Restructuring the Health Sector in Guyana

Introduction: Guyana embarked on a Health Sector Reform Program when Cabinet approved a menu of health sector reforms (Appendix 1) contained in a paper submitted to Cabinet by the Minister of Health in September 1998. The Ministry of Health, after extensive consultation, approved a Health Sector Reform Program 1999-2005 (appendix 2). The Program was informed by the Draft National Development Strategy and the National Health Plan 1995 - 2000.

Aspects of the Reform Program have been addressed through a twenty-four month Bill/GOG Health Sector Project (Appendix 3). This project has suited detailed recommendations that will profoundly alter the structure and function of the health sector, public and private. The changes are designed to transform the health sector to become more accessible, effective, efficient, equitable and financially sustainable.

The Ministry of Health established a Health Sector Reform Unit in September 1998 and tasked it with the responsibility to develop, plan and implement the reform program. A Director for the Unit was appointed. The HSRU developed a Vision and a Mission for the Reform Program and the Health Sector Reform Program 1999-2005 and the Regional Health Authorities in the Decentralization Process Policy papers. These papers established that the main focus of the reforms were institution building, capacity building and restructuring of the health sector. The Report is Structured in three parts as follows: Part 1: Summary of The Reform Program; Part 2: Status of Each Component; Part 3: Annexes.

1.0 Part 1: Summary of the Reform Program

1.1 Part One of this Report describes the reforms or areas of reforms that the Ministry of Health has embarked on planning to implement between 1999 - 2005. While certain specific reform strategies and objectives have been identified and certain details developed (See Table 1 for listing of Available Policy Papers), all the strategies and approaches have not been conceptualized. Since this is a dynamic process, it is expected that other areas of reform might be added as the HSR implementation process proceeds.

1.2 Vision of the HSR: Health Sector Reform will result in a well managed health sector of the 21't century in Guyana that is committed to keeping abreast with good health care practices and procedures, maximizing community involvement and ensuring that all citizens have access to effective, efficient and equitable health care services provided by compassionate, caring, adequately trained, creative and resourceful personnel within an appropriately equipped, financially sustainable, comfortable and empowering health care environment.

1.3 Mission of the HSR: The HSR program will achieve its Vision by systematically and comprehensively transforming the present health system and its management processes into a decentralized, policy-driven, accountable structure with contemporary management systems that enable the Ministry of Health to achieve its new Vision and Mission, and the sector to promote health and provide effective, efficient and equitable health care for all through community health programs, and sound treatment methods in a primary health care setting, I complimented by secondary and tertiary health care services.

1.4 The HSR program is in keeping with the draft National Development Strategy and is a direct consequence of the National Health Plan 1995-2000. It is also consistent with the strong partnership in health between the Ministry of Health and the Government of Guyana's CARICOM partners, PAHO/WHO, Caricom and the Bill.

1.5 Although the Government of Guyana acknowledges that increased financial investment in the health sector throughout the 1990s (Appendix 4) has led to significant improvements; it recognizes that the health sector has not adequately met the health care needs of the population. This is not only due to deficiencies in the infrastructural and organizational deficiencies of the present system, but also because the system has failed to or is functionally and structurally incapable of responding to the changing health environmental.

1.6 Thus, the Government has embarked on an extensive program of health sector reforms. These reforms target the issues of effectiveness and quality, efficiency, equity, inter-sectoral and community participation and financial sustainability. A cabinet
The Health Sector that the HSR seeks to create is not based on a narrow definition whereby health was defined merely as an absence of disease or infinity. The HSR is premised on the WHO's definition of Health: Health is a state of complete physical, social and spiritual well-being. In keeping with this perspective, the HSR takes cognizance of the Ottawa Charter 1986 and the Caribbean Cooperative in Health (CCH). Guyana as part of the cooperative has adopted the vision for health in the Caribbean as v pronounced by the CCH.

1.9 The HSR program also is based on certain key elements of change. These elements are: Empowerment - maximizing community participation. Decentralization of the New Ministry of Health, steering, not rowing. Efficient Materials Management - value for dollar. Sustainable Financing. Primary Care is the most cost effective health investment -- Effective Hospitals Referral system is important in an integrated health care system. Opportunities for greater private sector involvement (Private-public sector mix for more effective health system) Effective information system that assist in decision making. Quality mechanisms, not just money, must drive changes. Audit and review Human Resources remain a critical component for success. Communication - a continuous dialogue between Government and the community Legislative Framework.

1.10 Decentralization is a major principle in Guyana's HSR (1.10 -1.16). A significant component of the Health U Sector Reform program is the separation of the direct providers of the services from the Ministry of Health that will finance and regulate providers, through the decentralization of health delivery functions. Various forms of decentralization have been considered in the present reform program. The main model of decentralization is one of devolution of responsibilities for services provision to incorporated public agencies with independent powers (e.g. the Regional Health Authorities, Georgetown Public Hospital, Materials Management Agency). Other agencies will only be delegated powers to coordinate and manage agreed set of programs and projects addressing specific health needs (for example, cancer care by the Cancer Board, mv/AIDS by the HIV/AIDS Secretariat and Mental Health by a Mental Health Board).

Devolution and delegation will be underpinned by legislation and implemented within an accountability framework. The Ministry will retain residual powers that v could be enacted under conditions of emergency, failure to exercise fiduciary responsibilities, non-compliance with regulatory requirements, criminal activity and the like.

1.11 Regional Health Authorities (RHA). As part of the decentralization process a major reform task included in the menu of reforms is the reform of the present regional system for health care services. In this system, the ten Regional Democratic Councils (RDCs, local government units) administer primary and secondary health care services. This decentralized system came into effect in 1986, but has not functioned efficiently. The present V HSR process proposes that primary and secondary health care provisions be devolved to Regional Health Authorities (RJL4s), which are similar to this established in Trinidad and Tobago, Jamaica and nine provinces Canada. The RHAs will assume responsibility for health care provisions and replace the RDCs in the role they presently perform for the Ministry of Health. The proposal for the establishment of RHAs in Guyana is discussed in detail in a document entitled Regional Health Authorities (RHAs) in the Decentralization Process in Guyana (May, 1999). The problems confronted in the present regional system of health delivery and the possible impact of different reform options, including establishment of RHAs, are presented in Appendix 5.

1.12 Devolution of responsibility for Georgetown Public Hospital to Statutory Board. A second major component of the decentralization process in the HSR program is the devolution of authority for the Georgetown Public Hospital to a statutory Board. The Ministry of Health has initiated the process to relinquish V management responsibility for the everyday operation of the institution to the board. The process to statutorize the Board has also been completed. An order made under the Corporations Act, 1988, was signed by the President and was published in the Official Gazette on May 7, 1999. This order was placed in Parliament (July v 1,1999) where it was subjected to negative resolution. Parliament approved the Order and it became part of the laws of Guyana on August 10, 1999. A Board was appointed on November 1, 1999 and assumed full responsibility for the hospital on January 2000.

1.13 Materials Management Agency. The Ministry of Health accepts that one great weakness in the present health sector is Materials Management. This includes both procurement and distribution of goods and services. The HSR program addresses this important function in the health sector. The HSR program includes a strategy to establish an autonomous agency to coordinate materials management within the public health sector. A transitional board has been named and a CEO for the agency has already been contracted. Legislation to give legal status to the Materials Management Agency is in preparation.

1.14 Delegation of Functions to Semi-Autonomous Agencies. Among other important reforms that have also been "v" defined and are in advanced planning Stages are more focused programs for primary health care, mental health, communicable diseases, chronic diseases, maternal and child health care, Sffis, HIV/AIDS and cancer programs. Some of these programs will be delegated to semi-autonomous agencies. The National Cancer Board and the National AIDS Secretariat, for example, have been established and will be delegated responsibilities for implementing programs for cancer and AIDS education and treatment.

1.15 Center for Disease Control: The possibility of establishing a Center for Disease Control is being considered an important part of the HSR.

1.16 Restructuring the Central Ministry of Health. The reform projects listed in 1.10 - 1.15 clearly demonstrate that the role of the Ministry of Health will be radically changed with the successful implementation of these objectives. In fact the successful implementation of the various programs is critically dependent on the restructuring of the central Ministry of Health. Indeed one of the significant goals of the HSR is to transform the Ministry of Health from its present function whereby it plans (make policies), implement programs (manage the provision of health care services), monitor and evaluate the services and regulate health care delivery in Guyana. In the transformed Ministry of Health, its role will be to set overall policies within the public health sector, regulate health delivery (public and private),
regulations and standards. These will include regulations, quality and standards for the private sector. Although not listed as a specific reform objective, formulation of policies pertaining to regulation, standards and quality will be an integral part of the reform process.

1.18 Sustainable Financing: A significant reform program that is occupying the attention of the Ministry of Health and the Government of Guyana is the attempt to establish a sustainable mechanism for financing and allocating resources within the health sector while maintaining equity.

1.19 Basic Set of Health Services: The public sector will not be able to meet all demands for health care. Governments around the world have sought to find ways of limiting their obligations, yet meeting the requirement of equity for their population. This is consistent with the need to develop a sustainable financial base for the health sector. One method to limit expectations for health provisions from the public sector is to define a publicly guaranteed portfolio of health care services (the basic health package). The HSR program envisaged by the MOH includes consideration of a basic health care package for Guyana.

1.20 Focusing on Primary Healthcare: Primary Healthcare (PHC) programs are the most cost effective investment in the Health Sector, i.e. they provide the most outcome impact from each dollar invested in the sector. The HSR seeks to emphasize PHC. With a focus on PHC and a commitment to make PHC the cornerstone for achieving "Health for All", the HSR seeks to direct a greater allocation towards PHC. The PHC program will focus on Health Promotion as pronounced in the WHO Ottawa Charter of 1986.

1.21 Formalizing Environmental Health as an Important Component of the Health Sector: Although environmental health has always been an integral part of the health sector, the actual structural and process organization of the sector make environmental health a side activity of the Ministry of Health. In addition, responsibility for environmental health is the purview of several organizations and agencies, with little coordination. The Ministry of Health recognizes that in the final analyses, the Ministry of Health speaks for all matters pertaining to human health. Therefore, mechanisms are to be put in place for coordination of all activities associated with environmental health issues. Included in the provision are MOOs to be signed with several Ministries, Organizations and agencies. Already, an MOO has been signed with the EP A.

1.22 Quality Health Services: A major objective of health sector reform in Guyana is to create a quality health care service for Guyanese. The HSR includes provision to establish a Patient's Charter (patient's Rights) and Health Quality Council. The quality component of the HSR includes establishing mechanisms for quality and performance improvement and measurement.

1.23 Effective Referral System: The reformed health system will depend greatly on an efficient referral system. The new referral system will seek to remove the difficulties that now contribute to breaches of the system. It will identify penalties for breaching the system for both providers and patients. The system will also present incentives for both users and providers to effectively use the referral system.

1.24 HIS (Health Information System) is a resource that cannot be ignored in a modern health care system. Health is an information intensive sector. Information is the sector's lifeblood, necessary for delivering treatment and care, providing sound management and ensuring accountability. Data from communities and from institution must inform policies and actions taken. For example, health policies must be dictated by needs assessment. However, acquired data must not be limited to health status or disease profiles etc. The data must include economic, financial, social and management information. This is a major weakness of the public health sector in V Guyana. The HSR intends to establish an efficient HIS system for the Guyanese public health sector.

1.25 Capacity Building: A successful implementation of the proposals in the HSR will depend critically on the capacity of the health sector to act on the proposals. This means that both the human and institutional capacity must exist. The HSR includes provision to build this capacity.

1.26 Legislative Actions: Given the magnitude and nature of the changes that the HSR is to effectuate, legislative support has been deemed to be necessary. Not only is there need to create legislation to provide support for some of the changes proposed, but also there is a recognition that many of the legislation that are Restructuring the Health Sector active within the health sector of Guyana are obsolete or archaic. Thus, an important component of the HSR program is to modernize existing legislation and create new legislation that governs the health sector in Guyana.

1.27 Some of the legislation affects regulation governing professional practice within the health sector. New institution regulation and regulation affecting doctors, nurses and paramedical professions are proposed. Regulation will be required for the Ministry of Health to perform its new steering role. Regulation is necessary in terms of quality (standards of care for the private and public sectors, licensing and accreditation of facilities, private practice by public physicians, staff regulation at facilities, minimal information to be disclosed to patients), and in terms of prices and quantities (controls over the purchase of equipment and expansion of capacity in order to control cost, regulation of manufacturing, distributing and sale of drugs).

1.28 Physical infrastructure and Technopolitical Capacity: Although not listed and not discussed as a component of reform, consideration must be given to strategies to deal with the physical infrastructure and technological capacity within the health sector. The present physical plant and technological capacity of the health sector are in a poor state. This is despite the fact that great financial investment has been made over the previous decade. Clearly, a different approach to infrastructural and technological development and maintenance is needed. However, it is hoped that the reformed health sector will more effectively deal with the issue of the physical plant and technological capacity of the health care system. As part of the technological capacity, emphasis will be placed on development of diagnostic technology. A system of a referral lab with satellite facilities (labs) will be instituted.
1.31/DBIGOG Project: The small HSR Unit will work closely with the Team from RMC (Resources Management - Consultants Ltd.) implementing the illB/GOG Health Sector Policy and Institutional Development Program. The program is financed through a technical assistance grant from illB. The objective of the illB/GOG program is to assist the Government of Guyana in the definition and implementation of policies to address institutional, financial, equity and quality problems in the health sector, and thus improve the efficiency, equity and quality of health services. RMC reports to the Policy Committee, which is chaired by the Minister of Health and Labor. Its members include the Director of the HSRU as Principal Advisor to the Minister on Health Reform, the PS and CMO of Health, the deputy PSs of public service Management, Local Government and the Head. Project Cycle. Division, State Planning Secretariat, Ministry of Finance.

Two critical and early tasks of the RMC led by the RMC Project Director/Health Policy Specialist are the reorganization of the Ministry of Health and implementing the restructuring of the health sector into regional Health authorities. Both have involved close consultation with the HSRU Director.

1.32 Consultation on Health Reform: A critical component of the HSR is the consultative process. The changes that are targeted will involve the active participation of all stakeholders. The Government is determined to establish "a process of interaction between itself and national and regional groups and the various communities in the main issues involve in the HSR. The aim is to mobilize and motivate large numbers of people to contribute to the common vision that HSR espouses.

Table 1. List of Policy Papers on Various Reform Components:

2. Regional Health Authorities in the Decentralization Process in Guyana. Prepared by Dr. Leslie Ramsammy, Director, Health Sector Reform Unit, Ministry of Health. September 1999.
8. Rebuilding the Infrastructure of the GPH by Dr. Leslie Ramsammy, March 1999.
Table 2. Principles of Health Reform

1. Improvement of life of all citizens is the goal of the reform.
2. Health is not merely an absence of disease or infirmity.
3. The reforms recognize that Primary Health Care services are the foundation of the people's health and improved quality of life.
4. Compassion in making decisions that affect people negatively.
5. All groups must be involved in health reform and community participation must be maximized.
6. The Ministry of Health speaks for all human health, but human health issues are dealt with in various sectors, e.g. education, environment, agriculture, housing, water. There must be inter-sectoral collaboration and the MOR must coordinate this.
7. Decentralized decision-making can be best made by citizens using a community development approach.
8. Public involvement requires information, communication, respect and trust.
9. Decision-making must be information-based.
10. Decisions by all must be transparent and decisions made about people's health services will not be made in secret.
11. Guyanese accord high value to health care and demand improvement in standards and accessibility.
12. Financing the health sector is challenging, but sustainable mechanisms must be developed.
13. Public expects to have a say in how public funds are spent, thus creating a dilemma because the same public expects increasing public expenditure on health.
2.0 Part 2: Status of the Reform Program:

2.1 A Health Sector Reform Unit has been established. The responsibility for planning and implementing the Health Sector Reform Program was tasked to the Health Sector Reform Unit. The Unit was established in September 1998. The Unit has no budget and no support staff at this time. It has a Director and it relies on utilization of various staff members at the Ministry and the expertise of the Consultants from the IDB/GOG Health Project in order for it to accomplish its goals.

2.2 The functions of the HSRU are as follows:
Facilitate the orderly and systematic implementation of the reform program.
Facilitate the timeliness of the reform program.
Establish prioritization of the reform process.
Monitor the implementation process.
Evaluate the performance or effectiveness of the refunded programs.

2.3 List of Health Sector Reforms and Status: Table 3 is a list of the various reform components. Column #4 briefly presents the status for each component. Even though the Reform process has completed only its first year, considerable advance have been made. In most cases, a recommended plan of action is already in place but a detailed implementation program is yet to be developed. In some cases, implementation plans are already in place and these components are already advanced in the reformed process.

2.4 Implementation of the Plan to Devolve Georgetown Public Hospital has begun: Several examples to demonstrate that the reformed process is progressing are evident from Table 3. For example, the goal of establishing an autonomous Board to operate the Georgetown Public Hospital has been accomplished. The Board derives its statutory authority from Order #3 of 1999 that established the Georgetown Public Hospital as a Corporation under the Public Corporations Act, 1988. The GPH has its own subvention from the Government. Already the Hospital has developed its first ever five-year strategic plan called Vision 2005 and has put in place a Year 2000 work plan and an investment plan for the rebuilding of its infra-structure. The work plan includes projected targets such as a reduction of maternal mortality from 8 per 10,000 (1999 rate) to 5 per 10,000 and neonatal mortality from 23 per 1,000 (1999) to 18 per 1,000 for Year 2000. Other projections include an increase in its surgical load from 4,800 in 1999 to 6,500 in 2000, an increase of 10% for C-section, decreases in average bed time per patient in the maternity (10%), surgical (25%) and medical wards (15%), an increase in its occupancy rate to 700/0, a 10% decrease in waiting time in the various out-patient clinics, a decrease of 5% for the cost per meal and a decrease of 10% in the cost of cleaning per piece of laundry. The Hospital is also developing a human resource department and implementing various quality measures. In terms of sustainable financing, the Hospital is categorizing its services in an attempt to establish its obligation to the general public and clearly distinguish its services as free service and cost-sharing services. The devolution of the GPH is serving as a learning experience for the Ministry as it seeks to implement more effective decentralization systems in the sector. In many ways, the experiences of the GPH serves as a pilot for the reformed process.

2.5 The Re-structuring of the Ministry of Health: The restructuring of the Ministry of Health from having responsibility of service delivery functions to a sectoral steering/leadership role with responsibility for policy, planning, legislative/regulatory functions, coordination, budgeting, monitoring and evaluation role is proceeding. A reformed structure and function strategy was proposed by the IDB/GOG Health Project and adopted by the Ministry of Health in February 2000 and a Cabinet paper on the restructuring has been submitted. Approval by Cabinet will pave the way for V implementation of the restructured plan. The Cabinet paper is presented as Appendix 7. While awaiting Cabinet approval, the Ministry of Health has permitted the IDB/GOG Health Project to conduct an assessment of the senior level human resources in the Ministry and to establish a gap assessment so as to determine training and recruitment needs. A fundamental change in the re-structured Ministry is that the position of Chief Medical Officer (CMO) is re-defined with different functions from the existing CMO. This is shown in Table 4. The proposed structure for the new Ministry of Health is shown in Fig 1.

2.6 Other Reforms that are Advanced: Other reformed programs that are advanced include the implementation of Regional Health Authority system, the establishment of a Materials Management Agency, the establishment of an autonomous agency to be delegated responsibility for provision of cancer services and the development of a set of basic health services for Guyana, designed as sets of services at each level of care.

2.7 A Guaranteed Portfolio of Health services (Basic Health Package) has been proposed and is under consideration by the Ministry of Health. If accepted by Government, the Basic Package plan will be piloted in one or more regions to evaluate its effectiveness. The Basic Package proposal is shown in Table 5.

2.8 An effort to update the legal framework within which the health sector functions is receiving attention from the Ministry of Health. A new Ministry of Health Act has been proposed. Amendments to the Nurse Practitioner Act 1953 and the Medical Practitioner Act 1991 are underway.

2.9 A sustainable financing of the Plan is being developed by the Ministry. This component of the reform considered crucial, but
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<td>I. Develop Vision</td>
<td>1.2 and 1.3</td>
<td>A logical program can only be developed if a clear Vision exists as to what the Government wants. The Mission of the Program must state how it intends to achieve the vision.</td>
<td>Completed. The Vision and the mission statements have been agreed upon. A new Mission Statement for the New Ministry of Health has also been agreed upon.</td>
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<td>2. MINISTRY OF HEALTH RESTRUCTURING (Includes formulation of regulations quality, and standards)</td>
<td>1.16</td>
<td>Ministry to be transformed to reflect its focus on policy creation monitoring, evaluation and regulation. The functions of direct provision of health care are devolved to decentralized bodies.</td>
<td>Policy, Recommendations and Implementation Report completed as part of the IDB/GOG Health project, and Ministry of Health approval obtained. Cabinet consideration underway. Resource assessment and gap analysis being completed in preparation for transformation of the MOH. A detailed action plan is available for implementation. (See Table 5)</td>
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<td>2. AUTONOMOUS HOSPITALS</td>
<td>1.12</td>
<td>The operational responsibility managing the Georgetown Public Hospital will be devolved from Ministry of Health to a statutory board. GPH will function as an autonomous public institution. Other hospitals will also be considered devolution to boards or management committees.</td>
<td>Georgetown Public Hospital has been devolved and functions as autonomous institution under Order #3 of 1999. GPH received a subvention that was 15% than its 1999 allocation in the Year 2000 budget. A five-year plan for the hospital and an investment plan were prepared for the hospital with the assistance from the IDB/GOG</td>
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<td>3. REGIONAL HEALTH AUTHORITIES</td>
<td>1.11</td>
<td>The delivery of primary secondary health care that is now responsibility of the ten RDCs will be restructured into four regional health authorities similar to those in Jamaica and Trinidad and Tobago</td>
<td>Plans are underway for a pilot RHA in Regions 5 and 6. A task force to implement the Berbice RHA (Reg. #5 and 6) was appointed by the Minister of Health. A Report on transitional matters was prepared by the RMC/IDB/GOG Health Project.</td>
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<td>4. MATERIALS MANAGEMENT AGENCY</td>
<td>1.13</td>
<td>Originally conceived as a procurement agency the Government's intention is to centralize procurement distribution, warehousing etc. in order to maintain accountability and to benefit from volume purchasing.</td>
<td>An Order to be made under the Corporations Act, 1988 has been prepared and will soon be presented to Parliament to establish the National Procurement Agency. An interim Board and a CEO have been appointed. A Materials Management Plan has been prepared by the IDB/GOG health Project. The Interim Board has been tasked with preparation of an Action Plan for the implementation of the recommendations contained in the report.</td>
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<td>5. SUSTAINABLE FINANCING (ALTERNATIVE FINANCING)</td>
<td>1.18</td>
<td>Resources are finite. Sustainable financing for the health sector relies on the development of</td>
<td>A Report has been completed by the Consultant from the</td>
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### 6. LEGISLATIVE REFORMS

The health sector now function in a new environment. The modernization of the State cannot proceed efficiently without addressing the legal framework within which the changes will occur.

A Draft Report outlining a strategic plan for legislative reforms has been prepared by the IDB/GOG health Project. Several drafts of new legislation have been prepared. These include an amendment to allow lay participation in the Medical Council, a new Ministry of Health Authority Act etc. On-going work is aimed at indexing, reviewing and possibly modify all existing statutes pertaining to health.

### 7. DEVELOPMENT OF BASIC HEALTH PACKAGE FOR PUBLIC SECTOR

The public needs and demand for health care are constantly increasing and continue to exceed Government's capacity to meet them. Even in countries where governments are able to provide good health care services, the question of sustaining the services is relevant. This has caused many governments to begin discussion about a guaranteed portfolio of health services to people to be financed through public sources.

A basic health package for Guyana has been proposed by the IDB/GOG Health Project and the MOH is presently fine-tuning the package for presentation to Cabinet. See table 4.

The GPH is in the process of categorizing its service so as to define a menu of services that is obligated to provide for free and to establish services that have cost-sharing implications.

### 8. QUALITY ASSURANCE AND QUALITY CONTROL PROGRAM – adopting CQI and TQM

Services provided must be of adequate quality. Good quality services also lower the cost of services in the long term.

Although several institutions have begun independent a comprehensive QA/QC program for the sector is yet to be developed. Needs develop recommendations for establishment of Quality Council.

### 9. SPECIFIC HEALTH CARE PROGRAM, e.g. NATIONAL CANCER CARE, HIV/AIDS, MENTAL HEALTH, etc.

While the Ministry of Health must seek to coordinate and integrate the Health services government feels that certain programs can be operated efficiently if placed under a semi-autonomous administration reporting to the Ministry of Health. In this sense, the MOH will examine the possibility of delegating functions for certain programs such as STDs/HIV/AIDS and Cancer to statutory agencies.

A National Cancer Board has been appointed. The NCB has already formulated plans National Cancer Treatment Center to be located at the GPH compound. The NBC has also already established a Cancer registry. A draft Cancer Board Act has been completed.

### 10 PRIMARY HEALTH CARE including Community Health Care

The most effective long-term investment in health has proven to be in primary health care. Government intends to increase the proportion of the health budget spent on primary and preventive services.

A Primary Health Care strategy is being developed as part of the IDB/GOG Health project. A pilot is to be developed in Year 2 of the project.

### 11. CAPACITY BUILDING – Human Resources and Institutional

The ambitious health program proposed by the Guyana Government is not possible unless there is a concerted effort to build the capacity building within the health sector. Capacity building within the human resources and institutional development is a prerogative.

A plan is being developed. This is an important component of the IDB/GOG Health Project. Training programs in clinical services (nursing and medicine) and in management are being considered. An action plan for Nursing Training is being refined.

### 12. HEALTH INFORMATION SYSTEMS (HIS)

Guyana lacks an adequate HIS. A modern Health Information and Management System are required to develop rational health policies...
| 14. COMMUNICATION/CONSULTATION PROGRAMME | 18 | The Ministry of Health considers participation through consultation, involvement of all key stakeholders and communication a central component to the success of any reform effort aimed at building partnership and consensus around the HSR programme. | PAHO/WHO support. Program has been ongoing. Wide consultation for Regions 1, 2, 3, 4, 5, 6 and 10 have been completed. |
| 15. ENVIRONMENTAL HEALTH | 12 | The Ministry of Health speaks for all matters pertaining to health. Environmental activities affecting human health are not coordinated in the present system. Mechanisms will be put in place for the Ministry of Health to coordinate environmental health. | MOU signed with EPA Program revision to be undertaken. Otherwise not addressed. in Will addressed as Year 2 item in the IDB/GOG Health Project. |
| 16. CENTER FOR DISEASE CONTROL | 7 | Suggestions have been made that to establish a Center for Disease Control as in the USA. However, no serious discussion has ensued. | Not addressed. |