 after establishing that the priority health issues remained the same. The BWP for 2008-2009 was predicated accordingly. Nevertheless, based on PAHO/WHO policy, it was imperative that the CCS be revised to more strategically inform subsequent BWPs.

While it was previously felt that an update of the

CCS would be sufficient, the initial discussion about the process quickly revealed that, in light of significant changes in the CCS guidelines, it would be necessary to formulate a new CCS. Consequently the entire process for CCS development was applied to the Guyana CCS for the period 2010-2015.

The starting point for the new version was a situation analysis to determine the national priorities and the extent to which those selected for PAHO/WHO's attention in Guyana were consistent with the regional, sub-regional, and global frameworks, mandates, and agreements for health development. Arriving at this involved an assessment of health and related aspects in which other UN agencies and development partners were involved in Guyana. Other agendas and frameworks which informed the CCS for Guyana included, but were not limited to: the draft Poverty Reduction Strategy Paper (PRSP), the National Health Sector Strategy 2008-2012; other national strategic documents in Health such as the NCD Strategy, the Mental Health Strategy and the Maternal and Child Health Strategy; the Millennium Development Goals; the 11th General Program of Work for WHO 2006-2015; the Health Agenda for the Americas 2008-2017; the WHO mid-term Strategic Plan (MTSP) 2008-2013; the PAHO Strategic Plan 2008-2012; the Port-of-Spain Declaration on CNCDs; the Nassau Declaration; the Report of the Caribbean Commission on Health and Development; the Caribbean Cooperation on Health - Phase III ; and the UNDAF for Guyana 2006-2012. Unfortunately, at the time of developing the CCS, the PRSP was not completed, but there was a strongly expressed view among UN agencies and other development partners that the global economic crisis in general, and in particular the recent increases in food prices, may have implications for poverty levels and the ability of the country to sustain the public health gains previously achieved.

The underpinning values of the Organization, including equity, social justice, social inclusion, excellence, solidarity, respect, integrity, human rights, and accountability, all served to inform the development of this CCS. It is in the spirit of such values that this Strategy sought to embrace the spirit of the Paris Declaration and strengthen the partnership and collaboration with other UN agencies and to give greater meaning to the UN goal of "Delivering as One".

The following sections of the CCS sets out the general socio-economic, health, and other development challenges in Guyana, as well as the national response; the response by development partners; and the strategic agenda for PAHO/WHO's engagement in technical cooperation in the country for the period 2010-2015. Many entities were interviewed and provided valuable inputs to the process of developing the CCS and the many documents reviewed provided useful material to guide the process. Despite this, it should be noted that obtaining supporting data on which to base the determination of national health priorities was not an easy task, since the information available was often fragmented and incomplete.

Nevertheless, no effort was spared in trying to ascertain that the information used was as accurate as possible. The publication of the National Statistical Bulletin, which fortuitously coincided with the CCS development, served to validate much of the health and related data and facilitated the development of a clear, concise and relevant Strategy for PAHO/WHO's technical cooperation for the next six years. The process followed in formulating at the CCS is described in Annex VII.

The CCS for Guyana was sent to and approved by the Ministry of Health. The Director of PAHO also approved and endorsed this second iteration of the CCS for Guyana for the period 2010-2015.

2. COUNTRY HEALTH AND DEVELOPMENT CHALLENGES AND NATIONAL RESPONSE

2.1 Socio-economic and Political Context

Political context

Guyana has the distinction of being the only English-speaking country in South America due to the fact that it was a former British territory which gained independence and became a republic on 26 May 1966. The country is a democratic republic functioning under a Westminster system of government. The legislative branch is represented by unicameral National Assembly comprised of 12 non-elected members and 53 members elected under a system of proportional representation. An executive president is both the Head of State and of Government. The country is divided into 10 administrative regions and the local government structure consists of 10 Regional Democratic Councils (RDC), 65 Neighbourhood Democratic Councils (NDC), 6 municipalities, and 76 Amerindian Village Councils. According to the existing government structure, the RDCs are administratively responsible for the delivery of services such as health and education to their respective populations.

Geographic profile

Guyana is approximately 215,000 sq. km (83,000 sq.miles), extending along the north–eastern coast of South America and sharing borders with Venezuela, Brazil, and Suriname. However, as a result of its historical and cultural development, Guyana is linked more to the English-speaking Caribbean than it is to countries of South America. In point of fact, the CARICOM Secretariat is located in Georgetown, Guyana. Notwithstanding, the well established links with the English-speaking Caribbean, the neighbouring South American countries are recognized as having the potential to become significant trading partners, and as a result, Guyana's relationship with them is likely to strengthen in the future. The hosting of the Rio Summit in 2007 signalled this possibility.

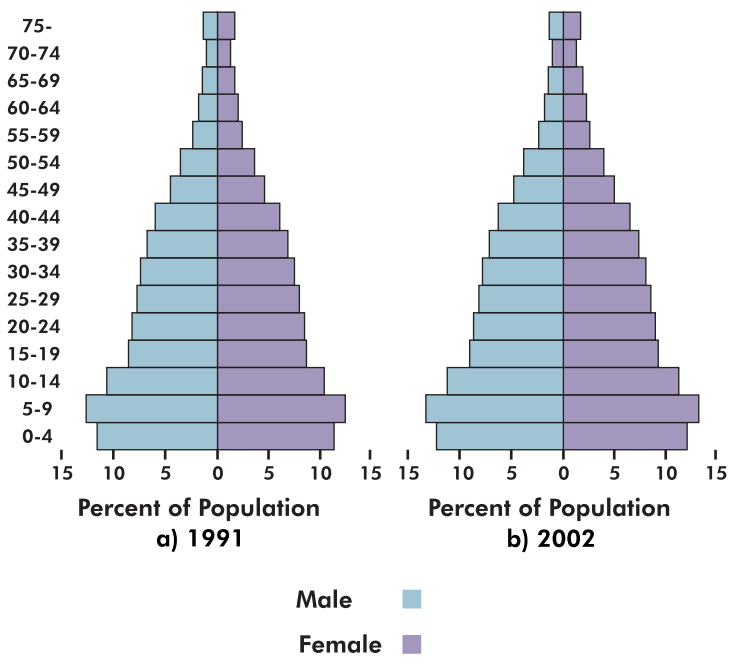
Georgetown, the capital, lies below sea level and as a result is prone to flooding, as highlighted in the 2005 floods which caused tremendous displacement, disease outbreak and economic loss.

Guyana can boast of 75% of its land mass being covered by pristine rain forest which, in the context of climate change concerns, could represent an important regional and global carbon sequestration to mitigate against the consequences of the climate change phenomenon. The national authorities are in the process of negotiating with other countries to ensure that the where-with-all is made available to protect this national treasure and environmental sustainability resource.

Demographic profile

The 2002 census recorded a population of 751,223, compared to the 1991 census of 723,673. The population pyramids for 1991 and 2002 (Figures 1a and 1b) from the Bureau of Statistics show distinct changes in the base of the pyramid with the biggest increase being in the 5-9 year age group. This has implications for education, health, and other social services.

Figure 1:
Population by age and sex
1991 and 2002



Source: Bureau of Statistics of Guyana

It is generally felt that these figures may be somewhat lower than stated due to the high rate of emigration. However, this will not be ascertained until the next census is conducted. According to the Economic Commission for Latin America and the Caribbean (ECLAC), almost 90% of Guyana's population lives along a narrow strip of the coastline which is the administrative, agricultural, commercial, and industrial hub of the country. The population of the capital city of Georgetown (156,000) comprises 20.7% of the total population. The interior is sparsely populated, with limited health infrastructure, and therefore poses tremendous challenges for access to health care and other essential services.

The 2002 census characterizes Guyana as having a multiethnic population with Indo-Guyanese representing 43.45%, Afro-Guyanese accounting for 30.20%, Amerindians representing 9.16%, and people of "mixed heritage" accounting for 16.73%. People of European and Chinese descent comprise a very small proportion of the overall population (0.07%).

As mentioned above, the population of Guyana is concentrated along the coastline (Regions 4 and 6), with 43.1% located in Region 4 alone. Region 3 is the third most populous, with almost 14%. Regional growth rates are highest for Region 8 (5.2% per annum), followed by Regions 1 and 9 with rates of 2.4 and 2.2 % respectively. The other regions have lower growth rates. In percentage terms the population grew by 3.8 % between 1991 and 2002, reversing the decline of -4.7% experienced between 1980 and 1991. The life expectancy at birth in years for 2002 and 2007 was 64.1 and 66.8, respectively. The Crude Birth Rate (CBR) was 17.1 per 1,000 population in 2007 and the Crude Death Rate (CDR) was 12.5 per 1,000 population for the same year. The total fertility rate in 2007 was 2.3, showing a downward trend from 3.1 in 1990.

Social context

Political, racial and ethnic tensions have erupted in Guyana from time to time. These tensions were significant prior to the 2001 general elections but less so in the run-up to the 2006 general elections, which were won by the incumbent People's Progressive Party (PPP-Civic). Crime has been identified as a matter of considerable concern and the potential for undermining development if it is not strictly curbed. Nevertheless, the social and political environment in which the CCS was developed was one of relative calm.

Marked disparities exist between coastal communities and the hinterland, especially as they relate to poverty levels, access to goods and services, employment opportunities, and income levels.

Economic context

The economy of Guyana is based on its abundant natural resources, including a fertile and productive soil, water resources related to many rivers and a continental shelf off the Atlantic coast, bauxite, gold and diamonds. In 2005, agriculture, forestry, and fishing accounted for 30.3% of the Gross Domestic Product (GDP), with sugar being the main contributor. Mining and quarrying accounted for 10.5%, followed by manufacturing 8%, and engineering and construction 6.2%. The remaining 45% of the GDP was attributed to services. Despite its abundant resources, Guyana is considered to be one of the poorest countries in this hemisphere and was, for some time, classified as a Highly Indebted Poor Country (HIPC). The per capita GDP in 2006 was US$974.90 and the country was ranked at 97 in the Human Development Index (HDI) by the UNDP in 2007, out of a total of 177 countries. The population group most affected by poverty and for whom issues of equity, access, and social inclusion are very germane is the Amerindian group. This group lives mostly in the country's vast under-developed interior (hinterland).

Poverty reduction has been identified by the government as a priority. The 2002 Poverty Reduction Strategy Paper (PRSP) examined how determinants of health outcomes affect the poor and proposed policies to address them. It also evaluated investments and policies for improving the health of the poor. Health and nutrition were key components of the PRSP and the role of health in development was underscored by both the PRSP and the National Development Strategy.

The recently published report on advances towards the achievement of the Millennium Development Goals (MDGs) noted that a number of

constitutional, regulatory, and institutional reforms were implemented by the government, and these served to undergird the economic progress made in the last half of the 1990s and prepared the stage for economic progress. Despite these efforts, the report further indicates that these recent reforms have not translated into growth, due to unfavourable developments in Guyana's external markets. The effects of two disastrous floods (2005 and 2006), internal political instability, and a protracted and destabilizing crime wave all contributed to depressing the economy, slowing the pace of policy implementation, and dampening the impact of reforms. These factors further led to slow progress towards the achievement of the MDGs.

2.1.1 Advances towards the attainment of the Millennium Development Goals

The most recent report on the progress of the MDGs in Guyana, compiled in 2007, concluded that on the whole Guyana has made reasonable progress towards achieving the MDGs and that while the goals that were on track remained unchanged from the MDG assessment done in 2003, improvements in specific targets have strengthened the likelihood that they will be achieved. The report summarizes the likelihood of the MDG goals/targets being achieved by 2015, as shown in the table below.

A detailed analysis of the health-related MDGs such as child mortality, maternal health, HIV/AIDS, TB, malaria and environmental sustainability can be found in the following chapter of this document.

GOALS	TARGETS	Likelihood of achievement by 2015
Goal 1	Target 1: Eradicate Extreme Poverty	Potentially
Goal 1	Target 2: Eradicate Extreme Hunger	Probably
Goal 2	Universal Primary Education	Probably
Goal 3	Promoting gender equality & empowerment of women	Probably
Goal 4	Reducing Child Mortality	Unlikely
Goal 5	Improving Maternal Health	Unlikely
Goal 6	Target1: Combating HIV/AIDS	Potentially
Goal 6	Target 2: Combating Malaria & other major diseases	Unlikely
Goal 7	Ensuring environmental stability	Probably
Goal 8	Not assessed	-

Source: Guyana's MDG Progress Report, 2007

2.2 Health Status of the Population

Overview

The epidemiological transition being experienced by most countries in the Caribbean region also characterizes the health trends in Guyana. That is to say, while some communicable diseases (CDs) still present formidable challenges to the health status of the population, the movement is towards the non-communicable diseases (NCDs), which account for the highest burden of mortality and morbidity. In addition, Guyana, like other countries in the region, is vulnerable to global epidemics and environmental threats.

While there have been undoubted advances in the network of health services in the periphery, access to health care in the more remote regions of the country such as Regions 1, 7, 8 and 9 makes equity in health for many indigenous persons tremendously challenging. This is due to the fact that these communities are very difficult to reach, and therefore delivery and monitoring of health services are extremely problematic.

Among the main factors affecting the health services as a whole are considerable systemic issues regarding availability and use of information to support decision-making in health. While a great deal of data is collected on a routine basis, these are not organized into a coherent system to facilitate ease of analysis across health disciplines and programs.

Figures 2a and b show the major causes of death by age groups in both males and females for 2006. Of note is the number of suicides which took place among the young female and male populations. Further analysis to determine causes would be helpful to inform appropriate interventions.

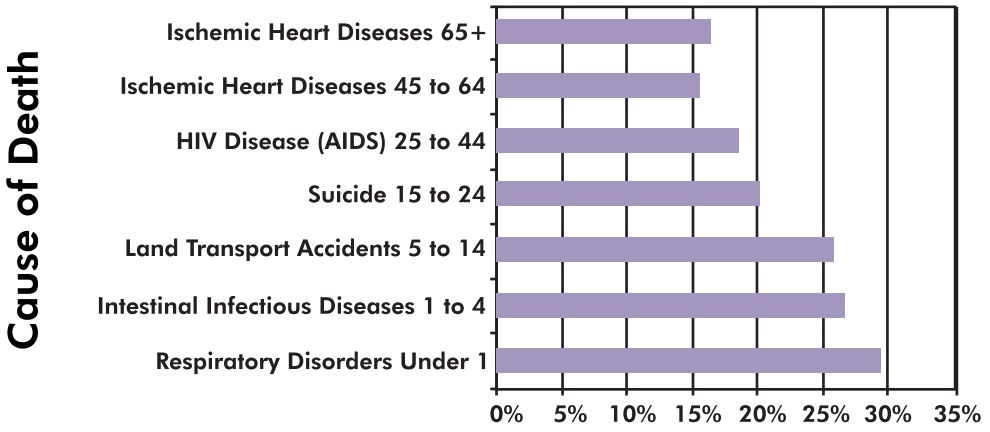
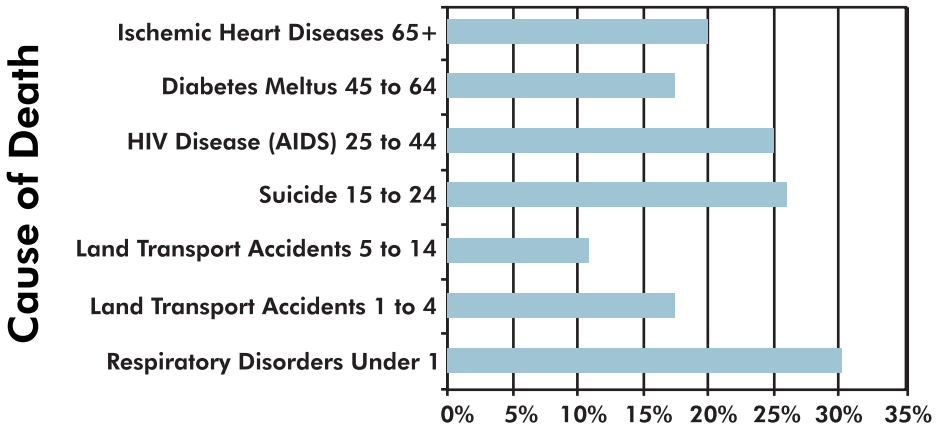


Figure 2:
Major causes of death by age and sex, 2006
(Left - Male; Right - Female)

a) Males



b) Females

Source: National NCD Strategy Document, 2007

2.2.1 Communicable Diseases

The main communicable diseases of concern to Guyana are HIV/AIDS, malaria and other vector-borne diseases such as dengue and filariasis. TB continues to be of concern in and of itself as well as in association with HIV/AIDS infection.

HIV/AIDS

The first case of AIDS was reported in a male homosexual in 1987 and a cumulative total of 5,429 AIDS cases had been officially reported to the MOH by the end of 2006. Although the HIV epidemic is generalized, a prevalence of greater than 1% has been consistently found among pregnant women attending antenatal clinics, while the prevalence is higher among specific sub-populations such as female sex workers, men who have sex with men (MSM), patients with sexually transmitted infections (STI), and prisoners. According to the Biological Behavioural Surveillance Survey (BBSS 2005), the prevalence among commercial sex workers (CSWs) and MSM in the capital city was 26.6% and 21.2% respectively. In 2007, a further BBSS revealed a prevalence of 5.24% among prisoners nationally. Among STI patients, the prevalence of HIV infection in males increased from 13.2% in 1992 to 17.3% in 2005, while for females, it increased from 6.7% in 1993 to 16.9% in 2005 (MOH). It can be concluded that while HIV appeared to have been more prevalent among males, the disease has been transmitted to increasing numbers of women. In 2003, the number of reported cases of HIV was higher among women and this trend has remained constant to date. According to national reports over the last five years, the epidemic in Guyana is showing a tendency towards stabilization, with a peak in 2006 (1258 cases), 993 cases were reported in 2007, while 959 cases in 2008. Young people (20-49 years) continue to be most affected, representing 81.51% of cases in 2008. Based on the data available from the MOH for 2006, there was a combined total of 25 HIV and AIDS cases reported among children aged 0-4 years. This represented 1.7% of the total HIV and AIDS cases for that year. The highest number of HIV cases occurred in the 30-34 and 34-39 year age groups during the same year. Low numbers of HIV/AIDS cases were reported among the elderly (aged 50 and above), with 1% of AIDS cases occurring in this age group in 2006. Cumulative data on AIDS cases from 1989 to 2006 indicate that Region 4 accounts for 68.96% of all cases, although that Region accounts for 41.3% of the total population. The proportion of all deaths attributable to AIDS has been declining from 475 in 2002 to 360 in 2005, a period that coincided with the introduction of anti-retrovirals (ARVs). There is a vigorous National HIV/AIDS Program (NAP) which is largely responsible for the successes to date. However, the HIV/AIDS program in general is confronted with formidable challenges, not least of which is the issue of stigma and discrimination. A concern for sustainability is the fact that most of the national response is funded with external resources.

Tuberculosis (TB)

The reported incidence of TB in Guyana was 91.7 per 100,000 population, and out of 701 new cases diagnosed in 2007, 198 were co-infected with HIV, which represented an estimated prevalence of HIV among TB patients of around 28%. A proposal prepared for Round 8 of the Global Fund in 2008 pointed out that while the case detection rate has improved, it was still lower than acceptable, and that treatment success was severely hampered in part due to serious problems with the DOTS coverage which also contributed to a 26% default, considered to be very high.

According to recently submitted data from the National TB Control Program to the WHO, at the end of 2007 the National TB Control Program had 14 TB basic management units, all of which were in the process of applying DOTS. These 14 units are a part of the general primary health care network in Guyana and provided treatment to clients in 2007. It was acknowledged that while DOTS had expanded to all ten administrative regions of the country, the needs of vulnerable and high-risk populations were inadequately addressed. Information was not available on multiple-drug resistant (MDR) TB, and given the dire consequences this lack of information could have, there is need for urgent research and attention.

Malaria

Malaria is endemic in Guyana, mainly in the interior regions (1, 7, 8 and 9). The migrant populations, primarily miners, and Amerindians are by far the most affected groups. This condition

seems to affect many more males than females at a ratio of almost 4:1 (males 78.2 % and females 21.8%). PAHO's Regional Strategic Plan for Malaria in the Americas 2006-2010, which is strongly aligned with strategies advocated by the WHO Global Malaria Program, and which focuses on the achievement of the Roll Back Malaria objectives and the UN Millennium Development Goals, is the basis for the National Malaria Control Program being implemented in Guyana. The implementation of this Program is made possible with extra-budgetary resources from the USAID through the Amazon Malaria Initiative / Amazon Network for the Surveillance of Antimalarial Drug Resistance (AMI/RAVREDA), the Global Fund, and the EU. PAHO/WHO successfully provided technical support for the development of proposals submitted to the Global Fund for Rounds 3, 7, and 8. This, along with other anticipated support, should guarantee funding for malaria control for the duration of this CCS.

The epidemiological profile of malaria in Guyana changed considerably to reflect a significant reduction in the total number of cases since 2000. The official report for 2007 indicated that there were 11,657 cases during that year, representing a 51.5% decrease in the total number of cases when compared with the year 2000, when 24,018 cases were reported. In addition, there has been a marked decrease in malaria-related mortality, from 34 deaths in 1998 to 10 in 2007 – a reduction of 71%.

Regarding the specific species, official reports show that in 2007, *P. falciparum* was 58% less than in 2006, while *P. vivax*, *P. malariae,* and mixed infections were 43%, 61%, and 34% less, respectively. This trend continues and is believed to be attributable to the community-based interventions initiated by the MOH and supported by PAHO/WHO. In addition to community-based interventions, since 2005 Guyana changed its treatment policy for uncomplicated cases of malaria and is now using artemether - lumefantrine combination (Coartem) as the first line treatment of choice for *P. falciparum* infections. Alternative interventions for vector control with impregnated mosquito nets and the integration of the malaria vertical programme into the Regional Health Services (primary health care) were also features of this revised policy. Further, the malaria surveillance system has been decentralized to the endemic regions and prioritized actions taken through the establishment of stratified localities. The malaria program is the only public health program that routinely collects and analyzes data, and produces weekly reports, which facilitates evidence-based planning and management at the local and central levels.

Not only has the program been concerned with the coverage, but with the quality of diagnosis as well. In this regard, the standard operational procedures for malaria microscopy diagnosis and quality control were initially developed and implemented by the Malaria Program with support from PAHO/WHO utilizing RAVREDA resources.

Dengue

Dengue is another vector-borne disease that is endemic in Guyana. While the reported cases may fall somewhat short of the reality, a total of 248 cases were reported by MOH in 2006 and 352 in 2007. Of the latter, 46% were female and 54% male, with most of the cases being from the coastal areas of Regions 1, 3, 4 and 9. So far, there have been no reported deaths from dengue hemorrhagic fever. However, serotypes 1 and 2 were identified through laboratory diagnosis by CAREC in 2000. The main control methods used are entomological surveillance to monitor larval and adult vector populations in order to maintain the adult *Aedes aegypti* mosquito population at a level below which the dengue virus could be transmitted. Pursuant to recent outbreaks, the MOH, with support from PAHO/WHO, developed and initiated the implementation of an integrated vector control strategy for the country. Also, PAHO/WHO will support the country in the development of a National Integrated Management Strategy for prevention and control of vector-borne diseases. This strategy will incorporate not only the vector control issues, but also the clinical management, laboratory performance, communication, surveillance, and environmental management.

Geohelminthiasis

A study was conducted by the MOH in 2005 to determine the concentration of geohelminths in Guyana. The findings showed that the highest

levels of concentration were in Regions 2, 4, 9, and 10 (14,814 cases). Twenty-seven percent of children under 5 years of age were reported infected in that study, with females having a greater distribution than males in all age groups. The MOH developed a de-worming program to respond to this issue. In this program every family member, with the exception of pregnant and lactating women and infants under two years of age, is to be given a single dose of albendazole and diethylcarbamazine. This program represents a community-based initiative and commenced in Region 5 in November 2008; and was scheduled for completion in all 10 regions by June 2009. The MOH plans to carry out this program of mass drug administration once per year for the next four to five years.

Filariasis

The program for the elimination of filariasis provides clinical and parasitological diagnosis and treatment for all patients seen and referred to the health centres. The objective is to detect, through passive case detection, the presence of asymptomatic and symptomatic carriers of filariasis, diagnosed by thick blood smears, collected for three consecutive nights.

Using school children, Guyana completed, filariasis mapping in all regions in 2001. This mapping exercise revealed that, countrywide, 9.3% of this population was positive. The distribution was mostly in the urban areas: Georgetown, New Amsterdam, and Linden. However, Regions 2, 3, 4, 5, 6, and 10 were also affected. The number of diagnosed cases decreased from 42 in 2006 to 31 in 2007. There are two sentinel sites for surveillance of filariasis and the morbidity reported in both sites was: lymphedema in 2.4% in 2003 and 0.6% in 2006, and hydrocele 1.7% 2003 and 0.2% in 2006. The data showed that persons of African descent were the most affected group, with 85.7% in 2006 and 77.4% in 2007. The prevalence was more in males than in females (88.1% in 2006 and 85.1% in 2007).

A Phase I Plan for transmission interruption for the period 2003 to 2007 was developed by the Ministry of Health. The main activities covered by this Plan were: social mobilization, the promotion and use of DEC salt, and monitoring. Work has already commenced on the development of a Phase II Plan for the period 2008-2010 that aims at elimination of the disease. This second phase will evaluate Phase I, identify "hot spots", implement Mass Drug Administration with DEC tablets and albendazole, and undertake monitoring and evaluation.

Leishmaniasis

The number of accumulated cases from 2002 – 2007 was 56, from the total number of 136 examinations done by cutaneous laboratory microscopy. Only one visceral laboratory microscopic examination was done and it was positive. Patients suspected of leishmaniasis are referred from the Army Medical Centre and the Palms Skin Clinic to the laboratory at the Malaria Clinic for diagnosis. Patients diagnosed positive or negative are sent back with their results to their health facilities for treatment and follow-up care. The objective of the programme is to undertake research and to provide critical clinical and diagnostic data for the control and management of leishmaniasis, and to determine the prevalence and distribution of the disease.

Chagas' disease

In the past Chagas' disease was not given much attention in Guyana, and therefore the magnitude of the problem was not known. However, in 2008 a system for screening all blood for Chagas' was introduced at the National Blood Transfusion Services (NBTS). This revealed that of the first 1,000 samples screened, 5 were reactive. Given that these cases had no history of contact with border areas where the risk of exposure would be considered high, the national health authorities have expressed concern and will continue to collaborate with Brazil to monitor the quality of screening and to build capacity in Guyana for managing this emerging health issue. The MOH has mandated that all blood collected at private facilities be screened for this disease. Early indications suggest that this may well become an important public health issue for Guyana in the years ahead.

Blood safety

The MOH, with financial support from PEPFAR and

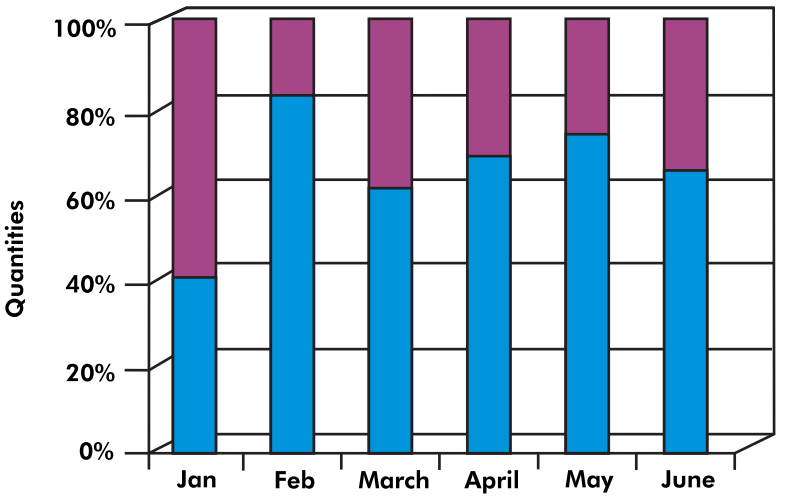


Figure 3:
Voluntary vs Replacement Blood Donations, 2008

Source: National Blood Service monthly reports

technical support from PAHO/WHO, has made safe blood a priority and plans to reach the target of 100% voluntary blood donations by 2010 seem feasible. However, there are many systemic challenges, not least of which involves human resources, that could well militate against the realization of this target.

The NBTS has been strengthened to screen all blood collected for HIV, HBsAg, HCV, HTLV, syphilis, malaria, filaria, and Chagas'. Blood is also collected and screened in private health facilities, but these are ill equipped to screen for all markers. Specifically, they are unable to screen for Chagas' and HTLV. Consequently, the MOH has adopted the position that by March 2009 all blood must be screened at the NBTS and that mechanisms will be put in place to ensure compliance. The Guyana Red Cross Society is also involved in blood donation drives, but not to the same extent as the NBTS. Figure 3 shows the disparity between blood donated by voluntary means and that donated for replacement purposes.

International Health Regulations (IHR, 2005)

Guyana, like most countries, committed itself to the implementation of the IHR (2005) from the time of its enforcement. To this end, a focal point was appointed and a national committee to coordinate the activities leading to the full implementation was established. A comprehensive assessment was conducted in October 2008 to determine the core capacities for surveillance and response, as required by the IHR 2005. This was done through collaboration with international experts from the Public Health Agency of Canada, PAHO/WHO, and the national authorities. The results of this assessment indicate that case investigation and response are among the weakest areas. Further, that the core functions of surveillance (detection, confirmation, reporting, data analysis, feedback, and response) are not performed systematically and therefore need to be improved. Activities aimed at establishing and strengthening these capacities were prioritized in a Plan of Action developed by national authorities.

There are valuable human resources at the Surveillance Unit in Guyana, who, with appropriate training, could go a long way in strengthening and improving the performance of the national surveillance system. The national legislation supporting communicable disease surveillance in Guyana needs to be updated in order to meet the obligations of the IHR, including updating and extending the list of notifiable diseases to include the reporting of unusual or unexpected events as defined by the IHR 2005. Dissemination of the national regulations and implementation of surveillance activities required by national legislation also need to be strengthened. Scaling up of activities to increase understanding and commitment of stakeholders at all levels for implementation of the IHR is required under the leadership of the health authorities. A further assessment to determine the national capacity for surveillance and response at airports, sea ports, and ground crossings was recently conducted and, along with the previous assessment, provides a more complete picture of the national capacity and gaps to be addressed.

2.2.2 Non-Communicable Diseases and Risk Factors

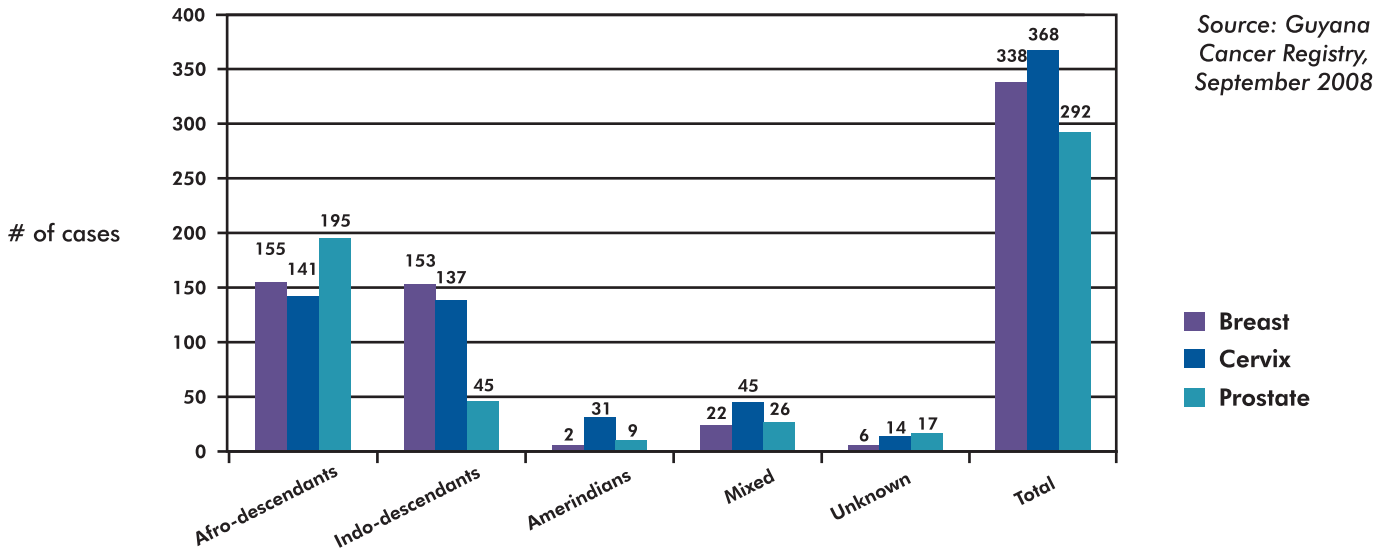
Chronic non-communicable diseases (CNCDs)

Guyana, like many other Caribbean territories, is burdened by high prevalence of CNCDs, which constitute the leading causes of death. In 2003, cerebrovascular diseases ranked as the number one cause of death, with ischemic heart disease ranking second, and diabetes and hypertension ranking 5th and 7th respectively. Diabetes is considered to be a major cause of not only mortality but morbidity as well. There is an average of 8,000 new cases reported each year and approximately 74% of all persons with diabetes are in their productive years of life (under 65 years), with twice as many females as males being affected. Hypertension is also a very prevalent disease in Guyana, with around 15,000 new cases being diagnosed each year, showing a high prevalence in people over 50 years of age and being associated with high mortality. Interestingly, intentional self harm (suicides) ranked as the 6th leading cause of death in 2003 and assault / homicide ranked 8th in the same year. Cancer is another chronic disease that is frequent, with the incidence rate in the period 2000-2004 showing an increasing trend. The most frequently occurring cancers are breast, prostate, and cervix – accounting for incidence rates of 85, 72 and 64 / 100,000 population, respectively, as opposed to 54, 53, and 27 in 2000. Information from the Guyana Cancer Registry on the number of reported cancer cases by type and ethnicity is shown in Figure 4.

Results of the Food Consumption Survey conducted in 2006 showed that overweight and obesity were increasing in the population, with 53% of adults being overweight or obese. Significantly more women than men were obese (27.4% and 10.5%, respectively). The report also showed that the prevalence of obesity increased with age – 32% of persons 50-64 years of age were obese. Given that obesity is a strong risk factor for almost all CNCDs, a well-coordinated strategy to address this is critical.

Another risk factor of some concern in Guyana is *tobacco use / smoking*. Data from the 2004 Global Youth Tobacco Survey revealed that 17% of students were current users of tobacco products, with only 29.5% of them never having tried smoking. At present, the Government of Guyana is working to further enact its commitment to implement the Framework Convention on Tobacco Control (FCTC). A National Tobacco Control Council was established in 2006 to coordinate the tobacco control initiatives in Guyana. The Council has developed a draft Plan of Action to guide its activities. High on the agenda of this Plan are the FCTC time-bound obligations (Articles 11 and 13) which are aggressively being pursued. Through Ministerial decree, schools and Ministry of Education (MOE) facilities and activities have been declared smoke-free environments, and through the Health Facilities Licensing Act (2008), all health

Figure 4:
Reported cases of cancer, January 2004 - December 2007



Source: Guyana Cancer Registry, September 2008

facilities (public and private) have been mandated smoke-free zones. Bupropion, a tobacco cessation drug, has been included in the Essential Drug List and will be provided free of cost in the public sector. Treatment for nicotine addiction has also been integrated in the health services.

At the Caribbean regional level, Guyana has been providing leadership and technical cooperation to the CARICOM Regional Organization for Standards and Quality (CROSQ) to advance the regional standards for the packaging and labelling of tobacco products in keeping with the FCTC Article 11.

A Physical Activity Survey undertaken by CFNI reported that 43.6% of the overall population consumed alcohol, with significantly more male consumers than females (73% vs. 28%). Among adolescents, 2.1% regularly, and 32% occasionally, drank alcohol. Anecdotally, alcohol use has been linked to domestic violence and suicide. Legislation regarding drinking and driving was recently prepared and received parliamentary sanction.

In keeping with the commitments of the Port of Spain Declaration on the fight against CNCDs, agreed by all CARICOM Heads of Government in 2007, Guyana has developed a Strategic Plan for the Integrated Prevention and Control of Chronic Diseases and their Risk Factors. The country has also established a multi-sectoral National CNCD Committee.

Injuries and violence

Road traffic accidents and the resulting injuries and deaths represent considerable public health concern for Guyana. The National Road Safety Council (NRSC), which was revitalized in 2006, reported at its 2008 Annual General Meeting that 2007 recorded the highest number of fatalities due to road traffic accidents in over a decade, when there were approximately 209 fatalities on the national road network. The Council is pursuing the development of a Strategic Plan for the reduction of road traffic events leading to injuries and deaths. Recent measures to curb road traffic accidents include the introduction of a seat-belt law, the use of helmets for motorcycle riders, the prohibition of the use of cell phones while driving, banning loud music on public transport which could be a distraction to drivers, breathalyzer tests, and speed control devices. However, the enforcement of these measures is variable.

According to the recently published National Policy on Domestic Violence (2008), domestic violence is the most pervasive form of inter-personal violence in Guyana. To address this problem, the GOG recently introduced an Act which is deemed to be an important mechanism towards the redress, reduction, and elimination of domestic violence in Guyana. It is recognized that the cases reported through official channels only represent the proverbial tip of the iceberg.

The National Policy on Domestic Violence advocates for the provision of appropriate health interventions, inclusive of referrals for counselling for victims and offenders, shelter, and other forms of assistance. The Policy calls for generalized education and sensitization regarding the issue of domestic violence to involve the general public, health care providers, and security personnel. It also seeks to improve reporting of cases through standardized reporting mechanism done in a manner to ensure victims' confidentiality.

Mental health and substance abuse

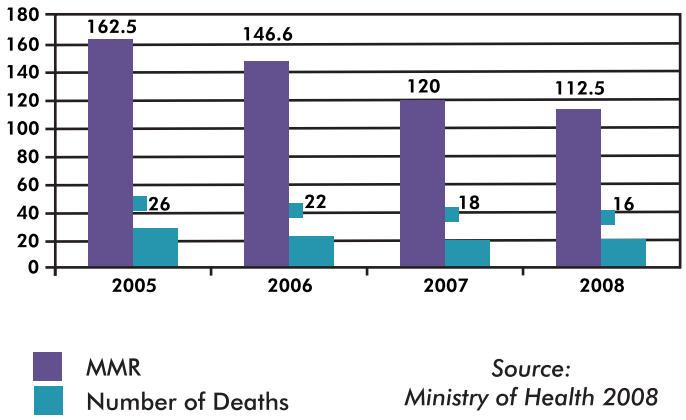
While reliable data for mental illness in Guyana are lacking, there is national consensus that this represents a significant public health challenge for the country. In addition to the traditional mental disorders, the country is now plagued with mental health issues that result from substance abuse. An indication of the severity of this problem is the high suicide rate, accounting for 13% of all deaths and estimated to be the third-leading cause of death among those 15-44 years of age. The mental health facilities in Guyana offer less than optimal services and there are only two qualified psychiatrists in the country.

Alcohol and other forms of substance abuse are considered to be serious problems. A national survey among school children showed that 11.6% had used marijuana or other drugs at least once, and one in three students had consumed alcohol at least once, while 50% had their first drink before 13 years of age (Global School Health Survey, Guyana Report 2004). A National Drug Strategy Master Plan (2005-2009) was developed and provides the

framework for the response by various public sector entities and NGOs such as the Salvation Army and Phoenix Recovery Program, which are the only two agencies providing in-patient services.

The country's capacity to effectively address these problems is very limited. There are only 0.5 psychiatrists per 100,000 population to provide specialist mental health services which is significantly below the world reference average of 4.2 per 100,000 (WHO, 2005). In order to build national capacity in this area, the Ministry of Health entered into a bilateral arrangement with the Dalhousie University of Canada, which is also a PAHO/WHO Collaborating Center.

Figure 5:
Maternal Mortality Ratio in Guyana, 2005 - 2008



Source: Ministry of Health 2008

2.2.3 Maternal, adolescent and child health

Maternal mortality

While maternal mortality still remains a public health concern in Guyana, it has been steadily reducing over the past few years. Ministry of Health reports show that there was a reduction from 162.5 per 100,000 live births in 2005 to 120 in 2007 and 112.5 in 2008, as shown in Figure 5. The regions that continue to show high rates of maternal mortality are Regions 4 and 6. According to the MOH, the leading causes of maternal mortality are hemorrhage and toxemia during pregnancy, which account for over 50% of deaths. Other causes include complications of the puerperium, malaria, and ectopic pregnancy.

According to the 2006 Multiple Indicator Cluster Survey (MICS), nationally, 81.4% of pregnant women received antenatal care from skilled health personnel (doctor, nurse/midwife, medex). However, this was considerably less in the hinterland (57.7%). The study also reports that overall, almost 83% of all deliveries were done by a skilled birth attendant (SBA) while the level in the hinterland was 56%. This raises questions about equity, availability and access to care.

The quality of care has been identified as the main factor contributing to the high MMR. This can be substantiated by the fact that most women die in a health care facility, with the majority of deaths occurring at the referral hospitals, which receive the most complicated cases. Other factors contributing to this situation include shortage of skilled professionals, inadequate referral and communication systems, geographic barriers, and other systemic limitations.

Sexual and reproductive health

The 2005 total fertility rate in Guyana stood at 2.5, down from 3.1 in 1999. In 2004, approximately 20% of all births were to women under 20 years of age, with 3% to girls under 16 (Health in the Americas, 2007). According to the 2006 MICS, only 34.2% of women in Guyana reported using any method of contraception, with the most common being the pill, which accounted for 13% of all contraceptives used in the country. There was 6% use of the male condom and intrauterine device (IUD) each, followed by injections (4%), implants (3%), and female sterilization (2%).

Contraceptive prevalence was lower among women from the interior (29%) compared to urban women and women from rural coastal areas (34% and 35% respectively). Overall, only 20% of young women aged 15-19 years use any form of contraceptives.

Sexual practices among the very young present a major problem since they are exposed to the consequences of risky sexual behaviours and unwanted teenage pregnancy. The GSHS / Guyana showed that 25% of all students have had sexual intercourse. Of these, 23% had their first sexual experience between ages 13-15, and 39% had done so by age 16 or older. In addition, 16% of students had sexual intercourse with multiple partners.

Infant and child mortality

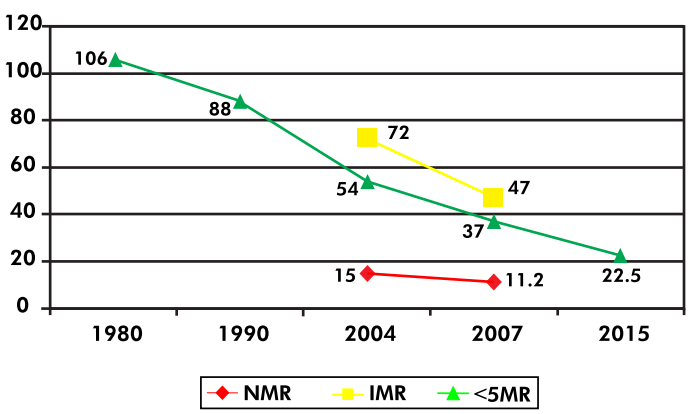
The MICS 2006 reports that the infant mortality rate (IMR) has significantly reduced from 54 per 1,000 live births in 2000 to 37 per 1,000 in 2006. If this trend continues, the country is likely to achieve the MDG target of 50% reduction by 2015. The hinterland regions have the highest rates of infant mortality and this could be mainly attributed to the remoteness of these regions. The MOH is making considerable efforts to improve relevant service delivery.

The neonatal mortality rate was 15 per 1,000 live births in 2004, with 72.3% of newborns dying within the first 28 days. Low birth weight increased from 11.2% in 2000 to 18.9% in 2006 and was considered to be the greatest risk for neonatal mortality.

The Under-five mortality rate reduced from 72 to 47 per 1,000 live births in the period 2000-2004. The government has been implementing the IMCI strategy over the last few years to address child morbidity and mortality in the country. Figure 6 shows the comparison among IMR, NMR and Under-5 mortality rates and Figure 7 shows the main causes of infant mortality.

The leading causes of deaths in children under five years of age were conditions originating in the perinatal period (47.3%), intestinal infectious diseases (11.6%), congenital malformations (10.0%), influenza and pneumonia (6.3%), HIV/AIDS (4.6%), malnutrition and nutrition anaemias (3.2%), septicaemia (2.1%), events of undetermined intent (1.4%), fluid/electrolyte disorders (1.0%), and land transport accidents (1.0%). The situation is compounded by shortage of skilled professionals, and inadequate supplies and diagnostic services in remote areas.

Figure 6:
Comparison of IMR, NMR and Under 5 Mortality



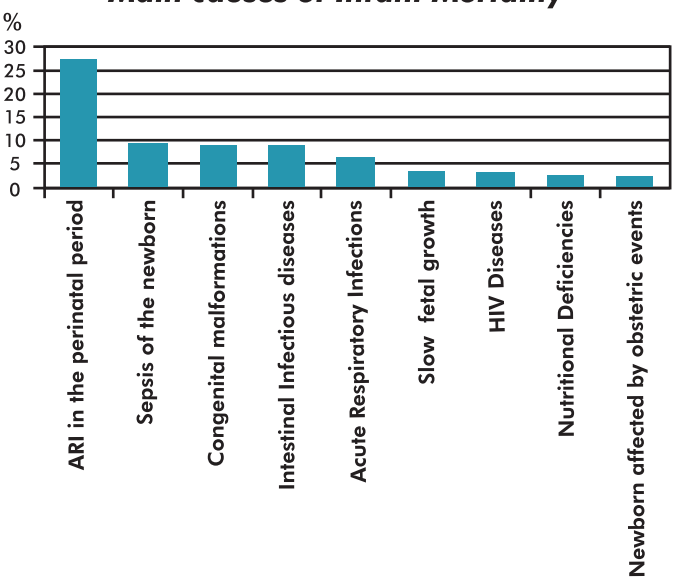
Source: MICS 2000 and 2006

Adolescent health

Youths under 25 years of age make up almost 50% of the population in Guyana. According to the 2002 census, adolescents aged 10–14 years accounted for 10.8% of the population, while 15–19 year-olds accounted for 8.9%. The main health problems faced by youths in Guyana include the lack of user-friendly services, inadequate access to dental and physical exams, unsafe sexual and other lifestyle behaviours leading to teenage pregnancy, HIV/AIDS, and other STIs. In order to make the health services friendlier, the government recently developed a strategic plan to address the health needs of young people.

A previous section reported on the use of alcohol, tobacco, and other substances among young people. In addition, the five leading causes of deaths among adolescents were: suicide 17.8%, land transport accidents 14.0%, assault (homicide) 7.8%, HIV/AIDS 6.2%, and events of undetermined intent 6.2% (*Bureau of Statistics*).

Figure 7:
Main causes of Infant Mortality



Source: Health in Americas 2006

Vaccine preventable diseases

Despite the geographical challenges, the 2008 EPI evaluation showed that the program has made significant gains since the previous evaluation in 2000. The average national coverage in the year 2001 for all antigens remained about 90%, demonstrating a steady increase in the coverage trends for each antigen since the initiation of the EPI program in 1977. The vaccination coverage of all antigens has increased (DPT3 from 83% in 1999 to 93% in 2006; BCG from 91% to 96%), as shown in Figure 8. The national laws of Guyana require all children to be fully immunized upon entering the school system.

There has been no confirmed case of polio since 1962 and the last reported case of yellow fever was in 1968. There has been no laboratory confirmed case of measles since 1991 and the last case of rubella and CRS was in 1998. Two new vaccines - hepatitis B and Haemophilus influenzae type B - have been fully introduced into the routine vaccination schedule since 2001. Pneumococcal and rotavirus vaccines were slated to be administered to all infants in 2008, but this was delayed for unspecified reasons.

The 2008 evaluation also showed that there were great disparities in coverage at the regional and sub-regional levels over the past ten years. The coverage of antigens in one hinterland region (Region 1) compared with a coastal region (Region 3) is illustrated in Figure 9, a and b. However, it is important to note that such disparities have been decreasing.

Figure 8:
National Immunization Coverage 2000 - 2007

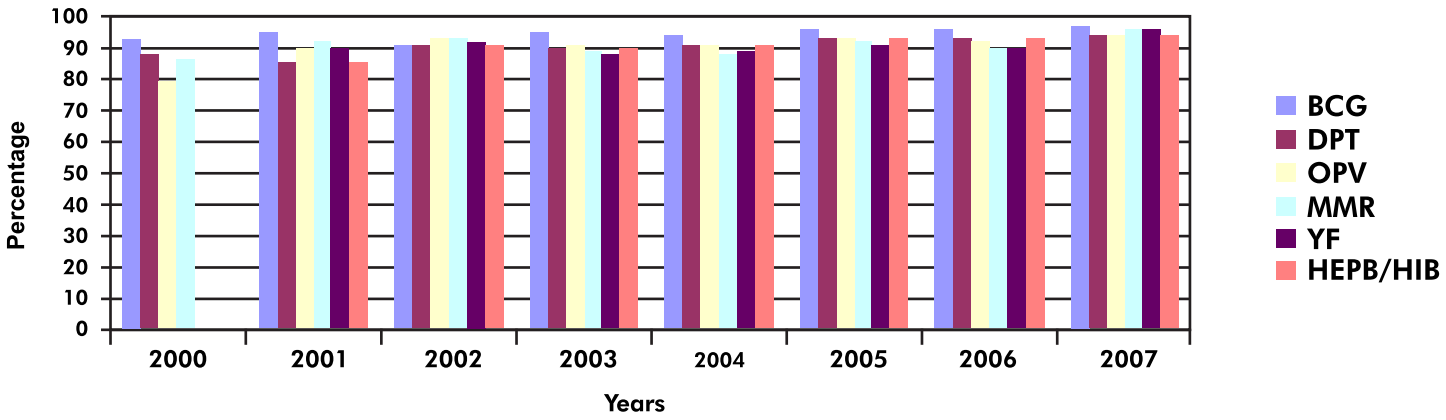
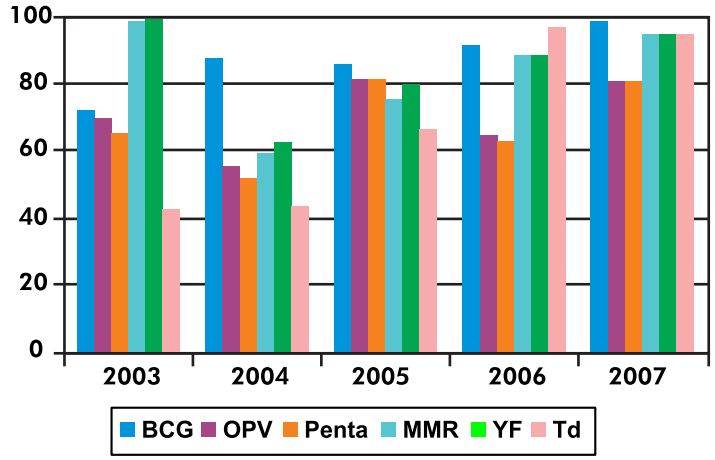
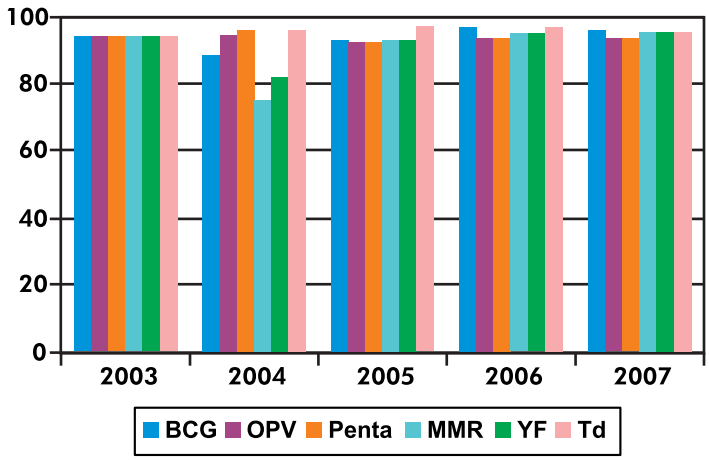


Figure 9:
Regions 1 & 3 Immunization Coverage (%)
2003 - 2007

a) Region 1 - Hinterland



b) Region 3 - Coastal



The Government procures vaccines through the PAHO Revolving Fund for vaccines and immunization and covers the associated cost. However, over the past few years resources have been provided to the country by GAVI to support establishment in 2008 of a state-of-the-art cold room for vaccine supplies, among other things.

2.2.4 Environmental risks to health

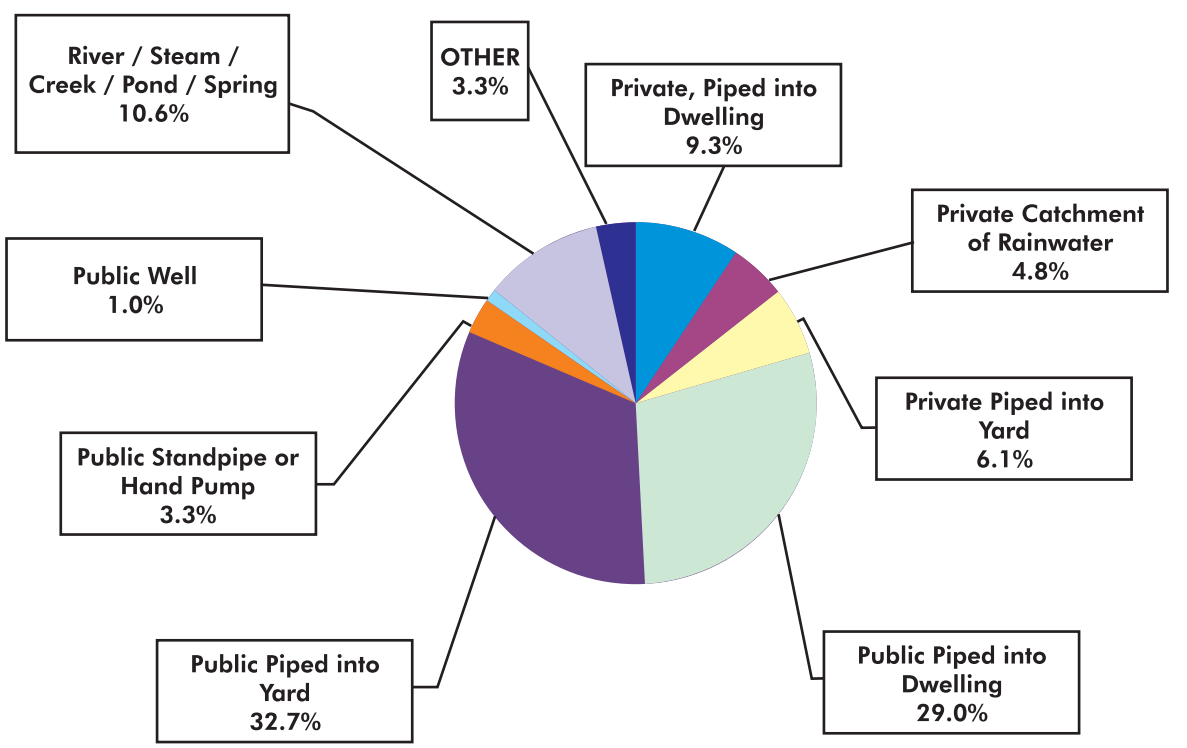
Water and sanitation

According to data from the Population and Housing Census 2002, 61.7% of households had access to pipe water in the dwelling or yard. The distribution by source represented in Figure 10 illustrates different sources of water for domestic consumption.

Major problems with quality, continuity, and reliability of service persist both along the coastal strip and in severely under-served hinterland regions. Adequate water treatment levels remain below the WHO guidelines in many water systems.

A 2007 household survey found that only 14% of household water supply had the minimum WHO requirement of 0.2 mg/liter of free chlorine. While no similar data exist for other regions, it could safely be extrapolated that this finding would be similar in other hinterland regions. This problem is accentuated by the intermittent water supply resulting in communities having an average of only 4.3 hours of service per day according to 2004 data. To compound matters, the poor condition of pipes allows for leakage and heightened risk of microbiological contamination. Inadequate inspection by the water authority has encouraged improper household connections, where it has been observed that pipes cross trenches with polluted water. The high rate of diarrhoea maybe an indication of the deficiencies of the water and sanitation sector, as suggested by an assessment conducted in 2002 by the Joint Monitoring Programme for Water Supply and Sanitation (JMP-WHO/UNICEF) which found that 7.7% of children under the age of five living in urban coastal areas had episodes of diarrhoea.

Figure 10:
Distribution of Households by sources of water supply in Guyana 2002



Source: Census Report 2002

In 2007, the Ministry of Health started the implementation of the Regional Drinking Water Surveillance Systems (DWSS) with the objective of establishing a National Water Surveillance Network that operates in accordance with international guidelines for the control, detection, and prevention of water-related diseases. This was initiated in Region 6 due to the high incidence of water-borne illnesses. It has since been extended to Regions 1, 3, and 9 and there are plans to roll it out to all other regions within the next five years. The recent launching of a Water Safety Plan (WSP) and a National Plan of Action (NPA) for Region 10 will also contribute to the improvement of drinking water quality.

According to the 2008 sanitation strategic plan for Guyana, 66% of households have pit latrines, and 24% have septic tanks. However, 50% of pit latrines are below WHO Guidelines (JMP-WHO/UNICEF 2002) and many septic tanks are not properly operated or maintained. The only waterborne sewerage system, serving 7% of the national population in central Georgetown, is old and in urgent need of major rehabilitation. The high percentage of inadequate practices to dispose of human excreta, combined with the issues related to drinking water quality and hygiene, represent major environmental health challenges.

Liquid waste is disposed of directly from the effluent discharged from the Georgetown sewage system and from septic tanks and pit latrines, resulting in pollution of surface water which could compromise the food chain and could affect human health.

Solid waste management

Increased waste generation and inadequate solid waste management practices have become important environmental health problems in Guyana. This problem has become increasingly acute over time, and besides creating aesthetically unpleasant conditions, it represents a major public health hazard. There is no effective mechanism for disposal of biomedical waste and this remains a matter of considerable concern. The negative impact of inadequate waste management was heavily felt during the January 2005 flood when the waste-filled canals did not permit adequate and efficient drainage, and contributed to outbreaks of leptospirosis.

According to the 2004 Sectoral Analysis of Solid Waste, 102,900 metric tons of solid waste are generated per year in the greater Georgetown area, of which only 63,700 are disposed of at the main landfill, which is about to exceed its capacity. The GOG, with financing from IDB, is finalizing arrangements to initiate a new sanitary landfill for the greater Georgetown area, which will significantly reduce hazards presented by the current situation. Collection coverage varies from 62% to 100% and the frequency rarely exceeds the once-a-week minimum standard. The waste not delivered to the landfill is burned, buried, or disposed of in empty lots, canals, and approximately seven community dump sites.

Special wastes, such as those from hospitals and slaughterhouses, are treated by burning in the open air in most municipalities or disposed of in the open landfill located in Georgetown. Since none of these methods is acceptable, there is an urgent need to implement technically sound and sustainable processes for hazardous waste disposal.

Occupational safety and health

The Government introduced a comprehensive Occupational Safety and Health (OSH) Act in 1998, but this has not been fully enforced and the issue of workers' health has not been placed sufficiently high on the national agenda. The Ministry of Health and the Ministry of Labour share the responsibility for workers' health, but there is limited inter-sectoral collaboration to address this issue.

Not unlike many other areas of public health importance, there is a paucity of data to accurately assess the magnitude of the workers' health situation in Guyana. Notwithstanding, in 2004 the Ministry of Labour reported the total number of workplace accidents at 2,202, of which 2,198 were non-fatal accidents. According to the same report, the fatal accidents decreased from 14 in 2000 to 4 in 2004. Ninety-five percent of the non-fatal accidents in 2004 occurred in the agricultural sector and about 2% occurred in the manufacturing sector. There is a lack of data on chemical poisoning, but due to the intensive use of chemicals in agriculture, the risk for such should be relatively high. In addition, mercury is extensively used in the mining sector and has in the past caused exposure

to miners and indigenous communities.

While child labour has not been nationally recognized as a problem, a 2004 survey conducted by the Ministry of Labour found that there were 133 working children, mainly involved in market vending, agriculture or fishing. UNICEF (2001) revealed that 45% of children were working in remote areas, 22% in the urban coast, and 26% in the rural coast. According to the same report the children appeared to be in reasonably good health, but the type of activities in which they engaged involved heavy lifting that could predispose them to back problems later in life. Further, these children are constantly exposed to physical and sexual abuses which render them vulnerable to HIV/AIDS and other STIs. On the positive side, the MICS Report (UNICEF 2006) showed that there was a reduction from 27% in 2000 to 16.4% in 2006 in the number of children between 5 and 14 years of age who were economically active, with more boys than girls being involved in economic activities.

Vulnerability to natural and man-made hazards

Flooding is one of the major natural hazards that affect Guyana. In January 2005 Guyana experienced its worst flood in recent history, occasioned by persistent heavy rains along with malfunctioning drainage structures and high tides. The greater part of the damage occurred in the capital city and its surrounding areas, causing social and other disruption to 62% of the population and a total GDP loss of 59.49%. The recurrence of such disasters is inevitable given that Guyana's coastal zone is below sea level, a large portion of the population resides along the highly vulnerable coastal strip, and the infrastructure is inadequate to prevent or mitigate the effects of such extreme weather events. The effects of climate change, such as extreme weather conditions (droughts and floods) and sea level rise, in conjunction with poor sanitary conditions, are expected to heighten the country's vulnerability and could result in increased communicable diseases such as malaria, dengue and diarrhoea, as well as other problems. These include contamination of drinking water sources and significant declines in agricultural production due to land loss as a result of coastal inundation. The recent focus of the government to preserve and sustain the large rain forest, and attract carbon credits and resources from other countries through the development of a Low Carbon Development Strategy (LCDS), could serve to minimize this anticipated impact.

2.3 Determinants of Health

Poverty

It has been reported that substantial progress towards poverty reduction was made from 1993 to 1999. The 2007 Household Income and Expenditure Survey found that 13% of the population was living in absolute poverty and concluded that the minimum personal living standard was out of reach for at least 31% of Guyanese (roughly 245,000 persons). While poverty is widespread, it is generally believed that indigenous persons are among the poorest in the country and have much less access to goods and services than other population groups living in less remote and inaccessible areas.

Nutrition and food security

The prices of food have been increasing steadily in the recent past and it is predicted that if urgent measures are not taken by the national authorities to cushion the impact, the people who will suffer most from this turn of events are those who are already living on the razor's edge of poverty, so to speak. Unlike most other Caribbean countries, Guyana is a net exporter of food. According to the National Bureau of Statistics, Guyana exported US$294 million worth of sugar, rice, shrimp, other seafood, molasses, fruits, and vegetables in 2007 and imported US$113 million of processed food, milk, wheat and other food. However, the prices for Guyana's exports are not rising at the same rate as its imports. In addition, fuel imports essential to all productive activities have been spiralling in cost. In 2007, the fuel import bill reached US$284 million, approximating one-third of the GDP. To put this in perspective, in 2007, the economy recorded a 14% increase in general price level, but a 21% rise in food prices. In general, the greater the share of resources required for food acquisition, the higher the vulnerability of the household to food and nutritional insecurity. The Household Income and Expenditure Survey undertaken in 2007 found that 31% of the Guyanese population is unable to afford the expenditure required for a basket of basic food and non-food items that define the national poverty line. Recognizing that the impact of this situation could offset the gains made in nutrition, the UN

agencies have been collaborating to develop a collective strategic response to mitigate the nutritional consequences of the food crisis.

Employment and income levels

According to the 2002 household survey, the working age population has grown steadily over the past decades and in 2002 it was two-thirds of the total population (475,219 persons), up from 417,770 in 1980 and approximately 467,173 in 1992. A little over one-half of the working–age population (56%) participates in the labour force which was 271,728 (56.1%) in 2002. Although males comprise a little over one-half of the total population, they only account for 49.6% of the working age population. Only 22% of the male working-age population is not engaged in any type of income-generating activity, as opposed to 66% of females. This shows a marked disparity. Also, while it is not easy to obtain objective unemployment figures, it is the generally held view that the unemployment level in the country is unacceptably high and would have been higher were it not for the fact that a sizeable percentage of persons, more females than males, are involved in the informal sector. Disparities in employment also exist between the rural and urban areas, but again, the specifics are difficult to come by. Notwithstanding the fact that health care provided by the government is free to users, the high levels of unemployment must inevitably impact on the health of the population. The government is the largest single employer in the country.

Gender

In Guyana, gender issues contribute to the broader social, economic, and political problems. Women carry a disproportionate burden relative to men both in economic and social terms, and gender roles and relations powerfully influence the course of health as well as the impact of health outcomes. This impact is highlighted by the growing "feminization" of HIV/AIDS as a result of unequal power relationships and the compromised ability of women to negotiate in the context of those relationships. The Ministry of Human Services and Social Security has been working assiduously to raise the awareness of the Guyanese population regarding the issue of sexual abuse and violence against women. To this end, the Government in 1998 formulated a National Policy on Domestic Violence charging the country to: "Break the Cycle and Take Control". This Policy has as its core the transformation of attitudes that condone or normalize domestic violence, such as gender stereotyping and discrimination. The Minister of Human Services and Social Security herself led the process to formulate the Policy and is at the forefront of its implementation. The Women's Affairs Bureau and the National Commission on Women engage in a number of activities designed to promote equality in gender relations, as well as advance the status of women. Despite these efforts, much work still needs to be done to ensure that policies and legislation are implemented in a manner that will make a real difference.

Education

In Guyana, education is a legal requirement for children from 5 years and 9 months of age to 14 years of age. Approximately 60% of the school-age population (up to 18 years) attends school, up from 55% at the time of the previous census in 1991. The highest percentages of children who actually attend school are in the 5-9 and 10-14 year age groups (94% according to the 2002 census), which means that Guyana is well on track to meet the MDG target with respect to universal primary education. The data provided in the recent report on the progress of the MDGs indicated that literacy rates were not available for those 15-24 years of age. While the report did not provide specifics on the drop-out rates from school, the maps provided in the report showed that the geographic areas with the highest primary school dropouts were Regions 5 and 6. No reason was given for this but suffice it to say that these regions are considered to be remote. According to the MDG Progress Report (2007), access to secondary education increased from 54.5% in 1991 to 65% in 2002. Information on literacy rates was not available.

The University of Guyana (UG) is the sole public tertiary level institution. It has been in operation since 1963 and provides education in a range of disciplines, including health.

Social inequities

Amerindians, the predominant population group

throughout most of the country's interior, are also the poorest social sector group and exhibit some of the lowest health indicators in Guyana. Recent statistics show that about 60% of all reported malaria cases occur in the Amerindian population.

Other health problems disproportionately affecting this group include: dental caries, snake bites, scabies, worm infestation, substance abuse, and HIV/AIDS. At the same time, Amerindian women are at a higher risk of poor maternal health due to limited access to health care. Community Health Workers are often the only type of health care provider serving the population in the interior of the country and their work is seriously hampered by transportation difficulties, staff shortages and difficult terrain, among other things. The gold mining communities, also located in Guyana's remotest areas, are characterized by rapid population growth due to the influx of miners and those who provide services for them. This, coupled with minimal basic sanitation and waste disposal facilities provides an ideal environment for vector-borne diseases, HIV/AIDS, and other health problems.

Other determinants

Other factors considered to be determinants of health in Guyana such as: water, sanitation, environmental factors such as climate change, and natural disasters, are addressed fully under aprevious section (2.2.4) dealing with environmental risks which impact on the health situation in the country.

2.4 Health System and Services

Organization of health services

The GOG considers health to be the right of every citizen. The responsibility for the health of the people of Guyana rests with the MOH. The Minister of Health is the political head of the ministry; the Permanent Secretary, the Accounting Officer, and the Chief Medical Officer have responsibility for all technical and professional aspects.

The Ministry of Local Government and Regional Development is responsible for managing finances allocated by the central government and for providing services at the regional level through the RDCs, which receive technical and professional guidance from the MOH. The private sector functions independently, but is regulated by the Health Facilities Licensing Regulation (2008), which

Table 1:
Public Health Facilities by Region

Region	Health Posts		Health Centres			District Hospitals		Regional Hospitals		National Hospitals
	Coastal	Hinterland	Urban	Coastal	Hinterland	Coastal	Hinterland	Coastal	Hinterland	
1	-	40	-	-	3	-	4	-	-	-
2	-	21	1	-	12	-	1	-	1	-
3	26	-	1	14	-	3	-	1	-	-
4	11	-	17	21	-	-	-	1	-	1
5	1	-	-	17	-	2	-	-	-	-
6	4	-	2	26	-	3	-	1	-	1
7	-	25	1	-	2	-	2	-	-	-
8	-	15	-	-	5	-	2	-	-	-
9	-	52	-	-	3	-	2	-	-	-
10	19	-	2	8	-	2	-	1	-	-
TOTAL	**61**	**153**	**24**	**86**	**25**	**10**	**11**	**4**	**1**	**2**

Source: Gap Analysis, MOH/PAHO 2008

mandates standards of care and practices. Some NGOs are actively involved in some areas of service delivery, especially with respect to HIV/AIDS.

In 2005 the passage of the Regional Health Authority (RHA) Act and the Ministry of Health Act changed the traditional role and functions of the MOH from that of provider of health care to mainly that of regulator. In order to effectively carry out this function, the MOH needs considerable strengthening of the structural and governance arrangements, the establishment of a sector accountability framework, enhancement of the human resources' planning capacity, and improved management capacity of the central ministry and the decentralized entities.

The service delivery model is founded on primary health care principles of equitable distribution of services, intersectoral collaboration, and community participation. As seen in Table 1, the model of health service delivery is based on a 5-tiered upward-moving referral system. Level I includes 214 health posts (the most basic health facility); Level II, 136 health centres; Level III, 21 district hospitals; Level IV, 5 regional hospitals; and Level V, the Georgetown Public Hospital Corporation (GPHC), which serves as the general hospital for the Greater Georgetown Area and the tertiary care referral hospital for the country, and the national mental health facility located in New Amsterdam.

Health financing

There is no national insurance system, but a national insurance scheme exists for employees. It is mandatory for all employed persons aged of 16-60 years including self-employed. The public health services are mainly financed by Government with contributions from the donor community. Over the years, the health sector received significant increases in allocation from the general national budget, and in 2007 received approximately 10% of the total recurrent Government budget. This compares favourably with other Latin American and Caribbean countries (LAC). In 2005, the total Government expenditure in health was US$34.2 million and the per capita expenditure increased over time from US$45.00 in 2005 to US$67.00 in 2007. Nevertheless, this is still much less than many other countries in this hemisphere. Table 2 provides additional details on budget allocation and expenditure for the Ministry of Health.

The Government is working to consolidate public and donor funding into a single arrangement, as well as to develop a new planning, budgeting, and sector performance management process that will ensure all funding is coordinated and put to the best use in meeting the National Health Sector Strategy (NHSS) 2008-12 objectives and ensuring sustainability of programs.

Table 2:
Guyana's Government Health Expenditures: 1995 - 2008

Year	GPHC & MOH Budget (Capital plus recurrent budget) G$'000	GPHC & MOH Budget (Recurrent Budget) G$'000	Health Expenditure as a % of total Gov't Exp.	Health Expenditure as a % of GDP
2001	4,571,698	4,392,442	6.95	2.32
2002	5,312,347	5,016,976	8.44	2.64
2003	6,394,152	5,269,200	8.90	3.02
2004	6,510,082	5,548,267	8.59	3.04
2005	6,846,202	5,935,154	7.41	3.06
2006	8,377,195	6,399,841	7.91	3.49
2007	10,039,519	7,316,464	10.04	3.61
2008	9,653,647	6,661,084	N/A	3.72

Human resources for health

Not unlike other Caribbean countries, there is a shortage of health care professionals in Guyana, especially in the area of nursing where the level of migration is considerably higher than for other professional groups. This reality, along with the inappropriate mix of skilled professionals, can contribute significantly to the less than desirable levels and quality of care in the health care facilities, both centrally and regionally. In 2008 PAHO/WHO collaborated with the MOH to conduct an analysis of existing health professionals throughout the country. The information from this analysis, coupled with the gap analysis which was completed in 2009, will contribute to the development of a strategic plan for human resources for health in Guyana. Such a plan has never been in existence and the MOH has expressed interest in its completion. Support from the PEPFAR was also provided to establish a Human Resources for Health Unit in the MOH, and while this has had some teething problems, there are recent signs that some progress is being made.

Training of health care professionals is somewhat complex in Guyana in the sense that it is provided by three entities at the basic and continuing education levels. These are: the MOH Health Sciences Division, the Georgetown Public Hospital Corporation (GPHC) and UG. The areas covered by each of them are depicted in the associated diagram below.

The continued loss of professionals, the inappropriate skills mix and the low levels of training output remain major causes of health sector problems. The majority of health workers and the better-qualified are mainly concentrated in the coastal urban areas. Although there has been an increase in the ratio of health professionals to population in all categories, as indicated in Table 3, external migration of health professionals continues to create a serious workforce shortage throughout the country.

The Government has embarked on an intensive training program both in Cuba and the University of Guyana to scale-up the number of physicians and nurses. The recent gap analysis revealed that if the present level of commitment is maintained and if the trend continues, in ten years there will be dramatic increases in the numbers of health workers in all categories. In light of this massive training thrust, in the longer term, the challenge for the Government would be how to effectively utilize all the persons trained and to find mechanisms to retain them.

Communication and transportation continue to be the major deterrents in access to services in the remote hinterland regions (Regions 1, 7, 8 and 9). Table 3 and 4 outline the ratio and health human resources distribution in Guyana.

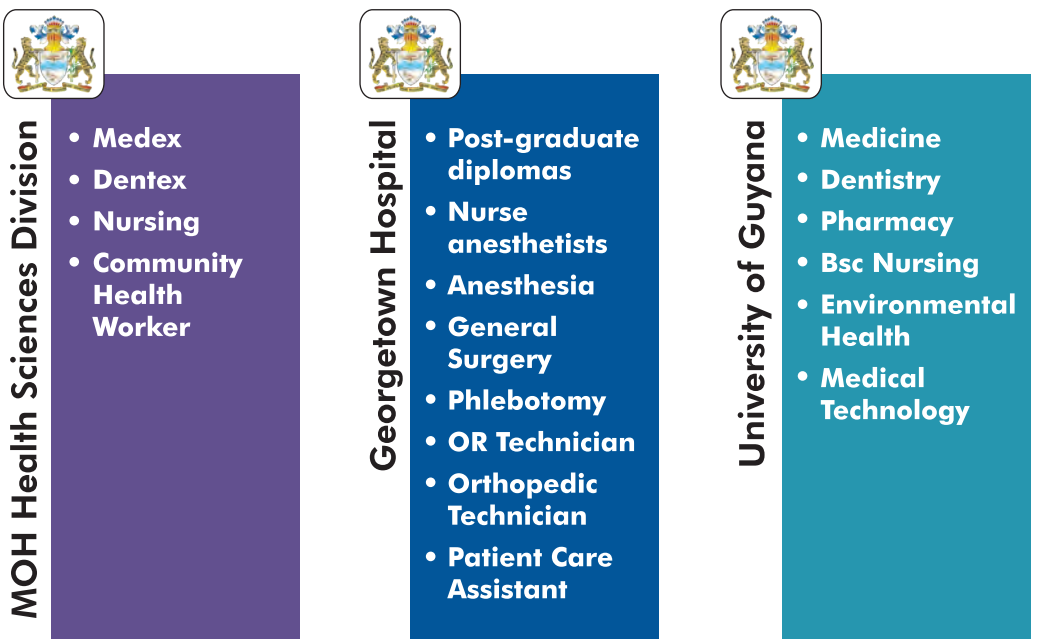


Table 3:
Distribution of Human Resources

Type of Human Resources / Period	2000	2001	2002	2003	2004	2005
Ratio of Physicians per 10,000 inhabitants	3.8	4.4	4.6	4.1	4.2	4.3
Ratio of Professional Nurses per 10,000 inhabitants	10.4	10.5	10.5	14.0	14.2	11.6
No. with graduate level degrees in Public Health	11	12	12	15	15	15

Source: Ministry of Finance - Budget Speeches: Years 2000-2007 and Planning Unit, MOH

Table 4:
Density of Health Workers by Region

Regions	1	2	3	4	5	6	7	8	9	10
Medex	1.29	0.61	0.29	-	0.40	0.73	3.41	5.94	3.09	1.78
CHWs	10.78	7.51	2.44	-	0.40	0.81	11.36	18.82	26.82	7.61
Physicians	0.86	1.62	0.98	3.50	1.00	1.46	1.7	1.98	0.52	2.54
Professional Nurses	0.86	3.45	1.76	4.00	3.00	3.96	1.14	2.97	1.03	12.18
Population	23,204	49,253	102,473	309,059	50,000	123,695	17,597	10,095	19,387	39,407

Source: Joint workforce project, MOH/PAHO 2007

Health information

Despite numerous attempts and considerable resource investment, there is still no comprehensive, integrated health information system (HIS) in the country. However, there are several successful "stand alone" systems that are disease focused. Some of these produce useful reports on a regular basis, which are used to guide policy formulation, planning and decision-making. The PAHO/WHO office in Guyana has been, for some time, advocating for a harmonized approach to information to allow greater timeliness, availability, retrieval and use of information to guide management decisions. The Ministry has recently indicated that this is an area in which the continued support of the Organization would be necessary. To this end, best practices models are being reviewed to determine the lessons that they could provide to help to advance Guyana in addressing its need for an effective health information system.

Medical products and technology

In 2009, the government budgeted over G$2.5 billion (US$1 = ~G$200) for drugs and medical supplies. A new inventory management system is soon to be introduced at the Georgetown, Linden, New Amsterdam and Suddie Hospitals and was also scheduled to be implemented in all regional hospitals by the end of 2009. This will allow for more efficient distribution and ready availability of drugs and medical supplies. An essential medicines list is published regularly, the most recent of which was for 2007-08. In addition, there is a national drug formulary committee which is working on the preparation of the Guyana National Formulary to include medicines and other supplies and equipment for dentistry, ophthalmology, surgery, rehabilitation orthopedics, and physiotherapy, among other specialties.

Leadership and governance

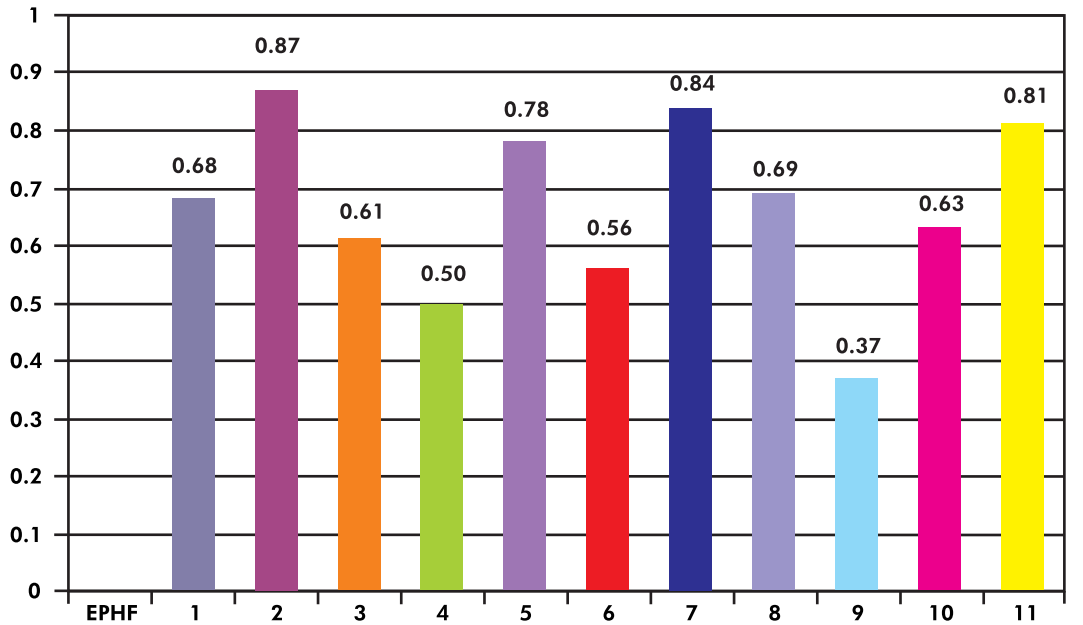
Guyana's health care system is highly decentralized. The responsibility for health care services is being devolved to Regional Health Authorities and to GPHC. These are statutory authorities created under the RHA Act, 2005, and are intended to operate under contract with the MOH. Their contracts will specify the level and quality of services they should provide in return for the funding they receive.

Along with the process of decentralization, the organizational reform of the central Ministry will need to be further advanced for it to assume the new role of stewardship of the entire sector. Such reform will need to better define and enhance the stewardship and oversight functions of the MOH and address the weak health workforce; the insufficient managerial capacity at national, sub-national and local levels, including financing, technology, and other resource management issues. It should also address the insufficiently integrated health service delivery network, quality of health care, especially for vulnerable populations, and the lack of a harmonized health information system for decision making. The organizational structure of the MOH can be found under Annex II.

Essential Public Health Functions (EPHFs)

The most recent assessment of the EPHFs in Guyana was in 2008. This showed an overall improvement over the 2001 assessment (0.55 in 2001 and 0.67 in 2008). Based on the 2008 assessment, Figure 11 clearly shows the following EPHFs to be persistently weak: 4, Social participation in health; 6, Strengthening of public health regulation and enforcement capacity; and 9, Quality assurance in personal and population-based health services. The analysis of the assessment also demonstrated the need to strengthen specific aspects of several

Figure 11
Essential Pubic Health Functions P Assessment, Guyana 2008



other EPHFs. These aspects include, but are not limited to: enforcement of regulations, empowerment of civil society and fostering partnerships, health information, improving the quality of the workforce, health systems and technology management, research in public health, and policy development, planning, and management.

2.5 National Policy Orientations and Priorities

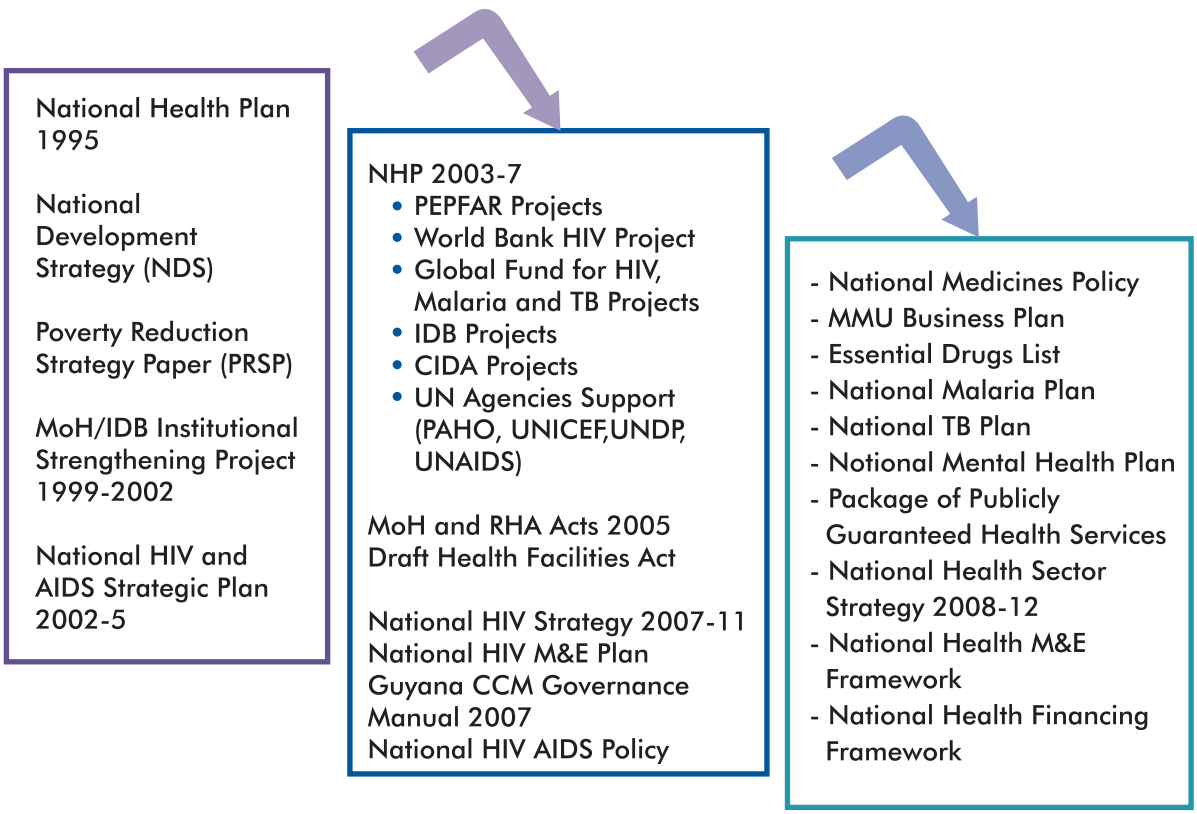
The National Health Sector Strategy sets out the Government's plans for providing equitable access to high quality and consumer-friendly health services. To achieve these broad sector goals, the NHSS 2008-12 focuses on five components:

1) decentralization of health services,
2) strengthening the skilled workforce and human resources systems,
3) strengthening government capacity for sector leadership and regulation,
4) strengthening sector financing, and
5) strengthening strategic information.

The following sets out the historical process of national policy orientations and priorities in various strategic frameworks from 1995 to 2012.

The GOG acknowledges that health is a fundamental right and a priority pillar for development. In that spirit, the MOH presented the 2008-2012 edition of the *Package of Publicly Guaranteed Health Care Services,* which is designed to improve the delivery of health services to all persons, especially vulnerable groups - women and children, person with disabilities, those living in poverty, and the people of remote areas, including indigenous peoples. The Package also addresses the need of all population groups in relation to NCDs and lifestyle-related disorders. The underlying considerations for the development of the Package were: 1) The potential for reducing the burden of disease, 2) Safety and effectiveness, 3) Availability of resources, 4) Contribution to MDGs, 5) Contribution to Guyana's PRSP, and 6) Implementation of the NHSS. The 2nd edition of the Package of Publicly Guaranteed Health Services also includes an Essential Package of Publicly Guaranteed Laboratory Services.

Historical Progression NHSS 1995, 2003-2007, 2008-2012



2.5.1 Health challenges and priorities

Based on the situation analysis presented in the previous sections of this document, as well as consultation with counterparts and partners, and the examination of key documents such as the NHSS, the following health challenges and priorities were identified:

Health challenges

1. High burden of CNCDs;
2. Persistent new and emerging communicable diseases: HIV/AIDS, TB, malaria and dengue;
3. Neglected diseases (e.g. geohelminthiasis, filariasis, Chagas' and leprosy);
4. High maternal and infant mortality;
5. High burden of mental disorders and demand for improved services;
6. Increasing rate of violence and injuries, including domestic violence and RTAs;
7. High rates of suicide and substance abuse;
8. Inadequate quality of health services and limited access, particularly in the hinterlands;
9. Insufficient human resources (HR) for health and absence of a HR strategic plan;
10. Weak epidemic alert and response capacity to effectively implement IHR 2005;
11. Absence of an integrated HIS;
12. Inadequate and inappropriate lifestyle practices leading to CNCDs and injuries;
13. Sustainability issues regarding stewardship, leadership and regulation of the health sector at all levels;
14. Incomplete mechanism to support decentralization of health services and the stewardship role of the MOH;
15. Low emphasis on sexual & reproductive health;
16. Vulnerability of the country to natural and man-made hazards;
17. Logistical and other difficulties in access to health care, especially in the hinterland;
18. Inadequate response to environmental health risks (water and sanitation, solid waste management, vector control, food safety and OSH);
19. Diminished capacity of the MOH to effectively and efficiently perform vital functions of oversight, stewardship, communication and coordination as a result of the recent fire which totally destroyed the MOH headquarters building along with infrastructure and records; and
20. Little or no attention to the determinants of health.

Health priorities

1. Non-communicable diseases and risk factors;
2. Maternal, adolescent and child health;
3. Mental health and substance abuse;
4. Communicable diseases, with emphasis on HIV/AIDS, TB and malaria;
5. Vector-borne diseases, with emphasis on dengue and filariasis;
6. Access and quality of health services;
7. Human resources for health;
8. Health information and research for evidence-based decision making;
9. Epidemiological surveillance;
10. Strategic planning, monitoring, and evaluation;
11. Disaster management and risk reduction;
12. Environmental health and risk factors;
13. Health information systems;
14. Governance, leadership, and management of health services;
15. Essential Public Health Functions, with emphasis on the weak ones;
16. Selected social determinants of health (i.e. gender, food security and violence); and
17. Health determinants.

3. DEVELOPMENT COOPERATION AND PARTNERSHIPS: TECHNICAL COOPERATION, AID EFFECTIVENESS, AND COORDINATION

Overview

Guyana's recognition of the importance of health to the achievement of its national development objectives is evidenced by the actions for improving health included in the National Development Strategy (2001-2010) and the Poverty Reduction Strategy (2001). The availability of these two clearly articulated national documents paved the way for a series of development cooperation agreements and partnerships with Guyana, and subsequent increased support to health development in the country.

According to the World Bank Website, the Official Development Assistance (ODA) received by Guyana as a percentage of its Gross National Income was 20.6% for 2006. Percentage breakdown was not available by sector. However, Table 5 provides some estimates of resources received for the health sector along with the key contributing partners, among whom were the Development Banks; international non-governmental organizations; and bilateral, multilateral and United Nations agencies.

3.1 Summary of Key Challenges and Opportunities in Development Cooperation

The challenges and opportunities encountered within international cooperation are considerable given the implications of the slow economic growth in Guyana since 2000 on household income and subsequent health-seeking behaviour.

Key challenges

- Multiplicity of international development and donor agencies operating in Guyana with different project management requirements and high transaction costs;
- Weak mechanism for coordinating and harmonizing the aid-flows into the country;
- Low efficiency of international cooperation programs and the need for better allocation of resources in accordance with the established priorities;
- Inconsistent data on financial flows into the health sector due to fragmented and inaccessible health financing and expenditure information systems;
- Significant human resource deficit both in health and in other sectors;
- Difficulties utilizing the considerable amounts of donor funds available to the country;
- Sustainability of the health and related programs once donor funds are no longer available;
- Weak mechanism to bring about real intersectoral partnership for health development;
- Weak private-public partnership for health development.

Key opportunities

- Health is allocated a relatively high percentage of the national budget indicating positive political commitment towards health improvement;
- Interest of several donor agencies to support public health initiatives in the country, resulting in sizeable amounts of extra-budgetary funds;
- High level of interest of the current Minister of Health for improvement of the services;
- Partnership arrangements with CARICOM, the University of Guyana and other entities;
- Revision and updating of key legislation to support fairness, equity, and accountability in the practice of health care providers (public and private);
- Availability of oversight mechanisms for various aspects of health;
- Health sector reform and the regionalization / decentralization of health services;
- The existence of a current UNDAF which represents the first real efforts to harmonize the UN presence in Guyana; and
- Commitment of the country to regional health agendas eg. the Port of Spain and Nassau Declarations, as well as to the Caribbean Cooperation in Health Initiative and the recommendations from the Caribbean Commission on Health and Development.

3.2 External Development Support to Guyana

3.2.1 Aid flows from bilateral and multilateral partners

Guyana has been classified as one of the two Highly Indebted Poor Countries (HIPC) in the Caribbean - the other being Haiti - but this classification has been undergoing some change with respect to Guyana. Nevertheless, Guyana's eligibility and permanent access to debt relief totalling US$365 million under the HIPC and Enhanced HIPC (E-HIPC) initiatives from 1997 and 2007, respectively, has led to an overall reduction of the country's external debt from 122% of GDP at the end of 2002 to 38% in 2008. Most of the freed resources are targeted towards supporting the social sector, including education, water supply, and health. This HIPC status also led to considerable external attention, which translated into sizeable aid flows into the country, with many of the bilateral and multilateral partners having physical presence in the country.

The key multilateral agencies supporting Guyana's health sector reform through infrastructural development and institutional strengthening are the IDB, World Bank, GFATM, GAVI, and RAVREDA, while the CIDA, China, Cuba, European Union (EU), USAID, and JICA are the major bilateral agencies. Other regional bodies and non-governmental organizations providing funding and technical support to the MOH include: CAREC, CFNI, PEPFAR, CDC, and the Clinton Foundation. Details of these and other funding sources and the areas for which resources were provided can be found in Table 5. It should be noted that the figures presented in the said Table may not represent the totality of external aid for health, but the information reflected, while not being precise, represents the best estimates that could be obtained at the time the CCS document was being prepared. Notwithstanding, it is believed that the external resources to health may be more, rather than less, for the period referenced.

Despite efforts to mobilize resources for other priority public health areas, HIV/AIDS continues to attract the majority of external health-related funds, as reflected in Table 5 overleaf. Given the country's move to integrate HIV/AIDS into the mainstream of public health and primary health for HIV/AIDS could redound to the overall improvement of health systems and services.

In addition to the external financial resources to which the country has access, considerable technical support is received on a regular basis from Cuba in particular. Cuba assigns more than 150 health professionals to Guyana, including physicians, nurses and allied health professionals. In addition, more than 400 students from Guyana are being trained in Cuba as medical doctors. This training supplements significantly the capacity of the University of Guyana to train medical doctors. Important to note is the dependence of Guyana on human resources from Cuba to work in underserved hinterland areas, and should anything interfere with this arrangement, the human resource deficit in the country would become more critical.

The UN system in Guyana

Of the UN agencies present in Guyana, UNDP, UNICEF and PAHO/WHO have a substantial country presence, while UNFPA, ILO, FAO, and UNESCO operate liaison offices, and UNAIDS has a country coordinating officer. Other agencies such as UNIFEM and ECLAC operate from base locations in other Caribbean countries.

The UN in Guyana has articulated a Development Assistance Framework (UNDAF) with the Government of Guyana (2006-2010). The UNDAF provides a basis for joint programming and advances the notion of "Delivering as One". It addresses the MDGs, and health is represented as an important component. A mid-term review of the UNDAF was done in 2008 and concluded that, mainly as a result of joint action and collaboration, significant progress had been made towards the achievements of the outcomes, the priorities remain relevant, and the agencies were focused on addressing them.

Table 5:
External Funding for Health Care in Guyana

Partners / Donors	Major Areas of Support	Estimated funding (in US$) and Period
CIDA	HIV/AIDS prevention, communicable disease control; health surveillance; Health information system; microbiological laboratory	5M (2003 - 2007)
CUBA	Health human resources	Ongoing [1]
DFID	Water, sanitation	25.74M
EU	Direct non-targeted budget support program with health sector indicators; Making Pregnancy Safer; HIV/AIDS surveillance; MDGs	25.81M
JICA	Health infrastructural support: rehabilitation of New Amsterdam Regional Hospital	12M
USAID	HIV/AIDS; reduction of mother to child transmission of HIV infection	12M
CAREC	Improvement in laboratory capacity	5.1M*
IDB (HSDU) Health Sector Development Unit	Health sector reform: organizational development and institutional capacity improvement; health service delivery improvement to support decentralization; Health infrastructural development; basic nutrition program; Increasing access to primary health care; strengthening mental health program	5M; (2003-2009), 25M (2005-2010) 17.8M disbursed to 2009 0.7M (2005-2010) 6M to 2009 .1M (2008-2010)
World Bank (HSDU)	Institutional capacity strengthening, monitoring, evaluation, and research for HIV/AIDS and STIs	10M (2004-2009)
GFATM (HSDU)	HIV/AIDS, TB, malaria	23M
GAVI	Vaccines and immunization	19,915*
IICA	Nutrition and food security	50,000
CDC	Support to National Blood Transfusion Service, surveillance; disease control and Regional Health Services; procurement of drugs, reagents, office material and equipment; logistics and capacity building	22,178,076 (2008-2009)
PEPFAR	HIV/AIDS and human resources	4,761,111,600* 34 M

[1] *While no dollar figure is available, Cuba provides significant support to Guyana in the form of human resources for health.*

Partners / Donors	Major Areas of Support	Estimated funding (in US$) and period
Clinton Foundation	Supplies and equipment for paediatric HIV/AIDS	605,540
AIFO	Equipment provision for rehabilitation program for people with disabilities	183,355 on-going
RAVREDA	Malaria	278,532
PAHO/WHO	Technical cooperation in: health sector policy development, organization and management; human resource planning, management and capacity building; maternal, newborn, child and adolescent health; food & nutrition; environmental health and disease control	5,266,091M on-going
UNAIDS	HIV program coordination; strategic planning; generation; collection and analysis of strategic information; governance; policy guidance, inclusion of civil society, with a special focus on PLHIV, HIV prevention; AIDS competence; UN Coordination and joint programming; advocacy, convening and brokering	1,334,132 (2004-2009)
Global Links	Hospital supplies and equipment	284,073
UNDP	Provision of UNVs in health; capacity building to support adolescent health	394,591 (2004-2009)
UNESCO	Supporting basic education and some HIV/AIDS education	93,779
UNFPA	HIV/AIDS prevention for youth in especially difficult circumstances, improving maternal health; and support to MOH (Adolescent Health Unit, MCH, NAPS)	1,186,000
UNICEF	HIV/AIDS; maternal and child health; adolescent health; food & nutrition and disease control, M&E of PMTCT	3,873,822 million on-going 105,600,000

Inter-American system

Guyana, like other Caribbean countries, is a member of the Organization of American States (OAS). There are four entities of that system operating in the country: the OAS country office, the Inter-American Development Bank (IDB), the Inter-American Institute for Cooperation in Agriculture (IICA), and PAHO.

The OAS office consults on a regular basis with the national authorities to ensure that the mandates of the Summits of the Americas are applied in Guyana and that there are synergies and no duplication among the various elements of the system. It has also been involved in overseeing the electoral process in the country and issues of governance. The IDB Country Strategy focuses on sustainable economic growth, improving governance and public sector efficiency, and strengthening social programs. IICA focuses on improving the lives of rural communities through agricultural development within the framework of the Summit of the Americas Agri-Plan 2006-2010. In light of the recent food crisis, IICA's strategy provides an important platform for strengthening interagency collaboration to ensure that gains in the area of nutrition are not eroded.

CARICOM

Guyana is also part of the Caribbean Community (CARICOM) and hosts its Secretariat. As such, the country participates in and benefits from regional political, economic, and trade initiatives. The Council for Human and Social Development (COHSOD) is an important mechanism of CARICOM and one that sets regional policies and strategies in relation to health, education, and human development. The MOH is very active in this forum.

3.3 Aid Effectiveness

National ownership

The main framework being used by Government to guide development is the Poverty Reduction Strategy Paper (PRSP), even though this document has been in draft form for an extended period of time. In the absence of such a framework, it is difficult for Government to take the lead in setting priorities and in allocating resources based on need. In addition, there is no mechanism to ensure that funds are assigned in a rational manner and meaningfully accounted for.

Furthermore, national capacity is weak to sustain the achievements made by various nationally and externally funded initiatives. While this is so at the national level, the MOH has been putting systems in place to strengthen its leadership and stewardship role. To this end, several policy documents and strategic plans have been developed and are in place. There have been successive iterations of the national strategic plan for health, which clearly delineates what the government considers to be the national health priorities. Legislative reviews have also been done to allow the MOH to have a firm hand in leading and regulating the health services. In the context of decentralization of services, the Ministry is in the process of developing contractual services agreements to enable it to effectively oversee the decentralized programs. It is felt, however, that despite the mechanisms already in place, institutional capacity strengthening could serve to strengthen the ownership capacity.

Alignment and harmonization

As explained above, the lack of a national strategic development plan impedes effective program and resource alignment on a national level. However, the NHSS sets out Government's agenda, which focuses on providing more equitable access to improved quality health services. This strategic framework provides a useful platform for technical cooperation and contributes to improving external aid effectiveness and coordination. As mentioned before, the MOH has been increasing its leadership role and the Minister himself chairs several task forces and oversight committees designed to ensure that health programs and initiatives are aligned with the strategic orientation of the MOH. The Ministry of Finance has recently been assigned responsibility for addressing external aid coordination.

Consistent with the Paris Declaration, the UN agencies have been encouraging the Government to put in place appropriate mechanisms to support alignment and harmonization. In addition to the UNDAF, the UN System in Guyana, in collaboration

with the Government, has developed a draft document for improved UN coherence. Operationally, the UN Country Team (UNCT) has organized thematic groups to better coordinate program implementation. The UNCT has also been moving forward to give meaning to the concept of "Delivering as One".

The government has recently issued a call for UN agencies to adopt a more coherent approach to program development and implementation. It has expressed its desire to see existing projects condensed, where practical, into a few macro programs that will better rationalize the inputs from the agencies, and at the same time place greater emphasis on inter-sectoral cooperation among government entities and civil society.

Accountability

While the UNDAF provides a mechanism for program monitoring and evaluation, there is no effective national coordinating mechanism for accountability of external resource investment in the country. It is unclear how the resource investment from other external development agencies, such as the EU, OAS and IDB are accounted for. In the health sector, the Thematic Group on Health chaired by the Minister of Health, provides an opportunity for all actors in health to report on achievements and constraints relative to program implementation. PAHO/WHO has adopted the results-based management (RBM) approach, which is reflected in its Strategic Plan 2008-2012. This is accompanied by a financial accountability system.

4. PAST AND CURRENT PAHO/WHO COOPERATION

4.1 Historical perspective

There has been a long history of PAHO/WHO collaboration with Guyana, even before the country became independent in 1966 and was awarded its own Country Office in 1967. Prior to that, the country received technical cooperation through the PAHO/WHO Zone 1 Office located in Caracas, Venezuela. The guiding framework for the arrangement between Guyana and PAHO/WHO is contained in "The Basic Agreement between the World Health Organization and the Government of Guyana for the Provision of Technical Advisory Assistance". The Agreement was first signed in 1968 and has been amended several times since then. The Organization is accorded diplomatic immunity under the provisions of the Basic Agreement.

The Ministry of Health has traditionally been the main interlocutor with PAHO/WHO. However, based on the recognition that health is not the business of the health sector alone, efforts have been made to broaden the partnership base with other government sectors, other international development agencies, and selected civil society groups.

4.2 Review of past PAHO/WHO technical cooperation

Over time, there has been a subtle change in the engagement of PAHO/WHO with the Government of Guyana. Whereas at the time the Basic Agreement was signed the emphasis was on "technical assistance", given the dynamics of the work of the Organization, the emphasis has changed to "technical cooperation". This change, while it may have come about subtly, marked a significant thrust towards working together side by side with the nationals in a cooperative manner as opposed to doing for the country in a manner suggested by providing assistance. Since the engagement of PAHO/WHO with the Government of Guyana, tremendous public health gains have been achieved. Many of these gains, such as improvement in vaccine coverage; reduction in communicable diseases; availability of health information and education; improved maternal and child health services; and improvements in drinking water quality, sanitation, and hygiene, can be traced back to thirty years ago when PAHO/WHO was the only international organization working with Guyana to implement the Primary Health Care strategy. As a result, the current epidemiological transition was possible.

4.3 Overview of PAHO/WHO technical cooperation

The national authorities have been very vocal about the high regard in which PAHO/WHO is held, as well as the high level of confidence in the ability of the Organization to respond to the public health needs and challenges of the country.

The strategies or functional approaches used to support technical cooperation in the past few years included: training, information dissemination, direct technical support, technical cooperation among countries (TCC), development of policies, protocols and guidelines, considerable resource mobilization, infrastructure strengthening, and health information development and support.

The previous CCS guided the development of the last two PAHO/WHO Work Plans for the country (2004-2005 and 2006-2007). The health priorities for the attention of PAHO/WHO were defined in conjunction with the national counterparts and were consistent with those specified for attention in the national health plan as well as regional and global priorities. While efforts were made to ensure alignment of the biennial work plans with the CCS, a mid-term evaluation of the CCS implementation revealed that there were some areas of misalignment. This misalignment has been considered in the preparation of the current CCS.

The PAHO/WHO Guyana Country Office (CO) has had difficulty in attracting and retaining suitable human resources to effectively implement the technical cooperation program. This has resulted in interruptions to the program, loss of momentum, and reduction in the achievement of planned outcomes. On the other hand, the country has been able to attract considerable financial resources, which helped to support the implementation of the

previous CCS, and if this trend continues it would be of benefit to the current CCS. Efforts were made to obtain technical support from all levels of the Organization. However, this support has been drawn mainly from the Regional Office (RO) and selected country offices, but less so from the sub-regional and global levels. This reality should be addressed if the current CCS is to be successfully implemented.

The CCS for 2004-2007 addressed four strategic directions:

1. Reducing excess mortality, morbidity, and disability
2. Promoting healthy lifestyles and reducing risk factors
3. Development of equitable health systems
4. Policy and institutional development

The priority areas for each of the strategic directions were reviewed and Table 6 outlines the relative weight given to these areas with respect to the WHO core functions, subsequent to the implementation of the CCS.

Table 6:
Assessment of priority areas against WHO core functions for CCS 2004-7

Priority areas for TC	1. Providing leadership and engaging in partnerships	2. Shaping research, stimulating knowledge dissemination	3. Setting norms and standards, promoting and monitoring their implementation	4. Articulating policy options	5. Establishing TC catalyzing change, building institutional capacity	6. Monitoring health situation and assessing health trends
Prevention and control of communicable diseases	+++	+	++	++	+++	+++
Prevention and control of NCDs	+++	+	++	++	+++	+++
Healthy growth and development	+++	+	++	++	+++	++
Promotion of healthy lifestyles and social environments	+++	++	++	+++	+++	++
Promotion of safe physical environments	+++	++	+++	+++	+++	++
Ensuring universal access to integrated, equitable and sustainable health systems	+++	+	+++	+++	+++	++
Disaster preparedness and response	+++	+	++	+	+++	++
Placing health at the centre of development policies	++	+	++	+	++	+

4.4 Structure and Ways of Working

The CO's operational biennial work plans are developed, implemented and monitored in close consultation with the various stakeholders at national and subnational levels. While the MOH is the main counterpart, the CO actively engages in inter-sectoral and inter-institutional collaboration. The work plans are approved by, and monitored from the PAHO RO and the outputs of the BWP provide input for the global reporting system.

The PAHO/WHO Representative (PWR) provides overall management and leadership of the CO Team. The PWR is the first level supervisor for all international staff as well as the National Professional Officer in Health Promotion. Most of the other national professionals are supervised by a technical officer in the program area that they support. The support personnel, mainly assigned by the MOH, are supervised by the Administrative Officer. In addition to the fixed-term positions, short-term professionals are contracted on a needs basis; the staffing situation at the CO has improved over the last few years.

The current BWP is organized into four technical and one managerial project. While several technical officers may contribute to the implementation of each project, one technical officer has responsibility for the overall coordination. This approach promotes horizontal and inter-programmatic collaboration. In designing the program, the CO places emphasis on addressing the needs of vulnerable and marginalized population. Despite having a core group of technical and administrative staff, it is necessary to obtain additional resources from the regional and global levels, as well as from specialized centres, regional institutions, and collaborating centres to effectively implement the CCS.

In maximising resources and addressing common public health issues, the technical cooperation among countries (TCC) strategy has been employed. In addition, bilateral arrangements have been negotiated through the CO to strengthen the national public health capacity.

4.5 Resources

Human resources

Presently, there are a total of 27 persons working at the CO, of which 16 are females. The organizational chart of the office can be found in Annex I and sets out the categories of staff and lines of supervision and communication. There are 17 administrative personnel, of which the majority (over 80%) are assigned by the MOH under the Basic Agreement arrangement. There are 8 international staff members, comprising the PWR and 7 technical officers, including one internationally recruited Special Services Agreement (SSA) contract; there are 2 national SSAs. Short-term professionals are hired as necessary to provide technical support for certain aspects of the Technical Cooperation (TC) program.

A staff development plan is updated every two years along the BWP time lines to address identified competency gaps, and resources are assigned from the CO and the RO accordingly. Section 6 of this document includes a review of the additional competencies required to successfully implement the strategic agenda.

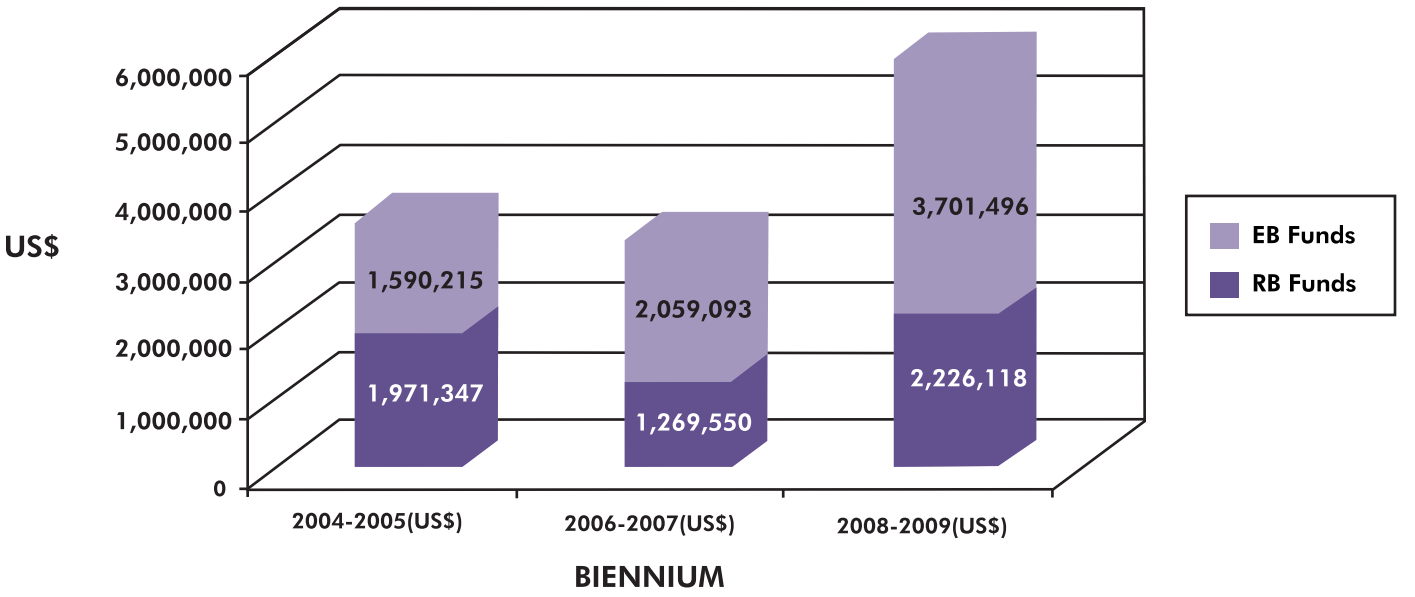
Financial resources

The TC program budget comprises PAHO/WHO regular budget (RB), which consists of assessed contributions from Member States, and miscellaneous income, in addition to funds from all extra budgetary (EB) or voluntary contributions (VC) projects.

For the biennium 2008-2009, the total RB (inclusive of personnel costs) was US$2,226,118. This represents an 11.5% increase over the RB assigned in 2004-2005 ($1,971,347) and a 42.9% increase over the RB for 2006-2007 ($1,269,550). It should be noted that funds from EB sources have increased significantly over the last three biennia (Figure 12). In 2006-2007, funding from EB sources was $2,059,093, which reflected an increase of 29.5% over that of the previous biennium. For the current biennium (2008-2009), the EB funds amount to $3,701,496 which reflects an increase of 80% over the previous biennium. This significant increase in EB funding, positions the CO well to deliver on the strategic agenda for the coming biennium since

since some of these resources spill over into the 2010-2011 planning and programming period.

Figure 12 - PAHO/WHO Investment in Guyana



The TC Program Budget covers the five (5) Program Areas outlined in Table 7.

Table 7:
Funding by BWP Projects 2008-2009

Project Title	RB FUNDS	EB FUNDS	TOTAL
Reducing the burden of disease - communicable and non-communicable	150,155	1,351,870	1,502,025
Health systems and services development	137,851	918,361	1,056,212
Supportive environments for health	119,115	525,455	644,570
Enhancing the health of the family	41,810	875,809	917,619
Managing for results	424,071	30,000	454,071
Total	**873,002**	**3,701,495**	**4,574,497**

The first four projects correspond to the technical areas, while the Managing for Results project addresses the leadership, administrative and logistic support to facilitate the delivery of the TC program. The figures in the above table do not include personnel cost for PAHO regular staff.

Office infrastructure

The CO is located in the capital city, Georgetown, in a building provided by the Government at no cost to PAHO/WHO. The Government also covers the cost of all utilities. The building is a 2-storey concrete and wooden structure. The staff complement at the CO has grown over the years and the physical space was unable to adequately accommodate them. To address this space deficit and increase utilization of the Documentation / Knowledge Centre, the latter was relocated to the UG Library on the basis of a mutual agreement, and the office is being refurbished and reorganized to better accommodate staff.

There is a dedicated information technology (IT) function for the CO. An assessment done by the Manager of the ITS Area in PAHO HQ in February 2009 revealed certain inadequacies and made recommendations to address them. The most critical of these was the inefficient internet access arrangements with a private company, which resulted in the CO entering into a joint service agreement with the other UN agencies to have internet services via satellite. This will improve connectivity and bandwidth as well as reduce cost. Over the past few years, the CO has also benefitted from the ***Elluminate*** web conferencing tool. The CO has the necessary computer hardware and software to support the work of the office, and to effectively participate in the PAHO/WHO network.

There is a fleet of three vehicles and one motor cycle to facilitate the TC program, especially in rural areas. One of these vehicles, the mini bus, has exceeded the life span recommended by the Organization and measures are being taken to replace it in the not-too-distant future.

The United Nations Department of Safety and Security (UNDSS) has designated Guyana as a Phase I country and the CO has been following all security recommendations to ensure it is MOSS compliant. The MOH provided 24-hour security services to the PAHO/WHO premises through a local company. However, the poor quality of the services provided by the company, including inappropriate conduct of the security guards, resulted in measures being taken to replace the security guard services, with the CO undertaking to underwrite the difference in the cost between what the MOH was contributing for the previous security service and the higher cost of contracting a new, more efficient service. Incidentally, the new company is the one used by all other UN agencies operating in the country. Other measures to improve the security of the premises were undertaken and will need to continue into the next biennium.

4.6 Strengths, Weaknesses, Opportunities and Threats (SWOT)

A SWOT analysis of PAHO/WHO's TC program was conducted to inform the development of the revised strategic agenda and the results are outlined below.

STRENGTHS	WEAKNESSES
• Respect and recognition of the Organization's leadership at country level; • Recognition of the Organization's role as an honest broker and trusted partner; • Ability to mobilize financial resources for TC; • A range of professionals and a mix of competencies and skills of staff for TC; • Ability to interface with subregional, regional and global levels to access technical support;	• Location and size of the office building contributing to vulnerability to physical and social hazards; • Difficulty in attracting and retaining technical staff; • Insufficient capacity to plan and manage projects effectively; • No clear definition for addressing priority country needs;

STRENGTHS (cont.)	WEAKNESSES (cont.)
• Strong partnerships with UN and other agencies; • Defined frameworks for planning, implementation, monitoring, and evaluation of TC; • Considerable achievements in several priority areas (e.g. malaria, safe blood, maternal and infant mortality); • Established mechanism to facilitate horizontal, inter-programmatic and intersectoral collaboration; and • Ongoing Government commitment to the provision of local support staff and office premises for TC.	• Continued parachuting from the regional and global level; • Disproportionate availability of external resources to address priority health needs; • Centralized and excessively bureaucratic process to facilitate TC (e.g. HR); • Limited engagement with some non-health sectors and civil society; • Insufficient resident competencies in key TC areas such as epidemiology, health information systems, IHR and research; and • Different and inadequate contractual arrangements for people doing similar work.
OPPORTUNITIES	**THREATS**
• Leadership of MOH; • Recognition of health and its importance to development; • Presidential focus on climate change and its impact on health and development; • Guyana's classification as a PAHO/WHO priority country; • Sustained and expanded relationships with traditional and non-traditional partners; • The existence of a national strategic plan for health and several sub-sector plans; • Revised CCS and systems in place to monitor and evaluate its implementation; • Potential for mobilising additional resources; and • Possibility to utilize funds earmarked for HIV/AIDS to strengthen the health system.	• Vulnerability of the country to natural and anthropogenic hazards; • Absence of an approved PRSP; • Social and demographic disparities; • Vulnerability of the CO (safety and security); • The unstable national security situation; • Limited national institutional capacity for sustained health development; • Human resource deficiencies and limited public health leadership; • Limited national absorptive capacity for TC; • Different timelines for planning country programs of UN agencies impacting on coherence; • Increased number of international actors in health; and • Limited coordination among partners and absence of national coordinating mechanisms.

5. STRATEGIC AGENDA FOR PAHO/WHO COOPERATION

5.1 Strategic Priorities of the CCS

Based on the situational analysis, consultation with national authorities and partners, and considering national, subregional, regional and global frameworks, as well as the comparative advantage of the Organization, PAHO/WHO's technical cooperation will focus on the following five strategic priorities for 2010-15:

I. Strengthening health systems governance, organization and management based on primary health care approach

II. Addressing the social and environmental determinants for improved health outcomes

III. Reducing the burden of diseases

IV. Enhancing family and community health

V. Leadership and management for results: strengthening the Country Office to effectively implement the CCS.

The overall strategic approaches to be employed in addressing these areas are:

- The six cross-cutting priorities of the Organization: ethnicity, human rights, gender, primary health care, social protection and health promotion ;
- Alliances, partnerships and networking internally and externally;
- Resource mobilization: internally and externally;
- Resource optimization at all levels of the organization to better respond to Guyana as a priority country;
- Strategic information for decision making;
- Direct technical cooperation to address gaps;
- Training and capacity building;
- Innovative technologies;
- Technical leadership in public health;
- Sustainability of projects and initiatives;
- Compliance with international agreements; and
- Technical Cooperation among Countries (TCC).

PAHO/WHO's core functions, as listed below, will also be applied throughout the implementation of the CCS:

1. Providing leadership on matters critical to health and engaging in partnerships where joint action is needed
2. Shaping the research agenda and stimulating the generation, translation and dissemination of valuable knowledge
3. Setting norms and standards, and promoting and monitoring their implementation
4. Articulating ethical and evidence-based policy options
5. Providing technical cooperation, catalyzing change, and building sustainable institutional capacity
6. Monitoring the health situation and assessing health trends

The main areas for action for each strategic priority, along with the strategic approaches that will be employed to address them, are detailed in section 5.2.

5.2 Strategic Areas, Main Focus, Areas for Action and Approaches

5.2.1 Strengthening health systems governance, organization and management based on primary health care approach

MAIN FOCUS: GOVERNANCE AND MANAGEMENT OF THE HEALTH SYSTEM

Areas for Action	Core Functions[2]	Approaches
Enhance the stewardship and oversight function of the MOH	1,3,4	• Promote evidence-based policy development and decision making • Provide direct TC to strengthen leadership • Provide direct TC to implement and monitor EPHFs • Build sustainability into projects
Strengthen managerial capacity at national, sub-national and local levels, including financing and resource management	3,5	• Provide direct TC • Information gathering • Development of tools for management and oversight • Mobilize resources
Increase capacity for planning, monitoring and evaluation (M&E), including the development of a harmonized national M&E framework	5,6	• Provide direct TC • Build capacity and develop tools • Collaborate with MOH to develop and use a national M&E framework
Strengthen essential public health functions (EPHF) with emphasis on social participation and quality assurance	1,3,5	• Support the implementation of the recommendations from the 2008 assessment • Promote social dialogue and community involvement in health • Development of tools • Advocate for application of norms and standards

MAIN FOCUS: HUMAN RESOURCES FOR HEALTH

Areas for Action	Core Functions	Approaches
Strengthen health workforce capacities	5	• Build sustainable capacity in collaboration with partners, including educational institutions • Promote and support continued education

(continued)

[2] *See PAHO/WHO Core Functions in Section 5.1*

MAIN FOCUS: HUMAN RESOURCES FOR HEALTH *(continued)*

Areas for Action	Core Functions	Approaches
Enhance the operations of the MOH HR Unit (to convert it into a planning unit)	3, 5, 6	• Provide direct TC to develop operational tools and guidelines • Monitor operations of the HR Unit
Strengthen human resource planning and management	1,4, 5, 6	• Provide direct TC in HR strategic planning, recruitment and retention • Foster partnerships/engage relevant partners/sectors, including the Public Service.

MAIN FOCUS: QUALITY HEALTH SERVICES

Areas for Action	Core Functions	Approaches
Strengthen the decentralized health service delivery network to foster integration and improved quality, especially for vulnerable populations	1,3, 5, 6	• Provide direct TC to develop and apply tools • Foster collaboration and knowledge sharing • Advocate for increased access of vulnerable groups • Foster social participation to improve accountability and quality in health
Support the implementation and monitoring of the Package of Publicly Guaranteed Health Services	5, 6	• Monitor and evaluate • Provide tools to strengthen financing and quality assurance component • Advocate for definition of roles and responsibilities in the delivery of the package
Support the integration of mental health services into the primary health care network	3,4,5	• Provide direct TC for capacity building • Advocate for the application of ethical standards
Support access to and use of appropriate technologies and essential medicines for prevention of diseases, improved diagnosis and treatment	1,3,5,6	• Provide evidence for medicines, technologies and vaccines • Provide tools for quality assurance and control • Monitor and evaluate

(continued)

MAIN FOCUS: PUBLIC HEALTH INFORMATION FOR DECISION MAKING

Areas for Action	Core Functions	Approaches
Support the development of a national public health (PH) research agenda and its implementation	1,2,4	• Provide direct TC • Identify strategic areas for PH research • Provide evidence to influence national policies • Promote the incorporation of ethical aspect in research studies • Engage with CHRC
Support the harmonization and use of health information	3,5,6	• Collaborate with partners • Advocate for integrated Health Information System (HIS)
Undertake knowledge management and information sharing	1,5,6	• Promote innovative information technologies and tools • Collaborate with partners • Strengthen the functions of the knowledge center and the Virtual Health Library (VHL)
Strengthen vital statistics	1,3,5,6	• Provide direct TC • Collaborate with key partners

5.2.2 Addressing the social and environmental determinants for improved health outcomes

MAIN FOCUS: SOCIAL DETERMINANTS OF HEALTH

Areas for Action	Core Functions	Approaches
Advocate for poverty alleviation, improved access to services and the reduction of other social inequities	1,2,4	• Advocate for health to be considered as key a pillar for development • Collaborate with partners • Provide evidence to guide interventions to reduce inequities
Support the mainstreaming of gender and human rights in health programs and interventions	1,2,3,4,5,6	• Advocate for gender and human rights approach as central to program planning • Incorporate gender and human rights approaches in all CO programs • Monitor and evaluate • Promote data disaggregated by sex in the HIS.

(continued)

MAIN FOCUS: SOCIAL DETERMINANTS OF HEALTH *(continued)*

Areas for Action	Core Functions	Approaches
Support the development of policies and initiatives to improve nutrition and food security	1,3,5	• Collaborate with partners to minimize the impact on nutrition of the population due to global food crisis • Promote the repositioning of nutrition as central to health • Provide direct TC • Monitor and evaluate

MAIN FOCUS: ENVIRONMENTAL DETERMINANTS OF HEALTH

Areas for Action	Core Functions	Approaches
Conduct risk assessment and support risk reduction measures	1,3,4,5,6	• Provide direct TC for capacity building, development of tools and procedures • Collaborate with partners • Disseminate information • Monitor and evaluate
Support implementation of the water safety plan	3,5,6	
Support implementation of strategic plan for sanitation	3,5,6	
Support establishment of Poison Control Centre	1,3,4,5	
Improve healthcare facility waste management	1,3,5,6	• Provide direct TC to determine the status and build capacity • Support introduction of appropriate technology and practices • Monitor and evaluate
Support the implementation of food safety standards	1,3,5,6	• Provide direct TC • Provide tools • Monitor and evaluate • Promote organic food products
Support implementation of national occupational safety and health (OSH) program	1,3,5	• Provide direct TC • Provide tools • Monitor and evaluate • Share information

MAIN FOCUS: EMERGENCY PREPAREDNESS AND RESPONSE

Areas for Action	Core Functions	Approaches
Support the development of a national disaster response plan	1,3,4,5,6	• Provide direct TC • Promote intersectoral collaboration • Promote mitigation measures • Develop and disseminate information, education and communication (IEC) materials • Mobilize communities and resources
Raise awareness of health effects related to climate change	1,2,5,6	• Collaborate with the National Climate Change Unit (NCCU) • Gather and share information

5.2.3 Reducing the burden of diseases

MAIN FOCUS: COMMUNICABLE DISEASES

Areas for Action	Core Functions	Approaches
Support the development and implementation of a plan for integrated management of vector-borne diseases	1,2,5,6	• Promote community responsibility and involvement • Adapt regional malaria elimination plan and support its implementation • Adapt the regional strategy for integrated management of dengue
Scale up interventions for filariasis elimination	1,3,5,6	• Promote community responsibility and involvement • Provide direct TC to support implementation of mass treatment programs • Provide direct TC to MOH in filariasis elimination program to meet 2010 target • Promote integrated vector management • Monitor and evaluate
Assess drug resistance for HIV/AIDS, STIs, TB and malaria	1,2,3,4,5,6	• Provide direct TC to assess the quality and efficacy of drugs • Provide tools and support their application • Monitor and evaluate • Collaborate with national authorities in updating the national integrated vector control strategic plan to include malaria
Support of the mapping of geohelminth infections in school-age children throughout the country and development of an integrated program for their control	1,2,3,4,5,6	• Employ synergistic approaches to address NTDs • Provide direct TC for mass drug admin. • Monitor and evaluate • Improve access to proper drinking water and to improved sanitation, as well as to health education

MAIN FOCUS: COMMUNICABLE DISEASES *(continued)*

Areas for Action	Core Functions	Approaches
Support the implementation for Integrated Management of Adult and Adolescent Illnesses (IMAI)	1,2,3,4,5,6	• Focus on HIV/AIDS, STIs, TB • Expand the patient monitoring system • Collaborate with NAPS, National TB Program and other relevant stakeholders
Strengthen the National TB Program	1,3,4,5,6	• Provide direct TC to expand and support DOTS • Promote co-management of TB HIV/AIDS • Monitor and evaluate • Implement the Stop TB Strategy focus in TB/HIV activities and MDR-TB prevention
Support the development and implementation of the IHR plan	1,2,3,4,5,6	• Provide direct TC for capacity building for Epidemic Alert and Response (EAR) • Strengthen capacity of the CO team on EAR • Undertake intersectoral coordination • Monitor, survey, and evaluate

MAIN FOCUS: NON-COMMUNICABLE DISEASES

Areas for Action	Core Functions	Approaches
Support mechanism for reporting on cancers and other NCDs	1,3,5,6	• Provide direct TC to develop a national cancer registry • Provide direct TC to address metabolic diseases
Support the development of healthy public policies	1,2,3,4	• Advocate for healthy policies • Undertake intersectoral collaboration • Support gathering of evidence
Promote healthy lifestyles to reduce risk factors related to NCDs	1,2,5,6	• Promote social mobilization and community participation • Undertake intersectoral collaboration • Provide direct TC in IEC
Support the implementation of the FCTC articles	1,2,3,5	• Support the development of tools to implement FCTC, public awareness, partnerships
Guide and support national initiatives for violence and injury prevention, and substance abuse	1,4,5,6	• Advocate for integrated response to gender violence and road traffic injuries • Provide direct TC to support policy implementation at all levels in collaboration with committees and task groups, including social mobilization and community involvement • Foster coalitions

MAIN FOCUS: INTEGRATED SURVEILLANCE

Areas for Action	Core Functions	Approaches
Strengthen national capacity for early detection of outbreaks	1,3,4,5,6	• Provide direct TC for development and implementation of tools, M & E
Support active and passive surveillance	1,2,5	• Provide direct TC • Advocate for involvement of community and health facilities
Support the development of a public health surveillance system	1,3,5,6	• Provide direct TC to expand surveillance system to include health conditions and risk factors, including the implementation of the WHO STEPwise approach to Surveillance of NCD Risk Factors (STEPS)

5.2.4 Enhancing family and community health

MAIN FOCUS: HEALTH OF WOMEN

Areas for Action	Core Functions	Approaches
Support the implementation of policies, strategies and interventions to improve maternal and newborn health at all levels of care, including community and family	2,3,4,6	• Advocate for women's empowerment • Provide direct TC to develop tools and advocate for quality measures • Monitor and survey • Promote increased access to equitable and culturally sensitive sexual and reproductive health services • Promote male responsibility in sexual and reproductive health • Collaborate with UN and other relevant stakeholders • Mobilize resources
Strengthen national capacity to protect women from vaccine preventable diseases	1,3,4,5,6	• Provide evidence for new vaccines (e.g. HPV) • Provide direct TC for policy development to guide introduction of new vaccines in the national vaccination program

MAIN FOCUS: CHILD & ADOLESCENT HEALTH

Areas for Action	Core Functions	Approaches
Support implementation of child survival strategy	1,3,4,6	• Provide direct TC in the application of IMCI

(continued)

MAIN FOCUS: CHILD & ADOLESCENT HEALTH *(continued)*

Areas for Action	Core Functions	Approaches
Support the EPI	1,3,4,6	• Support the country to maintain gains and expand, and improve quality, where possible • Provide direct TC for rapid response to outbreaks • Monitor and evaluate • Foster partnership and resource mobilization, and cross-border collaboration
Strengthen national capacity to address adolescent health in an integrated manner	1,2,4,5	• Support the implementation, monitoring and evaluation of the plan for comprehensive adolescent care • Support Integrated Management of Adolescent Needs (IMAN)
Support development and implementation of school health initiatives	1,2,3,5,6	• Provide direct TC in capacity building and IEC • Collaborate with partners and promote community participation

5.2.5 Leadership and management for results: Strengthening the Country Office to effectively implement the CCS

MAIN FOCUS: HUMAN RESOURCES

Areas for Action	Core Functions	Approaches
Build competencies of current staff to address gaps identified	5	• Revise the CO staff development plan to address the weak technical and administrative areas identified for action • Employ training methodology to most effectively address in-service training
Review existing posts to align them to CCS priorities and mobilise additional HR support to fill competency gaps	5	• Conduct a re-profiling exercise • Fill vacant posts, recruit STCs, and obtain secondments internally and externally • Maximize opportunities available through collaborating centres
Sustain high morale and positive team work	5	• Convene meetings, retreats, workshops and seminars for personal and professional enrichment

MAIN FOCUS: INFRASTRUCTURE DEVELOPMENT

Areas for Action	Core Functions	Approaches
Upgrade the physical facility	5	• Review and revise the Office Development plan based on needs assessment • Partner with UG for the management of the Knowledge Centre • Foster safe and healthy workspace conducive to increased productivity and MOSS compliance
Upgrade IT & communication including internet access	5	• Conduct an assessment of IT and communication needs and upgrade where necessary
Enhance equipment	5	• Mobilize resources to replace and upgrade equipment based on MOSS

MAIN FOCUS: OPERATIONS AND MANAGEMENT OF THE OFFICE

Areas for Action	Core Functions	Approaches
Apply organization rules and procedures	3	• Update manuals and train staff in required procedures
Ensure compliance with accountability and reporting requirements	3	• Conduct periodic review of documentation to identify and correct lapses • Submit in a timely manner the FRM checklist and BWP progress reports
Supervise and monitor staff	1,3	• Ensure PPES are prepared and evaluated according to the guidelines, and measures undertaken to address weaknesses in work performance
Undertake maintenance and inventory control	3,5	• Implement a scheduled maintenance system, review the status of equipment, and amend the inventory list accordingly

MAIN FOCUS: CORPORATE ENHANCEMENT

Areas for Action	Core Functions	Approaches
Undertake leadership and internal and external coordination	1	• Foster alliances, identify opportunities to improve corporate image and public health leadership
Prepare and disseminate strategic information	2	• Tailor information to different audiences using appropriate technology
Promote alignment and harmonization with the UN and other key partners	1	• Engage partners in the progress review of CCS against national strategic agendas and UNDAF

6. IMPLEMENTING THE STRATEGIC AGENDA: IMPLICATIONS FOR PAHO/WHO SECRETARIAT AS A WHOLE

Based on the strategic priorities identified and the main areas of focus, this section sets out an analysis of PAHO/WHO's capacity to respond to the revised strategic agenda for Guyana.

6.1 Shift in the requirements of PAHO/WHO's TC

PAHO/WHO's technical cooperation for this CCS is expanded to include critical and emerging public health issues, social determinants of health, implementation of IHR, epidemic alert and response, and health information systems, compared to the 2004-2007 agenda. While the areas of governance, health services and systems strengthening in the context of PHC, communicable and non-communicable diseases, and environmental health remain relevant for the current CCS, certain shifts in the public health agenda for the region, the decentralized health services in the country and the changing role of the MOH, require a corresponding shift in the response of PAHO/WHO at country level. As shown in Table 8 overleaf, there is the need for greater emphasis on core functions 3 to 6, and therefore the Organization's capacity to respond would have to be addressed through competency realignment and resource mobilization, where required. It is also noted that research remains an important core function and the Organization should better position itself to respond more effectively in promoting and engaging in public health research.

6.2 Implementation of the Strategic Agenda

Country Team

It is not expected that the CO would have all the necessary resources to implement the CCS and therefore the success of the CCS is premised on the mobilization of the technical and financial resources of all levels of the Organization (sub-regional, regional, and global).

Based on the analysis presented in Table 9, the Country Office will address, through its human resource development plan, those required competencies that lend themselves to continuing education initiatives and that can be addressed in country. For competency deficits that require more in-depth and formal education pursuits, opportunities will be sought through the PAHO Learning Board, virtual means, and relevant courses and seminars. The resources for this will be provided in part from the regular CO allocation, as well as through partnerships with other levels of the Organization and partners. Despite these efforts, the CO requires immediate scaling up of its human resource complement in the areas of epidemiology and program monitoring and evaluation, and will require full support from the three levels of the Organization to augment the existing competencies in the Office. In reviewing the competencies that would be required, and allowing for those that can be addressed by the CO, direct support will be required from the various Organization entities as outlined in Table 10. It is also noted that some key positions such as advisors in family and community health (FCH), malaria, and blood safety, are supported by extra-budgetary funding, and this presents some continuity and sustainability issues for the CO when those funds are exhausted sometime in the mid-point of the CCS.

An analysis of the competencies which currently exist in the CO, as well as those that will be required over the life of the CCS, are summarised in Table 9. Against this background, the country team will:

- Develop, implement, monitor, evaluate, and report on progress of operational plans for the two biennia covered by the duration of the strategic agenda in close collaboration with partners and other relevant stakeholders; collaborating centres; specialized centres; bilateral and multilateral cooperation agencies; academic institutions; and NGOs working in health;

- Articulate a plan for institutional development to strengthen the CO to effectively implement the CCS, including human resources enhancement, infrastructure development, and results-based management;

Table 8 – PAHO/WHO's Main Focus and Core Functions of the CCS for Guyana 2010-2015

Main Focus	Core Functions					
	1. Providing leadership and engaging in partnerships	2. Shaping research, stimulating knowledge dissemination	3. Setting norms and standards, promoting and monitoring their implementation	4. Articulating Policy Options	5. Establishing TC catalyzing change, building institutional capacity	6. Monitoring health situation and assessing health trends
Governance and management of health systems	+++	+	+++	+++	+++	+++
Human resources for health	+++	+	++	++	+++	++
Quality health services	+++	++	+++	++	+++	++
Public health information for decision making	+++	+++	++	++	+++	+++
Social determinants for health	+++	+	+	++	++	+++
Environmental determinants for health	+++	++	+++	++	+++	+++
Emergency preparedness and response	+++	+	+++	++	+++	+++
Communicable Diseases	+++	++	+++	+++	+++	+++
Non-communicable Diseases	+++	++	+++	+++	+++	+++
Integrated surveillance	+++	+	+++	++	+++	+++
Health of women	+++	++	+++	+++	+++	+++
Child & adolescent Health	+++	++	+++	+++	+++	+++

- Mobilize resources, human and financial, from internal and external sources to address the priority areas set out in the agenda and operational plans;
- Strengthen existing strategic alliances and build new ones for effective implementation of the CCS;
- Build national institutional capacity to enhance the role in the implementation of the TC program and ensure sustainability of interventions;
- Enhance international cooperation in health in line with the principles of the Paris Declaration;
- Collaborate with other UN agencies to bring about greater coherence and harmonization between the CCS and the UNDAF;
- Identity and develop TCC and other projects to address priorities of the CCS;
- Collaborate with the sub-regional, regional and global levels of the Organization in a mutually beneficial manner to achieve Organizational goals; and
- Identify, document and disseminate lessons learnt and best practices.

Sub-regional Level (OCPC, CAREC, CFNI, and PHCO)

- Involve the CO in the development, implementation and monitoring of key sub-regional health initiatives (CCH III, CARPHA and CARMEN);
- Engage the CO in the articulation of the Caribbean Strategic Agenda and joint programming;
- Provide direct technical support to strengthen competency gaps in the CO as outlined in Table 10;
- Support resource mobilization to address priority areas of the CO;
- Establish effective communication and coordination mechanisms with the CO; and
- Support the country in building synergies to address subregional declarations such as the Nassau and Port of Spain Declarations, and the Caribbean Health Promotion Charter.

Regional Office

- Recognize Guyana as a priority country and provide the necessary administrative and technical attention to help address the country's needs;
- Mobilize and allocate resources to address the priorities of the CCS and implementation of operational plans;
- Provide clear orientation and guidance on Organizational policies, norms, and standards to facilitate the effective implementation of the strategic agenda and respective operational plans;
- Support the implementation of regional and global frameworks such as IHR and FCTC;
- Provide the necessary tools and information to equip the CO in addressing complex health issues (GAVI vs. Revolving Fund, Intergovernmental Working Group on Public Health, Innovation and Intellectual Property, IGWG); and
- Provide direct technical support to strengthen competency gaps in the CO as outlined in Table 10.

Global Level

- Recognize Guyana as a priority country and provide the necessary financial and technical support to address country needs as identified in the CCS and operational plans;
- Mobilize and allocate the necessary resources to the CO as a priority country;
- Provide direct technical support to strengthen competency gaps in the CO as outlined in Table 10;
- Support the CO in implementing global frameworks and resolutions;

(continued)

- Provide administrative and technical support to facilitate partnership arrangements with relevant international partners and donor community; and

- Facilitate access to expertise available in collaborating centres.

Table 9 sets out the existing competencies and those required to effectively implement the CCS.

In addition to the aforementioned human resource development aspects, there is need to address some key functional and infrastructural issues as follows:

Functional

- Increasing alliances and partnerships, internally and externally;
- Consultation and negotiation;
- Resource mobilization;
- Compiling information on aid flows for health in the country; and
- Determination of the total PAHO/WHO contribution to the country.

Infrastructure

- Additional space and improved location;
- Upgrading of IT;
- Enhancing the office facilities; and
- Replacement of one vehicle.

Table 9 - Core capacities required to implement the CCS

MAIN AREAS OF FOCUS	EXISTING COMPETENCIES	REQUIRED COMPETENCIES
Governance and management of the health system	• Leadership • Planning and policy development • Project management, monitoring and evaluation • PHC strategies	• Health economics and financing • Public health legislation • Sustainability mechanisms
Human resources for health	• HR development policy • Analysis of HR capacity • Networking and partnership • Development of guidelines	• HR strategic planning • Recruitment and retention policies • Hospital administration • Knowledge and use of virtual tools for HR development
Quality health services	• Community involvement and social participation • Standard and protocols development	• Decentralization processes and experiences • Mental health • Appropriate technologies and essential medicine
Public health information for decision making	• Applied research • Identification of research opportunities • Analysis and use of information • Packaging for dissemination of research findings	• Strategies to influence use of research findings • Integrated health information • Utilization of statistical tools • Vital statistics • Virtual Health Library

(continued)

Table 9 - Core capacities required to implement the CCS (continued)

MAIN AREAS OF FOCUS	EXISTING COMPETENCIES	REQUIRED COMPETENCIES
Social determinants of health	• Utilization of tools to advocate with partners • Tools for identifying inequities in health	• Mainstreaming human rights and gender • Understanding of cultural sensitivity and diversity • Violence and injuries
Environmental determinants of health	• Water and sanitation • Norms and guidelines • Risk assessment	• Solid waste management, including biomedical waste • Food safety • Occupational health and safety • Risk assessment
Emergency preparedness and response	• Preparedness and response planning • Networking and collaboration • Risk communication	• Disaster mitigation • Safe hospitals • Climate change and health
Communicable diseases	• Surveillance and outbreak response • Drug resistance studies • Prevention and control of HIV/AIDS, malaria and NTDs	• IHR • Integrated vector control management • TB management
Non-communicable diseases	• Promotion of healthy lifestyles and reduction of risk factors • Advocacy for implementation of FCTC • Advocacy for healthy policies • Advocacy for violence and injury prevention • Social communication	• Surveillance, risk analysis and costing the burden of diseases • Nutrition • Mental health • Substance abuse
Health of women	• Maternal mortality surveillance • Norms, protocols and standards • Perinatal information system • Emergency obstetric care	• Maintaining the current ones and extending where possible • New vaccines
Child and adolescent health	• IMCI • EPI management	• Adolescent health

(continued)

Table 9 - Core capacities required to implement the CCS (continued)

MAIN AREAS OF FOCUS	EXISTING COMPETENCIES	REQUIRED COMPETENCIES
Leadership and RBM	• Administration • Financial management • HR management • Team building • Accounting and reporting • Knowledge management • Information technology • Networking and building partnerships	• Operational planning • Spanish and English language for local and external staff, respectively • Computer software application to enhance TC

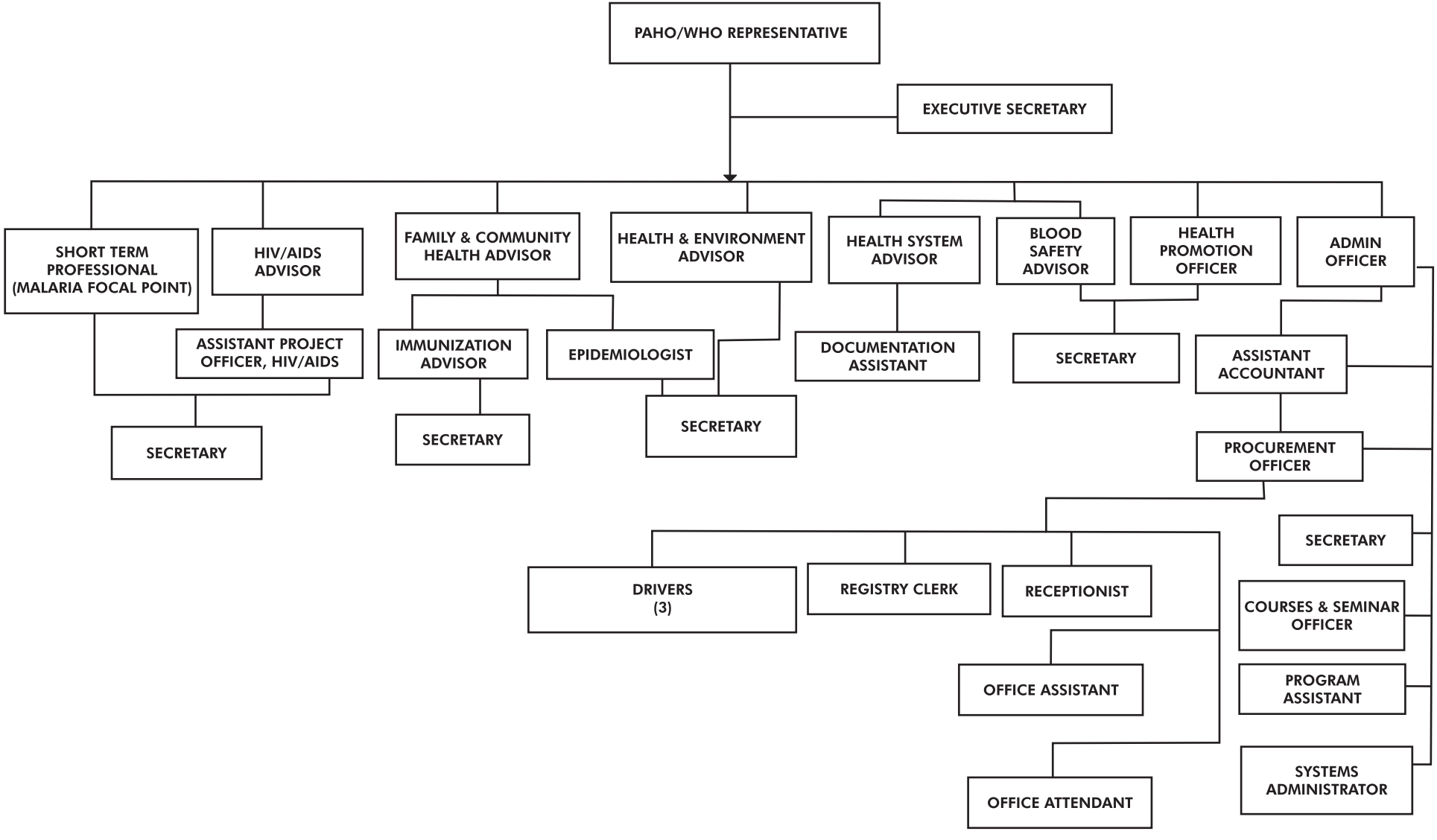
Table 10 - Additional Areas of Support from Sub-regional, Regional and Global Levels

Main Areas of Focus	Entity	
	Internal	External
Governance and management of the health system	HSS/PAHO and HSS/WHO	UNDP, ECLAC, IDB
Human resources for health	HSS, OCPC	UG, UWI, CIDA
Quality health services	HSS, THR	UG
Public health information for decision making	HSD, CAREC	CDC, PHAC, UNICEF
Social determinants of health	HSS, SDE, HSD, CFNI	FAO, CARICOM, IICA, ECLAC, IDB
Environmental determinants of health	SDE, PANAFTOSA	CARICOM, DFID CCCCC, IDB
Emergency preparedness and response	PED, OCPC, HAC	CDERA, USAID, DFID, ECHO
Communicable diseases	HSD, CAREC, PHCO	CDC, PHAC
Non-communicable diseases	HSD, OCPC, CAREC, CFNI	CARICOM, CDC
Health of women	FCH, CAREC, PHCO, CLAP	UNICEF, UNIFEM, UNFPA
Child and adolescent health	FCH, CLAP	UNICEF, UNFPA
Leadership and RBM	CFS, PBR, HRM,CCO FRM, PRO, GSO	UNDP

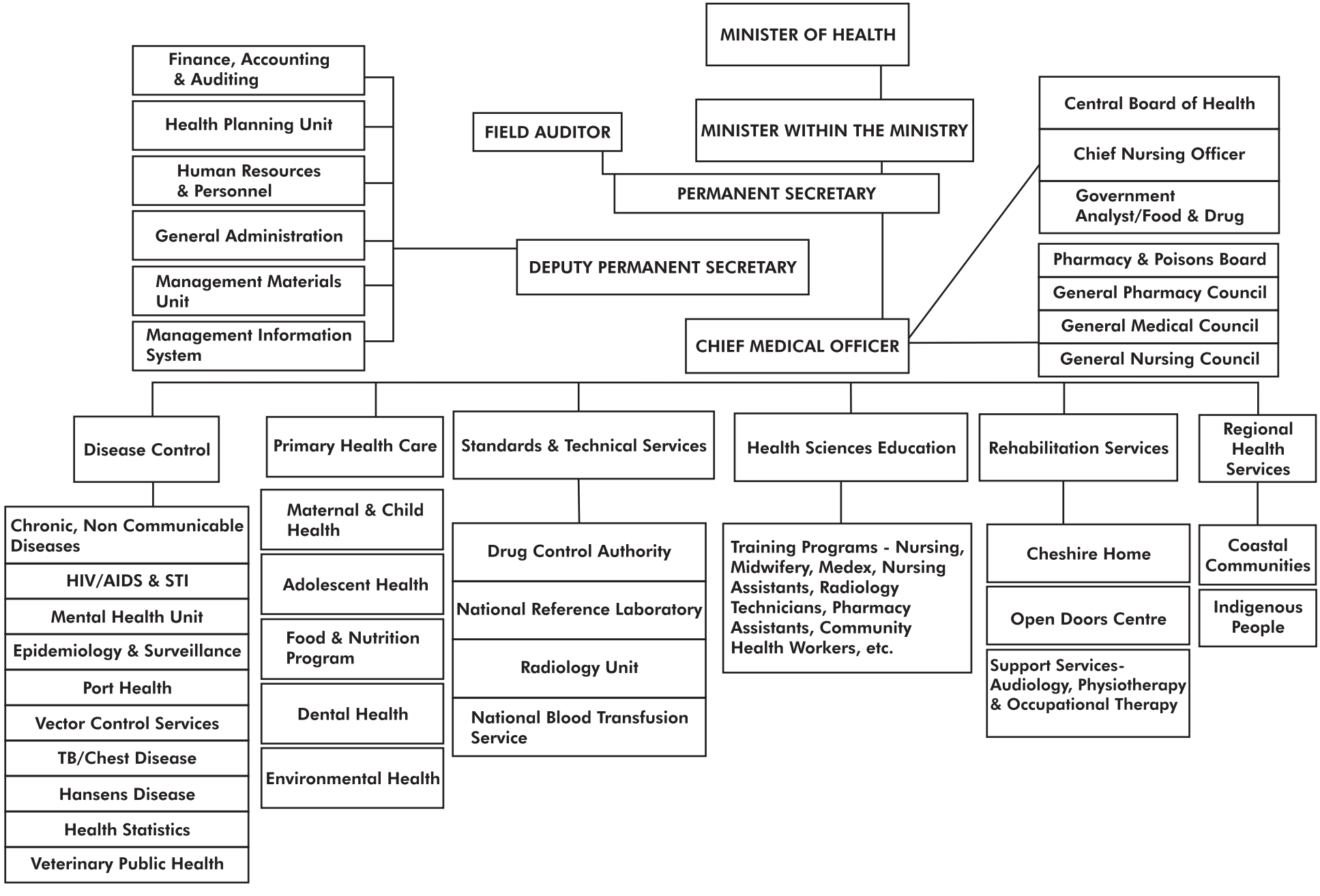
REFERENCES

1. Basic Agreement between the WHO and the Government of Guyana for the Provision of Technical Advisory Assistance (1968).
2. Biennial Work Plan, 2008-2009.
3. Cancer cases for the period January 2004-December 2007, Guyana Cancer Registry, September, 2008.
4. Caribbean Cooperation on Health (CCH) - Phase III.
5. Caribbean Heads of Government: the Report of the Caribbean Commission on Health and Development (2006).
6. Draft National NCD Strategy (2009).
7. EPI Evaluation Guyana Report.
8. Food Consumption Survey 2006.
9. Gap Analysis, MOH/PAHO, 2009.
10. Global School Health Survey, Guyana Report 2004.
11. Guyana Population and Housing Census Report, National Bureau of Statistics, 2002.
12. Guyana Strategic Plan for Sanitation (2008).
13. Health Agenda for the Americas 2008-2017, PAHO, 2008.
14. Health Facilities Licensing Act, MOH, 2008.
15. Health Facilities Licensing Regulation, 2008.
16. Health Statistics of Guyana 2000-2007.
17. Household Income and Expenditure Survey, National Bureau of Statistics, 2007.
18. International Health Regulations 2005.
19. Joint Workforce Project, MOH/PAHO, 2007.
20. Mental Health and Maternal and Child Health Strategies of Guyana.
21. Millennium Development Goals (MDG) 2005.
22. Millennium Development Goals.
23. Millennium Development Goals (MDG) Progress Report, 2008.
24. Multiple Indicator Cluster Survey (MICS) Report (UNICEF 2006).
25. Nassau Declaration, 2001.
26. National Development Strategy, 2001-2010.
27. National Drug Strategy Master Plan (2005-2009).
28. National Health Plan 2003-2007.
29. National Health Sector Strategy 2008-2012.
30. National NCD Strategy Document, 2007.
31. National Mental Health Strategy.
32. National Policy on Domestic Violence, Ministry of Human Services and Social Security, 1998.
33. National Policy on Domestic Violence, 2008.
34. National Strategic Plan for the Reduction of Maternal and Neonatal Mortality in Guyana 2006-2010.
35. Package of Publicly Guaranteed Health Care Services, MOH (2008).
36. PAHO/WHO Country Cooperation Strategy 2003-2007.
37. PAHO Strategic Plan 2008-2012.
38. Plan of Action, National Tobacco Control Council, (1998).
39. Population and Housing Census, National Bureau of Statistics, 2002.
40. Port of Spain Declaration, CARICOM, 2007.
41. Poverty Reduction Strategy (draft).
42. Regional Health Authorities Act, 2005.
43. Sectoral Analysis of Solid Waste, 2004.
44. UNDAF for Guyana 2006-2012.
45. WHO 11th General Program of Work 2006-2015.
46. WHO Mid-term Strategic Plan 2008-2013.

ANNEX I - ORGANIZATIONAL CHART: PAHO/WHO GUYANA COUNTRY OFFICE

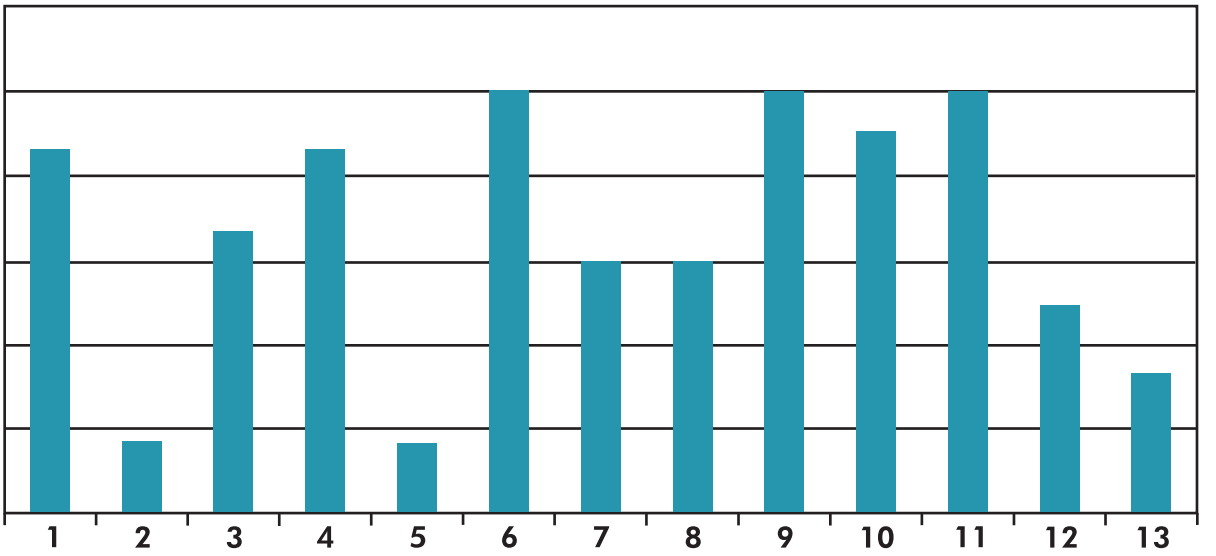


ANNEX II - ORGANIZATIONAL CHART: MINISTRY OF HEALTH, GUYANA



ANNEX III - MAPPING OF THE CCS STRATEGIC AGENDA TO THE MTSP 2008-2013

Strategic Objectives - degree of focus in CCS Guyana



Strategic Objective	Description
S01	To reduce the health, social and economic burden of communicable diseases
S02	To combat HIV/AIDS, Malaria and Tuberculosis
S03	To prevent and reduce disease, disability and premature death from chronic noncommunicable conditions, mental disorders, violence and injuries
S04	To reduce morbidity and mortality and improve health during key stages of life, including pregnancy, childbirth, the neonatal period, childhood and adolescence, and improve sexual and reproductive health and promote active and healthy ageing for all individuals
S05	To reduce the health consequences of emergencies, disasters, crises and conflicts, and minimize their social and economic impact
S06	To promote health and sustainable development, prevent and reduce risk factors for health conditions associated with use of tobacco, alcohol, drugs and other psychoactive substance use, unhealthy diets, physical inactivity and unsafe sex
S07	To address the underlying social and economic determinants of health through policies and programmes that strengthen health equity and integrate pro-poor, gender-responsive, and human rights-based approaches
S08	To promote a healthier environment, intensify primary prevention and influence public policies in all sectors so as to address the root causes of environmental threats to health
S09	To improve nutrition, food safety and food security, throughout the life-course, and in support of public health and sustainable development
S010	To improve health services through better governance, financing, staffing and management, informed by reliable and accessible evidence and research
S011	To ensure improved access, quality and use of medical products and technologies
S012	To provide leadership, strengthen governance and foster partnership and collaboration in engagement with countries, to fulfil the mandate of WHO in advancing the global health agenda as articulated in the 11th General Programme of Work
S013	To develop and sustain WHO as a flexible, learning Organization, enabling it to carry out its mandate more efficiently and effectively

ANNEX IV - LIST OF COUNTERPARTS AND PARTNERS CONSULTED

1. MOH (PS, CMO, HSDU, Public Health Reference Lab)
2. Ministry of Education
3. Ministry of Local Government
4. Ministry of Agriculture
5. Ministry of Labour
6. National Aids Program Secretariat (NAPS)
7. Climate Change Unit
8. Guyana Water Incorporated (GWI)
9. University of Guyana
10. UNDP
11. UNFPA
12. UNICEF
13. IDB
14. IICA
15. DFID
16. USAID
17. CDC
18. Guyana Red Cross Society

ANNEX V - LIST OF TABLES

ANNEX VI - LIST OF FIGURES

ANNEX VII - CCS GUYANA DEVELOPMENT PROCESS

Preliminary Phase

The initial intention was to have the second CCS ready to be implemented by the end of the previous CCS period (2007). However, this was not realized due to a few constraining factors which included, among other things: the change of PAHO/WHO Representative to Guyana and critical staff shortages in the country office at that time. This delay caused the country office to conduct a review of the national health situation and to explore with the national authorities whether the national health priorities that guided the 2003-2007 CCS were still germane. It was agreed that they were and should form the basis for the development of the interim BWP. The 2007-2008 BWP was developed accordingly with the understanding that work would commence with some dispatch towards the preparation of the new CCS. The desire to do so was communicated to Country Focus Support (CFS) and the dialogue commenced with PAHO Washington DC and WHO Geneva to establish a commencement date and the timelines for the completion of the exercise. In the meantime, the national counterparts and the staff in the PAHO/WHO Guyana Country Office (CO) were briefed about the CCS process, since there were many staff changes subsequent to the preparation of the first CCS which rendered the CCS process new territory for many persons.

The CO proceeded to develop a proposal which detailed the objectives, the process, the logistics and the persons who would comprise the CCS Team. This proposal was shared with CFS at the PAHO Headquarters in Washington DC, which in turn, shared it with the WHO Department of Focus (CCO) in Geneva, and amendments were made accordingly.

Preparatory Phase

A questionnaire was prepared to assist with the advance collection of information from partners, national counterparts, and civil society regarding the Organization's past and present cooperation with Guyana; the health-related programs of other partners, whether these were aligned with the PAHO/WHO technical cooperation program and possibilities for synergies; the perception of stakeholders as to how well PAHO/WHO was responding to the public health needs of the country; their assessment of PAHO/WHO's technical cooperation to include the strengths and weaknesses; any barriers they could identify with respect to PAHO/WHO's ability to deliver on its responsibilities; and any recommendations for the improved alignment of PAHO/WHO's technical cooperation in Guyana to more effectively respond to the national health priorities. A stakeholder interview guide and response sheet was developed to be used by the CCS team during the actual visit in the country.

To ensure as comprehensive a CCS as possible, a comparative matrix was also developed to highlight the main health priorities contained in the following frameworks and strategy documents:

- Guyana National Health Sector Strategy (2008-2012)
- Other relevant national strategies such as the HIV/AIDS (2007-2011); Situation Analysis of Maternal and Neonatal Mortality (2005)
- Strategic Plan for Maternal and Neonatal Mortality Reduction (2006-2010)
- Adolescent Pregnancy Prevention Strategic Plan (2008)
- The Guyana Poverty Reduction Strategy (draft)
- The UN Development Assistance Framework for Guyana (2006-2010)
- Regional frameworks for health: 1) Caribbean Cooperation in Health III; 2) Port of Spain Declaration; and 3) Nassau Declaration
- Millennium Development Goals and the MDG Progress Report for Guyana (2007)
- Health Agenda for the Americas (2008-2017)
- PAHO Strategic Plan (2008-2012)

During this phase, the Country Office formulated the agenda for the CCS mission to Guyana which was scheduled to take place from September 15-19, 2008. The finalization of this agenda was done via telephone conference and emails. Further, in collaboration with CFS, the CO organized a CCS virtual workspace for the posting and sharing of information and relevant documents. In advance of the mission, the CO also prepared CCS sections 1, 2 and 3 and commenced some work on Section 4. The CCS team therefore had access to these draft sections before the in-country activities commenced.

In-Country Mission

The week long in-country mission took place September 15 – 19, 2008. The process was led by the PAHO/WHO Country Representative, and the following persons comprised members of the team from PAHO and WHO, external to the Guyana Country Office:

- Dr. Funke Bogunjoko (WHO/CCO)
- Mr. Rony Maza (PAHO/CFS/Country Program Analyst)
- Dr. Cecilia Acuña (PAHO/HQ/HSS Program Manager)
- Dr. Maria Paz-Ade (PAHO/HQ/Advisor HSD)

The CO team comprised the following:

- Dr. Kathleen Israel, PWR
- Dr. Hedwig Goede, Health Systems and Services Advisor
- Dr. Luis Seoane, Family and Community Health Advisor
- Dr. Nicolas Ceron, Malaria Advisor
- Dr. Lundie Richards, Blood Safety Advisor
- Ms. Astrid Foo, HIV/AIDS Assistant
- Mr. Devindranauth Bissoon and Esan Cadogan, Environmental Health Assistants
- Ms. Indira Badal, Health Promotion

While the CCS team members mentioned in the foregoing played central roles in the interviews, discussions, and formulation of some aspects of the CCS document during the in-country process, this does not negate the supporting roles played by all persons working in the Guyana CO at the time, including the role played by Mr. Brian Lewis, Administrative Officer.

Upon completion of the first draft, the document was circulated to staff in the wider PAHO/WHO community for review and comments. All comments received were seriously considered and the final document will reflect many of these.

Prior to the completion of the mission, a meeting was held with the PWR, Mr. Maza, and Dr. Bogunjoko, and the Chief Medical Officer, the Permanent Secretary in the Ministry of Health, and other national health authorities, to present to them the main findings of the process so far, as well as the strategic priorities identified on which the CCS would be premised.

At the end of the one-week mission, there was still much work to be done and this was divided up among various members of the team. The feedback was to be sent to the PWR who would work with the Country Program Analyst/CFS to prepare a first draft of the document. The other follow up actions included:

- Stakeholder consultation on the draft strategic agenda. This took place in October 2008 and provided an overview of the entire CCS process commencing with the reasoning behind the CCS.
- Revision and finalization of the CCS.
- Endorsement by the major parties, including the Ministry of Health, the Director of PAHO, and the Director General of WHO.
- Publication and dissemination of final CCS document - "launch" of CCS.
- CCS implementation, monitoring and evaluation.

ANNEX VIII

Country Cooperation Strategy
at a glance

GUYANA

Total population (2002 Census)[1]	751,223
Population distribution % urban (2002 Census)[1]	28.4
Life expectancy at birth Total (years)[2] Male Female	66.65 63.70 69.30
Maternal mortality ratio per 100,000 live births[5]	112
Infant mortality rate per 1000 live births[3]	37
Total expenditure on health as % of GDP[4]	4.88
General government expenditure on health as % of general government expenditure	9.8
Human Development Index[2]	114
Human Poverty Index Rank for Developing Countries (HPI -1)[2]	48
Gross Domestic Product (GDP) per capita US$[2]	1,462 (2007)
Adult (15+) Literacy Rate Total / Male / Female	NA
% population with sustainable access to improved drinking water[3]	91
% population with sustainable access to improved sanitation[3]	98

Sources:
[1]Bureau of Statistics
[2]Human Development Report 2009
[3]Guyana Multiple Indicator Cluster Survey 2006
[4]Guyana Budget 2009
[5]Ministry of Health Guyana

Guyana, a country of approximate population of 751,223 and 214,970 sq. km land mass, extends along the north-eastern coast of South America and shares borders with Venezuela, Brazil and Suriname. It is the only English-speaking country in the South American continent, being a former British territory which gained independence in 1966. Guyana is thereby very closely linked to the English-speaking Caribbean and the Caribbean Community (CARICOM). The country is a democratic republic functioning under a Westminster system of government. Guyana is divided into 10 administrative regions and the local government structure consists of 10 Regional Democratic Councils (RDC), 65 Neighbourhood Democratic Councils (NDC), 6 municipalities and 76 Amerindian Village Councils. The country has a multiracial population with Indo-Guyanese representing 43.45%, Afro-Guyanese accounting for 30.20%, Amerindians representing 9.16%, and people of "mixed heritage" accounting for 16.73%. People of European and Chinese descent comprise a very small proportion of the overall population (0.07%). Georgetown, the capital, which comprises 20.7% of the total population, lies below sea level and as a result is prone to flooding. The economy of Guyana is based on its abundant natural resources (bauxite, gold and diamonds), including a fertile and productive soil, water resources caused by many rivers and a continental shelf off the Atlantic coast. The vast rain forest of Guyana led to the recent development of a Low Carbon Development Strategy in response to climate change issues.

HEALTH AND DEVELOPMENT

The Government of Guyana considers health to be the right of every citizen and the responsibility for the health of the people rests with MOH. The country has in place some key national frameworks such as the National Health Sector Strategy 2008-2012 which provide strategic direction to the ways the national health systems and services are organized and delivered.

Guyana's health care system is highly decentralized with the Ministry of Local Government and Regional Development undertaking responsibility for managing, financing and providing health services at the regional level through the Regional Democratic Councils (RDC) and the Regional Health Authorities (RHA). The RDCs and RHAs receive technical and professional guidance from the MOH. The private sector functions independently, but regulated by the Health Facilities Licensing Regulation which mandates standards of care and practices. The involvement of NGOs in service delivery is largely biased towards HIV/AIDS. In spite of an advanced network of health services in the periphery, access to health care in the more remote regions, which are also sparsely populated, makes equity in health and other infrastructural services for many indigenous people considerably challenging.

The public health services are mainly financed by the government, with contributions from the donor community. There has recently been a significant increase in the allocation to the health sector amounting to 10% of the total government recurrent budget in 2007. Guyana's per capita health expenditure compares very favourably with other Latin American and Caribbean countries with an increase from US$45.00 in 2005 to US$67.00 in 2007. There is no national health insurance system, but a national insurance scheme for employees exists, and is mandatory for all employed persons between the ages of 16-60 years, including the self-employed.

In its steady march towards the achievement of the Millennium Development Goals, Guyana has made significant advances in its efforts to eradicate extreme poverty, combat HIV/AIDS and achieve environmental sustainability. The attainment of the health-related MDGs, such as improving child and maternal health, and reducing the level of HIV/AIDS, tuberculosis and malaria, still faces some major challenges. In addition, the epidemiological transition towards non-communicable diseases, which now account for very high burden of mortality and morbidity, combined with the presence of unrelenting communicable diseases, present considerable challenges to achieving better health outcomes for the population.

OPPORTUNITIES	CHALLENGES
• Very high level of political commitment towards improvement of health services and health outcomes of the population. • Availability of current and comprehensive policy guidance for health. • Availability of Package of Publicly Guaranteed Health Services. • Government financing of health services and commensurate per capita expenditure on health. • The passage of Regional Health Authority Act and the MOH Act to support decentralization and funding of health services.	• Unavailability of integrated health information system and limited use of health information to support decision making. • Limited infrastructural facilities, difficult terrain, and sparsely populated hinterland, making delivery and monitoring of health services difficult. • Insufficient human resources (HR) for health and absence of a HR Strategic Plan. • High burden of chronic non-communicable diseases • Persistent new and emerging communicable diseases including neglected diseases (eg: geohelminthiasis). • High maternal and infant mortality. • High burden of mental disorders, suicide rates and substance abuse. • Vulnerability to natural and man-made disasters and weak epidemic alert and response capacity. • Inadequate quality of health services.

PARTNERS

Guyana has benefited from the Enhanced-Highly Indebted Poor Countries (HIPC) initiatives since 1997 with an overall reduction of the country's external debt from 122% of the GDP at the end of 2002 to 38% in 2008. The HIPC status, which is changing, has also facilitated the flow of a significant amount of resources into the country from many bilateral, multilateral, and international partners. The key multilateral agencies supporting Guyana's health sector reform through infrastructural development and institutional strengthening include the Inter-American Development Bank (IDB), World Bank (WB), the Global Fund for AIDS, TB and Malaria (GFATM); and the Global Alliance for Vaccines and Immunization (GAVI). Bilateral partners include the Canadian International Development Agency (CIDA), China, Cuba, the European Union (EU), the United States Agency for International Development (USAID), the Japan International Cooperation Agency(JICA), the President's Emergency Plan for AIDS Relief (PEPFAR), the USA Centers for Disease Control and Prevention (CDC), and UN Agencies such as PAHO/WHO, UNICEF, UNDP, UNFPA and UNAIDS. Despite efforts to mobilize resources for other priority health areas, HIV/AIDS continues to attract the majority of the external funds for health. In addition to the external financial resources to which the country has access, considerable technical support is received on a regular basis from Cuba, particularly in relation to provision of health professionals.

OPPORTUNITIES	CHALLENGES
• Partnership arrangements with CARICOM, the University of Guyana, and other entities. • High interest of several donors to support public health initiatives in the country resulting in sizeable amounts of extra-budgetary funds. • The existence of a current UNDAF reflecting the first real efforts in harmonizing the UN presence in Guyana. • Revision and updating of key legislation to support fairness and equity in the practice of health care providers (public and private).	• Multiplicity of partners with variable project requirements and high transaction costs. • Weak mechanism for coordination and harmonization of aid flows into the country. • Improving aid effectiveness through better alignment of partners' resources with established national priorities. • Ensuring sustainability of donor-supported health and related programmes. • Weak intersectoral collaboration and private-public partnership for health development. • Low national absorptive capacity.

PAHO/WHO STRATEGIC AGENDA (2010-2015)

Over the period 2010-2015, PAHO/WHO's technical cooperation with Guyana will address the following five Strategic Priorities and the related Main Areas of Focus:

1. **Strengthening Health Systems governance, organization and management based on primary health care approach with emphasis on** governance and management of the health system; human resources for health; quality health services; and public health information for decision making.

2. **Addressing the social and environmental determinants for improved health outcomes focusing particularly on** social determinants of health; environmental determinants of health; emergency preparedness and response; gender mainstreaming; and supporting the development of policies and initiatives to improve nutrition and food security.

3. **Reducing the burden of diseases** with emphasis on communicable diseases; non-communicable diseases; integrated surveillance of communicable and non-communicable diseases; development of healthy public policies; and promotion of healthy lifestyles to reduce risk factors related to NCDs.

4. **Enhancing family and community health** particularly health of women; child and adolescent health; and supporting the implementation of policies, strategies and interventions to improve maternal and newborn health at all levels of care, including community and family.

5. **Leadership and management for results** with emphasis on strengthening the Country Office to effectively implement the CCS.

ADDITIONAL INFORMATION: WHO: http://www.who.int/countryfocus/cooperation_strategy/

PAHO/WHO Guyana Country Office: http://new.paho.org/guy

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Notes

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