



**Pan American  
Health  
Organization**



*Regional Office of the  
World Health Organization*

**FINAL**

**WHO/PAHO  
COUNTRY COOPERATION STRATEGY**

**GUYANA**

**2004-2007**

**Pan American Health Organization  
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## **LIST OF ABBREVIATIONS**

ADD:	Acute Diarrhoeal Diseases
AIDS:	Acquired Immune Deficiency Syndrome
AMRO:	WHO Regional Office for the Americas
ARI:	Acute Respiratory Infections
BMI:	Body Mass Index
BPB:	Biennial Programme Budget
CAREC:	The Caribbean Epidemiology Centre
CCA:	Common Country Assessment
CCS:	Country Cooperation Strategy
CDB:	Caribbean Development Bank
CDC:	US Centres for Disease Control and Prevention
CFNI:	The Caribbean Food & Nutrition Institute
CIDA:	Canadian International Development Agency
CPC:	The PAHO/WHO Office of Caribbean Program Coordination
CSU:	Country Support Unit
DALY:	Disability Adjusted Life Years
DEC-salt:	Diethylcarbamazine-salt
DMFT:	Decayed, missing and filled teeth
EC:	European Commission
EIP:	Evidence and Information for Policy
EPI:	Expanded Programme on Immunization
EU:	European Union
HIA:	Health in the Americas
HIPC:	Heavily Indebted Poor Country
HIV:	Human Immunodeficiency Virus
HSA:	Health Sector Analysis
IDA:	International Development Association
IDB:	Inter-American Development Bank
IFAD	International Fund for Agricultural Development
IMCI:	Integrated Management of Childhood Illnesses
IMF:	International Monetary Fund
JICA:	Japan International Cooperation Agency
MCH:	Maternal and Child Health
MICS:	Multiple Indicator Cluster Survey
MOH:	Ministry of Health
NCD:	Non-communicable Diseases
NGO:	Non-governmental Organization
NPO:	National Professional Officer
ODA:	Official Development Assistance
PAHO:	Pan American Health Organization
PMCT:	Prevention of Mother to Child Transmission
PNC:	National Congress – Reform
PPP:	Peoples Progressive Party-Civic
PRSP:	Poverty Reduction Strategy Paper
PWR:	PAHO/WHO Representative
STD:	Sexually Transmitted Diseases
STI:	Sexually Transmitted Infections

UN: United Nations  
UNAIDS: Joint United Nations Programme on HIV/AIDS  
UNDAF: United Nations Development Assistance Framework  
UNDP: United Nations Development Programme  
UNFPA: United Nations Fund for Population Activities  
UNICEF: United Nations Children's Fund  
UNV: United Nations Volunteers  
USA: United States of America  
USAID: United States Agency for International Development (AID)  
WB: World Bank  
WHO: World Health Organization  
YLD: Years Lived with Disability

## 1. EXECUTIVE SUMMARY

WHO/PAHO's Country Cooperation Strategy for Guyana focuses on the priority needs of the country that the Organization is best placed to address through its technical cooperation. It outlines a strategy for working with national counterparts, government agencies, non-governmental organizations, and other development partners for national health development in Guyana, while harmonizing the internal Organizational mechanisms to provide seamless technical cooperation with the country. The CCS implies a commitment that WHO/PAHO looks forward to fulfilling. Guyana is one of the Heavily Indebted Poor Countries (HIPC) in the Region of the Americas and is earmarked for special attention in the PAHO Strategic Plan 2003-2007.

### *Situation Analysis*

The critical development issues and challenges facing Guyana include: governance, affected by continuing political conflict and escalating violence; widespread poverty, inequity, and disparities among social, ethnic, and geographic groups; migration of qualified professionals, e.g., teachers and health professionals; and slow economic growth and lack of investment, despite abundant natural resources.

Guyana continues to experience a high burden of communicable diseases, as well as high levels of both non-communicable diseases and injuries. Compared to the other countries in the Americas, Guyana has a higher burden of disease per capita for all three groups of diseases.

The main critical health sector development issues and challenges include: strengthening the public health leadership capacity; ensuring availability and access to information on the epidemiological situation and system performance; ameliorating the highly inequitable access to health care; improving allocative efficiency; improving the managerial capacity of the sector in order to increase technical efficiency, i.e. productivity and quality; and developing a human resource policy and plan for the sector, which ensures optimal utilization of the available manpower.

Critical development partner coordination issues and challenges include: imbalance in distribution of health development aid; low absorptive capacity for health development programs in the public sector and civil society; tendency for development agencies to bypass government and over-stretch the limited capacity in the non-government sector; development agency drive for showing short- and medium-term results, which tend to sacrifice development of longer-term sustainable capacity; and weak management of development assistance in the health sector, which leaves coordination to individual approaches and initiatives.

The main challenges facing the WHO/PAHO country program include: maintaining technical leadership in public health with limited technical and financial resources; attracting and maintaining a critical cadre of technical staff; limited human resources nationally, affecting the availability and capacity of counterparts at national level and the sustainability of programmes; coordination of the contribution of the subregional

programmes to Guyana; and working collaboratively with other agencies and partners in the health sector.

### *Strategy Formulation*

The mission of WHO/PAHO in Guyana is to provide technical leadership in public health and bring together local, regional, and international partners to strengthen national capacity for health development. WHO/PAHO's work in Guyana is based on a belief in the rights of all individuals to basic conditions for health, irrespective of gender, race, age, religion, or sexual orientation, and on the values of the Organization.

The prime function of WHO/PAHO in Guyana during the strategic period is to provide specific policy advice; serve as broker; and influence policy, action and spending. In realization of the limited information available, this function needs to be supported by research and development, and monitoring of health sector performance. The third most important function in the strategy is information and knowledge sharing, i.e. providing generic policy options, standards, and advocacy.

For each of the functions defined in the strategy, specific criteria for engagement, priorities, critical success indicators, as well as targets are defined.

Compared to the current situation, during the strategy period greater emphasis is placed on: influencing policy, action and spending; strengthening the brokerage role of the Country Office among the multiple partners in health, working towards a common agenda; improving the quality of technical evidence to support shifts in policies/strategies; filling information gaps in areas where effective public health intervention exists; monitoring health sector performance; building capacity in the Ministry of Health for implementation of evaluation methodologies; and resource mobilization.

Four areas of gap in technical capacity in the Country Office are identified as: health systems development; epidemiology, biostatistics, and research; disease prevention and control (communicable and non-communicable); and maternal and child health (MCH).

The success of the CCS depends heavily on the recognition that the locus and responsibility for the coordination of all WHO/PAHO technical activities in Guyana lies in the Country Office. It also means that the technical cooperation needs are defined at the country level, which in turn calls upon support and assistance from sub-regional, regional, and global levels of the Organization. This might require a change in the method of working and emphasis on a country focus approach throughout the Organization.

Overall, WHO/PAHO needs to continue, and possibly accelerate, the development of global systems and mechanisms to facilitate intra-organizational networking and information sharing throughout the Organization on initiatives and lessons learned in other countries relevant to the situation in Guyana. Finally, to increase the technical capacity in the Country Office in Guyana, it will likely be necessary to shift technical resources from the global and regional level to the country level.

## 2. INTRODUCTION AND BACKGROUND

The Country Cooperation Strategy (CCS) of the World Health Organization (WHO) is aimed at articulating WHO's strategic agenda for technical cooperation in its Member States. The CCS will allow WHO to improve performance and put into practice new ways of working, focusing on the defined needs and priorities in each country. It is expected that the CCS will result in:

- *A more focused and selective program of work:* fewer areas of work, chosen explicitly in terms of their potential for influence and impact.
- *A more coherent program of work:* inputs and activities from different parts of WHO, which are mutually supportive and well coordinated, including those at global (WHO), regional (PAHO/AMRO) and country (PAHO/WHO Country Office) levels. This is the embodiment of the *One WHO* concept, with expertise drawn from the entire organization to provide a unified technical cooperation response to the countries.
- *A more strategic role for WHO:* well-considered shifts in the functions performed at country level, moving towards a greater role as catalyst, broker, convenor, and policy advisor, based on the needs and readiness of the country.
- *Greater emphasis on wider partnerships:* an extended range of partners within government, the private sector, non-governmental organizations (NGOs), civil society, other development agencies, and changes in the nature of the collaboration.

Guyana is one of the Heavily Indebted Poor Countries (HIPC) in the Region of the Americas and is earmarked for special attention in the PAHO Strategic Plan 2003-2007. The need for improvement in the execution of PAHO/WHO's Biennial Program Budget in the country, increased efficiency and effectiveness of its technical cooperation, and the plethora of donor and development agencies working in, and with, the country, prompted the PAHO/WHO Representative (PWR) in Guyana to request early development of the CCS.

A six-member CCS Team, comprising staff from WHO Geneva and PAHO Offices in Washington, Suriname, and Guyana, carried out two missions to Guyana in March and June 2003. The missions were informed by review of background documents on the health development situation in Guyana and in-house discussion of relevant issues with technical and administrative staff in WHO/PAHO. The mission format included interviews with representatives of health and development agencies and organizations working in Guyana, and a visit to the interior of the country.

The development of the strategic agenda took into consideration critical issues and challenges identified through the situation analysis, the WHO strategic directions and generic country functions, and PAHO's priority technical areas and functions as set out in its Strategic Plan 2003-2007.

# **PART ONE: SITUATION ANALYSIS**

## **3. GOVERNMENT AND PEOPLE**

### **3.1 ECONOMIC, POLITICAL AND SOCIAL DEVELOPMENT**

Guyana is located on the northeastern shoulder of South America. It is bordered by Venezuela, Brazil, and Suriname, and covers 215,000 sq. km. The only English-speaking country in South America, it is linked historically and culturally to the English-speaking Caribbean. It had an estimated population of 743,004 in 2000, consisting of 48% Indo-Guyanese, 34% Afro-Guyanese, 12% mixed race, and 6% Amerindian. In recent years, emigration has exceeded the natural population growth, resulting in an overall decline in the population. The population is mainly rural (70.3%), almost all of whom live within a few kilometres of the main coastal road. The country is divided into 10 administrative regions with varying population densities: the low density and difficult terrain in some regions hamper the provision of social services and infrastructure development.

Guyana is rich in natural resources, including a productive soil, water resources, bauxite, gold, diamonds, oil, and gas. Its interior has high grade rain forest, with potential for timber exploitation, eco-tourism, and conservation. Despite these resources, Guyana is one of the poorest countries in the Western Hemisphere, with a per capita income of US\$770 in 2000. In 2003, Guyana ranked 92<sup>nd</sup> of 173 countries on UNDP's Human Development Index, and an estimated 36% of the population lives in absolute poverty, on less than US\$510 per year. In 2000, overall life expectancy at birth was 63.5 years, with 58.9 years for males and 67.3 years for females. The crude birth rate has shown a slow decline from 26.5 per 1,000 population in 1989 to 23.2 in 1999. The total fertility rate is 2.5, down from 3.1 in 1990.

Political tensions have plagued Guyana throughout its history. Elections held in 2001 resulted in the People's Progressive Party (PPP)-Civic winning an absolute majority over the People's National Congress (PNC)-Reform. After a period of instability during which PNC supporters refused to accept the election result, some common ground on national development and governance issues was found, but waves of ethnically targeted crimes have continued and, as at March 2003, Parliament had not met.

After an unsuccessful inward-looking, state-led development strategy pursued throughout the 1970s and 1980s, a market-based economic recovery program was designed in 1988 that enabled the government to access external funding to refinance accumulated debt. Since then, a continuing relationship with international financial agencies has helped to maintain fiscal and monetary discipline. In 2002, the government developed a Poverty Reduction Strategy Paper (PRSP) that identifies the policies and programs needed to markedly reduce poverty, i.e. (i) economic policies to stimulate growth, (ii) good governance and the business environment, (iii) investment in human capital, (iv) infrastructure to support services, (v) social safety nets, (vi) infrastructure to support growth, and (vii) special intervention strategies. The implementation of the PRSP will be financed from both domestic and foreign sources.

Public services have suffered from insufficient funding, poor management, and a continuous outflow of trained professionals. An exodus of teachers and health professionals to the Caribbean and North America, as well as difficulties in stationing professionals in remote areas of the hinterland, has affected the quality of education and health services and contributed to poverty in disadvantaged areas. Although primary school enrolment was 97% in 2000, functional literacy of the population as a whole is believed to be low or moderate. There is a high drop-out rate in primary and secondary schools, drug abuse among students, teenage pregnancy, and suicide among youth; poor quality housing and deteriorating urban neighbourhoods have deepened poverty. There are significant variations in socioeconomic and health indicators across ethnic groups and geographical areas. Amerindians, who are the poorest ethnic group, have limited access to services and have some of the worst indicators in Guyana. Escalating crime and long delays in dispensing justice are also continuing concerns.

The PRSP recognizes the need to address governance issues, especially deepening and strengthening the dialogue between the two main political parties, and the strengthening of Parliament in oversight. In the social sector, education will be targeted, as well as improvements in water quality and access, in housing schemes and accelerating the processing of land titles. The PRSP also provides a framework for the activities of development partners.

### **3.1.1 Critical development issues and challenges**

1. Governance, including continuing political conflict and escalating violence.
2. Widespread poverty, inequity, and disparities between social, ethnic, and geographic groups.
3. Migration of qualified professionals, including teachers and health professionals.
4. Slow economic growth and lack of investment, despite abundant natural resources.

## **3.2 HEALTH PROFILE**

Data collected by the Ministry of Health and various development and health organizations, the Guyana specific burden of disease assessment done by WHO/EIP, and the situation analysis conducted by the PAHO/WHO Office for the preparation of the biennial program budget (BPB), provide the basis for the health situation analysis. It is recognized that in several areas data are lacking, incomplete, or of questionable quality.

### **3.2.1 Leading causes of death**

Over the last decade, ischaemic heart disease, cerebrovascular disease, and diabetes have been among the top five leading causes of death, but the most significant change in mortality has been the recent emergence of HIV/AIDS. Major causes of death by age group are as follows:

- Under 5 years: perinatal causes, acute respiratory infections (ARI), acute diarrhoeal diseases (ADD), and accidents/injuries
- 5-14 years: accidents/injuries, ARI, ADD, cancer, and malnutrition/anaemia
- 15-44 years: HIV/AIDS, accidents/injuries, suicide, ARI, and ADD
- 45-64 years: ischaemic heart disease, cerebrovascular disease, diabetes, and cancer

### 3.2.2 Burden of disease

Guyana continues to experience a high burden of communicable diseases, alongside high levels of both non-communicable diseases and injuries. Compared to the other countries in the Americas, Guyana has a higher burden of disease per capita for all three groups of diseases. Table 1 shows the major causes of disease burden in Guyana, programmatically grouped, and accounting for over 80% of the total Disability Adjusted Life Years (DALYs).

**Table 1.** Major causes of loss of DALYs, programmatically grouped

	DALY	Subtotal	%
<i>Communicable Disease Prevention and Control</i>		27,822	13.6%
HIV/AIDS/STDs	21,005		
Tuberculosis	4,581		
Malaria	2,236		
<i>Maternal and Child Health</i>		41,088	20.2%
Diarrhoeal diseases	9,154		
Respiratory infections	8,462		
Maternal conditions	2,516		
Perinatal conditions	15,517		
Nutritional deficiencies	5,439		
<i>Mental Health</i>		33,438	16.4%
Neuropsychiatric conditions	33,438		
<i>Non-communicable Disease Prevention and Control</i>		27,123	13.3%
Cardiovascular diseases	20,397		
Diabetes	2,955		
Malignant neoplasms	3,771		
<i>Risk Reduction</i>		35,504	17.4%
Unintentional injuries	26,474		
Intentional injuries	9,030		
<b>Sub-total major causes</b>		<b>164,975</b>	<b>80.9%</b>
All other causes		38,883	19.1%
<b>Grand Total</b>		<b>203,858</b>	<b>100.0%</b>

#### *Communicable, maternal, perinatal and nutritional conditions (Group I)*

Overall this group of diseases was responsible for 72,798 (35.7%) of the total of 203,858 DALYs lost in 2000. Out of this, HIV/AIDS/STDs, tuberculosis, and malaria contributed 27,822 (13.6%) and five maternal and child health diseases and conditions contributed 41,088 (20.2%) (table 1). HIV/AIDS was the second leading cause of death in 2000 and the leading cause of DALYs lost. At the end of 2001, there were 2,173 persons known to have AIDS in Guyana, with an estimated 60% underreporting. In 2000, the majority of reported cases were due to heterosexual contact and new cases are increasing at a faster rate among young women than among young men. HIV/AIDS prevalence among youth 15-24 years old is estimated to be among the highest in the Caribbean, after Haiti and The Bahamas.

Malaria is a major health problem and is endemic in interior regions. Tuberculosis has doubled in incidence since 1990, reflecting the concomitant increase in HIV/AIDS. Originally, almost a third of all cases of tuberculosis were found in the Amerindian population, but there has been a shift to the general coastal population, with peak incidence in males aged 25-34 years, mirroring the HIV/AIDS epidemic. Acute respiratory infections are the ninth leading cause of death overall and an important cause of death among children under age 14. These infections also cause significant morbidity. Diarrhoeal diseases are important causes of mortality in children under age 14 and rank as the 4<sup>th</sup> leading cause of DALYs lost. Filariasis, dengue, and Hansen's disease are other communicable diseases that impact the health of the population in Guyana.

Vaccine-Preventable Diseases have been successfully controlled through the Expanded Program on Immunization (EPI), with over 80 percent of children receiving all the recommended vaccinations during the first 12 months of life. There have been no cases of measles since 1991 and no reported cases of poliomyelitis since 1962. However, there are a number of communities with poor vaccination uptake, particularly in hard-to-reach areas in the interior and some squatter settlements on the urban coastal area.

Maternal mortality rates are significantly higher than in other countries in the region, the rate for 2000 being 133 per 100,000 live births. The 3 leading causes of maternal deaths are haemorrhage of pregnancy and childbirth, pregnancy with abortive outcome, and complications of the puerperium, which are linked to quality of care and reproductive health issues. Though abortion is legal in Guyana, abortion-related complications are reported as the most frequent cause of admission to the Georgetown Public Hospital. The official infant mortality rates in 1997 and 1998 were, respectively, 25.5 and 22.9 per 1,000 live births, though the 2000 MICS<sup>1</sup> indicated that the figure was likely to be closer to 54 per 1,000 live births. In 2000, conditions arising in the perinatal period were the 2<sup>nd</sup> leading cause of DALYs lost, accounting for 7.5% of all causes. Protein-energy malnutrition and iron-deficiency anaemia are important nutrition-related health issues in the country. The 2000 MICS found exclusive breastfeeding rates of only 15% among children less than 4 months and Guyana's malnutrition rates remain significantly higher than the average rates recorded for other Caribbean countries. Children from the rural coast are more likely to be underweight and wasted than those from the urban coast and interior, but chronic malnutrition with stunting is predominant in the interior, where the Amerindian communities are concentrated.

#### *Non-communicable diseases (Group II)*

Non-communicable diseases, as a group, are the main contributors to the burden of disease, accounting for 95,558 (46.9%) of all DALYs lost in 2000. Out of this neuro-psychiatric (mental) disorders caused 33,438 (16.4%) and cardiovascular diseases, diabetes, and malignant neoplasms accounted for 27,123 (13.3%)

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<sup>1</sup>Guyana Bureau of Statistics, Report of the Multiple Indicator Cluster Survey (MICS), July 2001.

Of the mental disorders, unipolar depressive disorders alone accounted for 10,061 DALYs lost and alcohol use disorders were, with 5,792 DALYs lost, the 8<sup>th</sup> leading cause of morbidity in 2000.

Cardiovascular diseases and malignant neoplasms caused, respectively, 20,397 and 3,771 of DALYs lost, while diabetes caused 2,955. Asthma causes significant morbidity and was ranked 16<sup>th</sup> among the leading causes of lost DALYs and 6<sup>th</sup> among the leading causes of YLDs<sup>2</sup> in 2000, causing 1.3% and 2.5%, respectively. Ischaemic heart disease and cerebrovascular disease, which may complicate diabetes and hypertension, are the 1<sup>st</sup> and 3<sup>rd</sup> leading causes of death, respectively, while diabetes itself is the 4<sup>th</sup> leading cause of death.

Oral conditions accounted for 1,397 DALYs lost in 2000 and dental caries are listed in some Regions among the 10 most prevalent diseases. The last dental health survey was carried out in 1995 and showed that the mean for decayed, missing and filled teeth (DMFT) was 2.97. The main contributor to the DMFT index was the decay component and at least 64% of children had one decayed permanent or primary tooth. Although the mean DMFT is below the WHO goal for the year 2000, the proportion of children with caries and missing teeth still shows a sizable prevalence of caries experience and untreated decay in both dentitions.

### *Injuries (Group III)*

Injuries are an important cause of death in all age groups, with males being more affected than females. In 2000, injuries caused loss of 35,504 (17.4%) DALYs – 26,474 were due to unintentional injuries (accidents) and 9,030 to intentional injuries. Suicide has been increasing, and in 1999 it was the leading cause of death among women aged 15-19 years and the 2<sup>nd</sup> leading cause of death among males in that age group.

### **3.2.3 Risk factors**

The 1998 Adolescent Health Survey showed that 50% of children have had sexual intercourse by age 13 years and 90% by age 14 years. 50% of adolescents under age 15 and 33% of those aged 16-18 years had never used any contraception. Contraceptive prevalence among women aged 15-49 years who are married or in long-term single partner relationships remains low, at 37.5%.

15% of the overall population are smokers, with significantly more men smoking than women (35% versus 4%) and 17% of students aged 13-15 years old are users of tobacco products.

51% of adults over age 20 have a BMI of 25 or higher (overweight) and 22.4% have BMI over 30 (obese).

Environmental risk factors play an important, albeit undocumented, role related to health status in Guyana. Despite efforts at improvement, the quality of drinking water and sanitation has not reached acceptable standards and conditions are such that

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<sup>2</sup> Years Lived with Disability

hepatitis A could become a concern. Occupational health hazards related to agriculture and the logging and mining industries demand continued attention.

### **3.2.4 Critical health challenges**

1. To effectively deal with the diseases and conditions that constitute the majority of the burden of disease, i.e.:
  - Selected NCDs: cardiovascular diseases, diabetes, cancer, asthma, and oral conditions,
  - Major communicable diseases - HIV/AIDS, malaria, tuberculosis, dengue fever, filariasis, and Hansen's disease (leprosy),
  - Maternal and child health, including high maternal mortality, nutritional deficiencies, diarrhoea, ARI, and reproductive health issues,
  - Neuropsychiatric conditions, especially depression and substance abuse, and
  - Unintentional and intentional injuries.
2. To effectively reduce behavioural and environmental risks and related diseases, including obesity, tobacco use, sedentarism, diarrhoeal diseases, and occupational health hazards.

## **3.3 HEALTH SECTOR DEVELOPMENT**

A National Policy on Public Health was drafted in 1995, forming the basis for the National Health Plan 1995-2000, which emphasized expansion of the primary health care coverage. In 1998, a broad strategic framework for redefining and modernising the public sector was established. Based on this, a draft National Health Plan 2003-2007 has been formulated.

### **3.3.1 Policy and performance analysis**

#### *Systemic level*

Access to health care is a 'right' established by the constitution. However, due to geography, scarce resources, and maldistribution of staff, the access to services is inequitable and 12.5% of Guyana's population does not have access to any health care. Most drugs and services are free at the point of delivery, but shortages of supplies in the public sector make it necessary for patients to seek supplementary care and treatment from the private sector, which is now estimated to provide about half of all curative services.

The public primary health care system comprises: 166 health posts, 109 health centres, and 19 district hospitals (473 beds). The four regional hospitals (620 beds) and the one national referral hospital (937 beds) constitute the higher levels of care.

Regional health services are the responsibility of the Ministry of Local Government and the MOH has no authority to implement policies or to set budgets for these. Regions, on their part, have limited managerial and planning capacity and decision-making remains highly centralized, with limited understanding of public health.

A Division of Standards and Technical Services was added to the MOH in 1991; however, the legal and regulatory framework for the sector as a whole is either outdated or inadequate.

The overall health spending is estimated at less than US\$50 per capita per year with about 57.1% funded from taxation, 10.8% from donors and 32.1% from private sources. Of this 32.1%, 7.8% is paid by employers and 24.3% by households. There is no national policy for cost-recovery through user fees, though the MOH implements some user charges mainly at the hospital level. The national insurance scheme covers public and private sector employees only.

Social involvement in meeting health objectives, e.g., through participation in planning, implementation, and monitoring of health service provision, is limited. However, there are several NGOs funded by international organizations and a NGO forum has been established in an attempt to guide and coordinate this sector.

#### *Programmatic level*

About 46% of government health expenditures are incurred for higher level hospitals and specialist care, 32% for primary care, and 22% for support functions. The National Health Plan 2003-2007 introduces a concept of an essential health care package to be provided using public funds. However, the content of the essential package and the associated prioritization process have not yet been completed.

#### *Organizational level*

Basic diagnostic/clinical support services are lacking or limited at the district hospitals and there is little support for such functions at the health posts and health centres. Referrals of common conditions are therefore made to higher levels more often than necessary. As a result, doctor-staffed clinic sessions at regional and central hospitals tend to be overcrowded, while community-based primary health care facilities and district hospitals are under-utilized.

There are considerable problems with productivity in the health sector, staff motivation is weak, and absenteeism is a major concern. A number of factors contribute to this, including low salaries and poor working conditions, insufficient managerial skills and authority for decision makers at various levels, maldistribution of staff, and poor management systems. The logistics, i.e. procurement, storage, and distribution systems of the health sector, need further improvement, since shortages of supplies still exist. The number of service units and programmes is too large, compared to the resources available. One result is that, paradoxically, while there are serious staff shortages in the system, some staff and facilities are under-utilized.

In a recent assessment of the public health functions of the MOH, quality assurance was rated lowest among all essential public health functions. Quality in the sector is perceived, both structurally and process-wise, as poor. Quality has traditionally been pursued as an option, not a requirement, and with an increased use of contracting and outsourcing, the issue of assessing and assuring quality is a growing concern.

### *Instrumental level*

The availability of reliable information on any aspect of health and health service in Guyana is extremely limited and the quality of existing data is poor, causing major constraints in effective health planning. Work on establishing a national health account started some time ago, but has not moved forward significantly. While some research capacity for conducting mostly operational research does exist, there is no formal public health research agenda and very limited scientific research takes place to guide policy. This is particularly worrisome at a time when profound changes are happening, or planned, in the sector.

The high level of emigration of trained health care workers, i.e. nurses, doctors, and other health care professionals, poses significant resource constraints for the sector and many of the public health facilities suffer from persistent shortage of skilled staff. The need for human resources in the sector is well articulated, but the formal instruments for developing the workforce are weak. Human resource development is constrained by lack of career opportunities, with promotion based on seniority rather than merit; limited opportunities for in-service training; a general shortage of adequately trained teaching staff; and the absence of a comprehensive human resources database and development plan. No single entity in the MOH has the overall responsibility for human resource planning and development.

#### **3.3.2 Health sector reform**

The National Health Plan 2003-2007 is a very ambitious plan that attempts to address most of the above issues. The plan has the full and vigorous support of the current Minister of Health. The formulation of the plan has had significant technical and financial support from the IDB, but interviews in the Ministry of Health suggest limited ownership and weak technical leadership capacity.

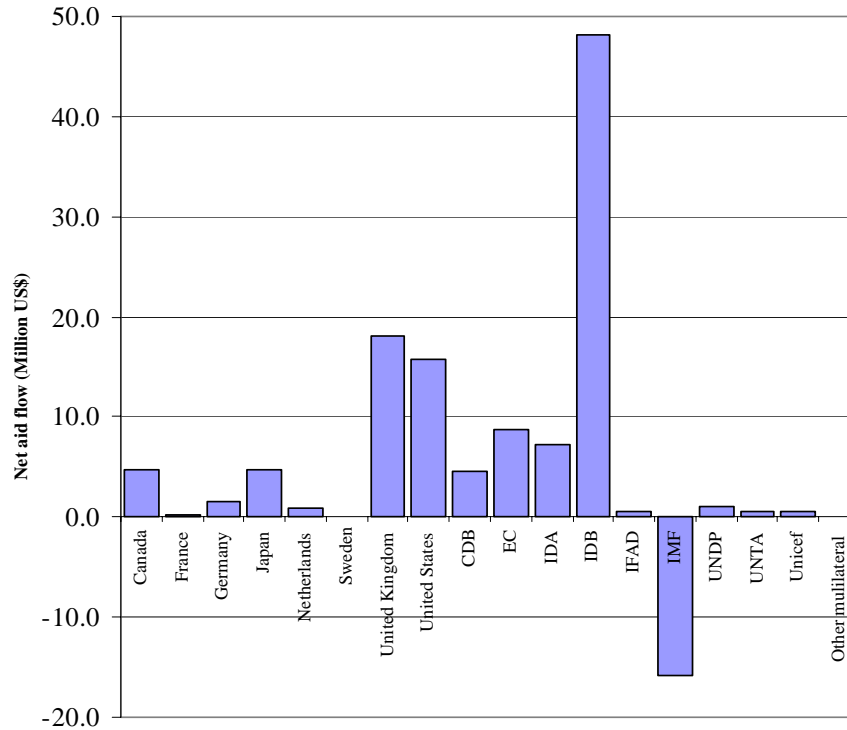
#### **3.3.3 Critical health sector development issues and challenges**

1. To strengthen the public health leadership and advocacy capacity required to formulate, develop, and implement the new policies, systems, and managerial practices outlined in the National Health Plan 2003-2007.
2. To ensure availability and access to information on the epidemiological situation and system performance for policy and planning through routine surveillance and monitoring systems as well as specific public health analysis and research.
3. To ameliorate the highly inequitable access to health care.
4. To define which services will be provided using public resources, i.e., to improve allocative efficiency through priority setting and cost-effectiveness analysis.
5. To improve the managerial capacity of the sector in order to increase technical efficiency, i.e., productivity and quality.
6. To develop a human resource policy and plan for the sector, which ensures optimal utilization of the available manpower and that renewal efforts are targeted towards serving the needs of the reformed health sector.

## 4. DEVELOPMENT ASSISTANCE

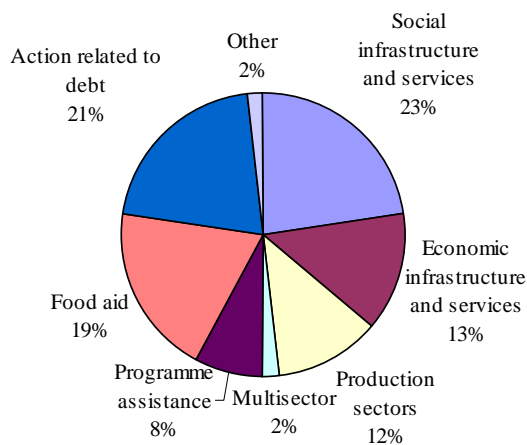
### 4.1 AID FLOW

**Figure 1:** Total net Official Development Assistance (ODA) in 2001 by contributor



Guyana has development collaboration with a wide range of countries and multilateral organization and agencies. The largest net contributor is the Inter American

**Figure 2:** Distribution of bilateral Official Development Assistance (ODA) in 2001



Development Bank (IDB), which in 2001 contributed US\$48.2 million, while the European Commission (EC), the International Development Association (IDA), and the Caribbean Development Bank (CDB) are other major collaborators. Among the bilateral collaborators, the United Kingdom, the United States of America, Canada, and Japan are the largest contributors (figure 1).

The bilateral official development assistance in 2001 totalled US\$43.1 million and was concentrated in

five sectors: social infrastructure and services, action related to debt, food aid, economic infrastructure and services, and production (figure 2).

#### 4.2 DEVELOPMENT PARTNERS ACTIVE IN THE HEALTH SECTOR

In the 1980s, PAHO/WHO was the major, and often only, source of technical assistance in the health sector, but now there are many more active players and development partners. Technical and financial assistance is now obtained from other UN agencies, through many bilateral arrangements and from sub-regional and international multilateral agencies and financial institutions.

In spite of the large number of agencies cooperating with Guyana, not all the health priorities are supported. Areas like HIV/AIDS receive significant support from several agencies and the Banks fund the provision of infrastructure for water and sanitation, but the area of environmental health receives insufficient support. The other priority areas for technical cooperation not receiving enough attention are non-communicable diseases and health promotion. The following are brief details of the assistance currently being received by, or planned for, Guyana.

##### United Nations

Three UN agencies have offices in Guyana: WHO/PAHO, UNICEF, and UNDP. Many others, including UNFPA and UNAIDS, serve the country from other locations.

*UNICEF* is a significant provider of support to the health sector, focusing on immunization ‘plus’, Integrated Management of Childhood Illnesses (IMCI), breast-feeding, nutrition, early childhood development, water and sanitation, HIV/AIDS, and child abuse. The agency works with the MOH, the Ministry of Local Government and the Regional Committees, as well as with several NGOs. Implementation of its programs are targeted to Regions 2, 4, 6, and 10 and it employs three strategic approaches, namely social policy and advocacy, education and life skills, and local systems for integrated child protection. Its current regular annual budget is \$640,000.

*UNDP* has a project titled “Integrated Health” which focuses on strengthening clinical capacity through provision of doctors as United Nations Volunteers (UNVs).

##### Other multilateral development agencies

*The Inter American Development Bank (IDB)* provides the largest amount of funds for health development in Guyana. It has just completed the execution of a grant for approximately \$2.5 million for studies of the health sector and the development of the National Health Plan 2003-07. It is expected that the Government of Guyana will apply for a loan estimated at \$10 million, to assist in the implementation of Health Sector Reform initiatives and the Health Plan. IDB will implement the project through strengthening of its management unit, already existing in the MOH, with national and international expertise.

*The European Union (EU)* has a Memorandum of Agreement with the Government, which provides for reimbursement of pharmaceuticals and other health supplies. The EU will move from program to budget support to the social sectors, including health and education, in its next five-year program.

*The World Bank (WB)* will be providing a grant to the government for the improvement of the managerial capacity of the HIV/AIDS program and is currently investigating further support in HIV/AIDS.

#### *Bilateral development agencies*

The *USA* has significant and increasing areas of technical cooperation with the Government of Guyana, with particular emphasis on HIV/AIDS. This is implemented through the USAID and the Centres for Disease Control and Prevention (CDC). USAID has an extended project on communication and outreach in HIV/AIDS and serves Guyana through its sub-regional and national programs. The program is being implemented through Family Health International (FHI) and Population Services International (PSI). The CDC has recently established a technical presence in Guyana and its priorities are STIs and HIV/AIDS. The HIV/AIDS program will focus on prevention of mother-to-child transmission (pMTCT); treatment and care, sourcing the most cost-effective antiretroviral drugs in the local or foreign market; voluntary counselling and testing; laboratory support; and training. The USA plans to increase its support to Guyana from \$1million to \$10 million per year for 4 years, to be executed by USAID, CDC, and the Peace Corps, primarily through NGOs and the private sector.

*Cuba* has a long standing technical cooperation agreement with Guyana and provides clinical support in a number of key areas in the national and regional hospitals. Currently, this includes about 20 doctors. Cuba has also provided scholarships for the training of 200 doctors from Guyana, as well as dentists.

*China*, through its bilateral agreements, is providing specialists for the hospitals, currently comprising 20 specialist doctors posted at the Georgetown Public Hospital.

Through *JICA*, the Government of Japan is supporting the construction of the New Amsterdam Hospital in Region 6.

*CIDA (Canada)* has subregional and bilateral health programs. Through the bilateral program, it will be funding a four-year US\$3 million project from 2003. The project aims to (1) improve the national programs for the prevention and control of STIs, HIV/AIDS, and tuberculosis and (2) the capacity to collect related health data, process it into information and communicate from the source to the point of use. This project will be executed by the Canadian Society for International Health. CIDA's subregional project on HIV/AIDS supports several subregional institutions including CAREC and CFNI, but the extent to which Guyana will benefit from these is not clear at present. Canada has, in recent years, shifted from mainly working with the government to primarily working with the private sector and NGOs.

## 4.3 DEVELOPMENT PARTNER COORDINATION

### 4.3.1 Institutional Coordination

There are several mechanisms that facilitate coordination of development partners in general and in health in particular.

- In support of the PRSP, the President chairs a group comprising all development partners, including PAHO. A PRSP Monitoring Unit has been established in the Office of the President to monitor progress towards the objectives.
  - In support of the above, thematic groups chaired by the lead sector have been formed.
  - The Theme Group on Health is chaired by the Minister of Health and PAHO is the Secretariat. It is expected that there will be sub-committees focusing on specific areas, such as HIV/AIDS and information systems.
- A Theme Group on HIV/AIDS has been in existence since the introduction of the expanded response model by UNAIDS. The Chairmanship of this group rotates among the UN agencies and is presently under the leadership of UNDP.
- The draft National Health Plan 2003-07, developed with IDB support to provide a frame for health sector development.
- The UN agencies collaborated to develop the Common Country Assessment (CCA) and the UN Development Assistance Framework (UNDAF) for the period 2001-2003. Guyana is earmarked to prepare its second CCA/UNDAF in 2004.

The purpose of all these mechanisms is to ensure that the development assistance is relevant to the national priorities, that there is maximal synergy and minimal duplication among the agencies, and that resources are utilized most effectively.

### 4.3.2 Critical development partner coordination issues and challenges

1. Imbalance in distribution of health development aid leaves some aspects relatively over-funded, while others are not funded or under-funded.
2. Low absorptive capacity for health development programs in the public sector and even in civil society makes most development programs fall behind in implementation.
3. Due to (2) above, development agencies tend to bypass government and over-stretch the limited capacity in the non-government sector.
4. Development agency drive for showing short- and medium-term results may sacrifice development of longer-term sustainable capacity.
5. Weak management of development assistance in the health sector tends to leave coordination to individual approaches and initiatives of Agencies and national counterparts.

## **5. WHO/PAHO Current Country Program**

### **5.1 WHO/PAHO and Guyana**

The PAHO/WHO representation in Guyana was established formally in 1966. The Basic Agreement between the Government of Guyana and the World Health Organization was signed in 1968 and establishes the terms for the provision of technical assistance by WHO to the Government. This Agreement substituted for the Basic Agreement between the World Health Organization and the United Kingdom and Northern Ireland in 1952 in relation to Guyana. The Basic Agreement between the Pan American Health Organization and the Government of Guyana provides the basis for the relationship between the Government and PAHO/WHO. The latest copy is dated 1984.

#### **5.1.1 Key areas of work**

Technical support to Guyana is developed in collaboration with the Government of Guyana and is based on the national priorities. The work plan of WHO/PAHO in Guyana for the 2002/3 biennium consists of 6 projects, each with several planned activities. The projects comprise:

1. *Managerial process for national health development*, which supports the functions of the Country Office itself, including National Health Development.
2. *Health Systems and Services Development*. The primary foci of this area are: supporting the steering role of the Ministry of Health, development of health information systems, health service research, promoting the quality initiative, supporting the essential drugs program, mental health, and human resource development.
3. *Health in Human Development*, which aims to strengthen the information base and the use of information, promoting research and training staff in research methodology and data analysis and use.
4. *Health of Special Groups*, focusing on child and adolescent health and health of the elderly. Support is also provided for the promotion of the healthy settings initiative and food security and nutrition are addressed in this project.
6. *Environmental Protection & Development*, focusing on occupational safety and health, environmental protection and development, and disaster preparedness.
7. *Disease Prevention and Control*, focusing on prevention and management of communicable diseases, non-communicable diseases, expansion of the IMCI strategy to all regions, food safety, and veterinary public health.

#### **5.1.2 Human and Financial Resources**

At present, the staff complement consists of three international technical posts, i.e. the PAHO/WHO Representative, an advisor on environmental health, and an advisor on health systems and services (vacant).

In addition, there are a number of technical staff recruited under local terms and conditions, including officers in information systems, health promotion, and disease prevention and control. Recruitment for the Post of Disease Prevention and Control in the last instance has been undertaken in collaboration with the Cuban Government under the Bilateral Agreement between the Governments of Guyana and Cuba. Administrative duties are supported by an Administrator at the professional level and two other UN staff, as well as additional support from staff seconded from the Ministry of Health under the Basic Agreement with the Government of Guyana.

The total Biennial Program Budget for 2002-03 is US\$2,013,164, i.e. posts of \$904,000 and activities of \$1,109,164.

**Table 2:** Country Office Work Plan 2002-2003

<b>Country Office Work Plan (W/P) Projects 2002-2003</b>	<b>N° of W/P expected results</b>	<b>RB Budget US</b>	<b>Extra Budget US\$</b>	<b>Total Budget US\$</b>	<b>% of Total</b>
Managerial process for national health development	6	415,078	110,257	528,335	47.6
Health systems and services development	6	92,470	20,240	112,710	10.1
Health in human development	3	14,206	-	14,206	1.2
Health of special groups	6	80,376	-	80,376	7.2
Environmental protection and development	10	67,420	-	67,420	6.0
Disease prevention and control	5	91,220	217,897	309,117	27.9
<b>Total</b>	<b>36</b>	<b>760,770</b>	<b>348,394</b>	<b>1,109,164</b>	<b>100%</b>

The WHO/PAHO work plan for 2002-2003 includes a total of 36 expected results and a total activity budget of US\$1,109,164 (table 2). The amount allocated as Regular Budget is \$760,770 or 68.5 % of the total allocated amount. Extrabudgetary allocations account for 31.5 % or US\$348,394 of the total budget.

The regular budgetary amount under “Managerial Process for National Health Development” represents 37 % of the total budget and is accounted for as follows: US\$195,920 or 47.2 % is allocated to fund the technical posts recruited under National Professional Contracts and salary related expenses for local staff; US\$73,389 or 17.2 % is allocated to fund National Health Development activities; and US\$147,769 or 35.6 % is allocated to offset direct operational (office) expenses. The operational costs for the Office represent 13% of the total budget.

### 5.1.3 Subregional Programmes and Offices

Guyana also receives support from WHO/PAHO subregional centres, i.e., CAREC, CFNI, and the CPC office in Barbados. However, while these provide valuable support, coordination needs to be improved in order to ensure better synergy between these points of support and the Country Office.

### **5.1.4 Partnerships**

Strong relationships exist with public sector ministries, non-governmental organizations, and development partners and agencies.

*United Nations Country Team:* Guided by the Common Country Assessment, the United Nations Development Assistance Framework (UNDAF) for Guyana, the Millennium Development Goals and other global mandates, the PAHO/ WHO Representation works in collaboration with its United Nations partners to achieve common goals.

*Ministries:* The primary interlocutor is the Ministry of Health. Significant work is also undertaken with the Ministries of Agriculture; Fisheries, Crops and Livestock; Education; Labour, Human Services and Social Security; and Culture, Youth and Sports.

*Private Sector/NGOs/Media:* Collaboration is being strengthened with the private sector, with special emphasis in the area of lymphatic filariasis control. It is expected that this collaboration will increase.

*Other Agencies:* Strong collaborative links have been established with the CDC, IDB, CIDA, USAID and other Agencies involved in the health sector in Guyana.

### **5.2 Critical challenges for the WHO/PAHO country program**

1. Maintaining technical leadership in public health with limited technical and financial resources, compared to the massive national needs and the relatively larger budgets of the development partners.
2. Attracting and maintaining a critical cadre of technical staff at the Country Office with adequate competencies and skills mix to provide the level of technical support required by the MOH and participation in technical discussions on inter-agency coordination.
3. Limited human resources nationally, affecting the availability and capacity of counterparts at national level, the sustainability of programmes, and the ability to recruit at national level.
4. Coordination of the contribution of the subregional programmes to Guyana.
5. Working collaboratively with other Agencies and other partners in the health sector.

## PART TWO: STRATEGY FORMULATION

### 6. THE CORPORATE POLICY FRAMEWORK

#### 6.1 TRANSFORMATION

The key principles that govern the proposed shifts from WHO's past program of work to its new strategic agenda are to:

- Be more selective and focused in determining which part of the government and health sector program to support;
- Leave room for responding to requests as they arise, while defining the boundaries within which the Organization will respond;
- Emphasise the role of policy advisor and broker;
- Differentiate the Organization's work and performance from that of the government, whilst continuing to work as government's key partner in health;
- Explicitly take into account the strategies and activities of other partners;
- Seek out opportunities to increase and strengthen partnerships with other agencies and actors;
- Maintain visibility, credibility, and focus on what the Organization does best while paying due attention to its weaknesses.

#### 6.2 STRATEGIC DIRECTIONS AND PRIORITY AREAS FOR TECHNICAL COOPERATION

WHO has defined four broad strategic directions for its work, into which PAHO's eight priority areas of technical cooperation can be integrated.

**WHO Strategic Direction 1:** Reducing excess mortality, morbidity, and disability, especially in poor and marginalized populations.

*PAHO Priority Technical Cooperation Areas*

- Prevention, control, and reduction of communicable diseases
- Prevention and control of non-communicable diseases
- Healthy growth and development

**WHO Strategic Direction 2:** Promoting healthy lifestyles and reducing risk factors to human health that arise from environmental, economic, social, and behavioural causes.

*PAHO Priority Technical Cooperation Areas*

- Promotion of healthy lifestyles and social environments
- Promotion of safe physical environments

**WHO Strategic Direction 3:** Developing health systems that equitably improve health outcomes, respond to people’s legitimate demands, and are financially fair.

*PAHO Priority Technical Cooperation Areas*

- Ensuring universal access to integrated, equitable, and sustainable health systems
- Disaster preparedness, management, and response

**WHO Strategic Direction 4:** Framing an enabling policy and creating an institutional environment for the health sector.

*PAHO Priority Technical Cooperation Area*

- Promotion of effective health input into social, economic, environmental, and developmental policies

### 6.3 COUNTRY LEVEL FUNCTIONS

For operations at country level, WHO has identified five distinct generic functions<sup>3</sup>:

**F1:** Supporting long-term implementation of routine activities.

**F2:** Catalysing adoption and adaptation of technical strategies; seeding large-scale implementation.

**F3:** Supporting research and development; monitoring health sector performance.

**F4:** Information and knowledge sharing; providing generic policy options; standards; advocacy.

**F5:** Providing specific policy advice; serving as broker; influencing policy, action, and spending.

These are synchronous with the functions identified in the PAHO Strategic Plan 2003-2007, which also explicitly identifies resource mobilization and the establishment of strategic alliances and partnerships as important functions.

## 7. WHO/PAHO STRATEGIC AGENDA FOR GUYANA

It is envisioned that WHO/PAHO, by 2007, will be the lead international technical partner for health development in Guyana, recognized by all actors working for health in the country as an honest broker and the premier source of technical guidance and information in public health.

### 7.1 MISSION IN GUYANA

The mission of WHO/PAHO in Guyana is to provide technical leadership in public health and bring together local, regional, and international partners to strengthen national capacity for health development.

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<sup>3</sup> The numbering of these functions does not indicate ranking or priority.

WHO/PAHO’s work in Guyana is based on a belief in the rights of all individuals to basic conditions for health, irrespective of gender, race, age, religion, or sexual orientation and on the values of the Organization, which are:

*Solidarity*: promoting shared interests and responsibilities and collective efforts to achieve common goals. This value drives the promotion of intra- and inter-country alliances and joint action.

*Equity*: striving for fairness and justice by eliminating differences that are unnecessary and avoidable, recognizing the diverse ethnicity, geography, and socio-economic status in the country.

*Excellence*: achieving the highest quality in what we do, drawing on the best technical resources, wherever they might exist.

*Respect*: embracing the dignity and diversity of individuals, groups, and countries.

*Integrity*: assuring transparent, ethical, and accountable performance of individuals and the Country Office as a whole.

## 7.2 OVERVIEW OF STRATEGIC EMPHASES AND FUNCTIONS IN GUYANA

The period for the application of the CCS will be 2004-2007. Based on the situation analysis and the challenges identified in Part One of this document, the main strategic emphasis of WHO/PAHO’s work in Guyana will be on Strategic Direction (SD) 1, “Reduction of excess mortality, morbidity and disability”, followed by Strategic Direction 2, “Promotion of healthy lifestyles and reducing risk factors”, and Strategic Direction 3, “Development of equitable health systems”.

The prime function of WHO/PAHO in Guyana during the strategic period will be to provide specific policy advice; serve as broker; and influence policy, action and spending (Function 5). In order to undertake this function and in realization of the limited information available, this function needs to be supported by research and development and monitoring health sector performance (Function 3). The third most important function in the strategy will be Function 4, i.e., information and knowledge sharing; providing generic policy options; standards; and advocacy. The relative emphases across all strategic directions and functions are illustrated in table 3.

**Table 3:** Relative emphasis across generic functions and strategic directions

	Function 1	Function 2	Function 3	Function 4	Function 5	Total
<b>Strategic Direction 1</b>	4	7	17	14	18	60
<b>Strategic Direction 2</b>	1	2	5	6	6	20
<b>Strategic Direction 3</b>	2	1	5	3	6	17
<b>Strategic Direction 4</b>	0	0	1	1	1	3
<b>Total</b>	7	10	28	24	31	100

Table 3 captures in an indicative way the emphasis which WHO/PAHO will place in each of the intersections between function and strategic direction during the period 2004-07. The table is derived by weighting the potential impact of technical cooperation in each of the areas in the context of Guyana based on the analysis of the CCS Team. The Team used the analyses and conclusions made at the level of priority technical cooperation areas and the critical issues and challenges identified. These are qualified, for each function, in section 7.3.

### 7.3 WHO/PAHO FUNCTIONS IN GUYANA

WHO/PAHO's overall criteria for engagement in any function and activity will be that it addresses an important health-related problem currently or potentially causing high burden of disease or contributing significantly to inefficiency and/or inequity within the Guyanese health system and that it contributes to the achievement of the Millennium Development Goals.

The actual activities of the Country Office (CO) may change over time depending on the needs and opportunities, but the criteria for engagement within each function, as well as the overall emphasis depicted in table 3, will remain during the 2004-2007 period.

The specific criteria for engagement, the priorities, and the critical success indicators for each of the five generic functions are described in sub-sections 7.3.1 to 7.3.5 below.

#### **7.3.1 Function 1: Supporting long-term implementation of routine activities**

##### *Specific criteria for engagement*

- WHO/PAHO intervention would make a *critical difference*.
- There is a *critical gap* in national and international resource flow.
- Short- and medium-term *national capacity* for control/action is limited or poor.
- *Extra-budgetary* or *additional* regular budget funding is available within the global or regional mandates of WHO/PAHO and requires the CO as executing agent.

##### *Priority Technical Cooperation Areas*

*Prevention, control, and reduction of communicable diseases:* Continued support in program planning, with particular emphasis on malaria, Hansen's Disease, and dengue, as well as continued support in procurement of drugs and vaccines.

*Prevention and control of non-communicable diseases:* Support in program planning and implementation in management of non-communicable diseases.

*Healthy growth and development:* Direct technical, managerial, and implementation support of continued training in the areas of Expanded Program on Immunization and maternal health.

### *Critical success indicators*

- At least one significant improvement (or avoidance of decline) in national level health service outcome in each of the above three priority technical cooperation areas due to WHO/PAHO support. The indicator will be validated through the national health reporting system or special evaluation studies.

### **7.3.2 Function 2: Catalysing adoption and adaptation of technical strategies; seeding large-scale implementation**

#### *Specific criteria for engagement*

This is a negotiable function with the following criteria for engagement:

- Existing interventions/strategies used in the country are *not effective*.
- There is a good chance that new or improved interventions/strategies will be *taken up by others*, once feasibility and effectiveness have been demonstrated.
- There is an *opportunity* to eliminate a disease with a short-term intervention.

#### *Priority Technical Cooperation Areas*

- *Prevention, control, and reduction of communicable diseases*: the focus will be on pilot projects, adapting strategies and seeding for scaling up for malaria and lymphatic filariasis control. Some work will also be supported in control of tuberculosis and dengue.
- *Prevention and control of non-communicable diseases*: in this area, focus will be on developing management protocols and improving the quality of care of non-communicable diseases.
- *Healthy growth and development*: this represents a major priority area with emphasis on maternal and child health. Several ongoing pilot projects will be continued and new ones launched, addressing problems such as maternal mortality, diarrhoeal diseases, ARI, and asthma.
- *Promotion of healthy lifestyles and social environments*: focus will be on non-communicable diseases, behavioural risk factors and adolescent health by starting pilot projects with the aim of eventual scaling up, once feasibility and effectiveness have been proven.

### *Critical success indicators*

- 75% of pilot projects completed and evaluated. The indicator will be verified through evaluation reports.
- 25% of evaluated piloted interventions scaled up. Reports from regions will be used for verification.

### 7.3.3 Function 3: Supporting research and development; monitoring health sector performance

#### *Specific criteria for engagement*

The shortage of reliable information about the health situation and system performance in Guyana makes it difficult to plan for appropriate and cost-effective responses to the problems faced by the sector. This is a critical and indispensable function in support of WHO/PAHO's work under Function 5 with the following criteria for engagement:

- There is a *critical gap* in information/evidence for policy.
- *Current information/evidence* on the health situation and/or system performance is *inadequate*.
- *Efforts and/or capacity* for gathering and analysing information/evidence of effectiveness of used interventions, strategies and impact of change are *inadequate*.

#### *Priority Technical Cooperation Areas*

- *Prevention, control, and reduction of communicable diseases*: priorities include drug resistance studies in malaria, operational research, and information gathering for the elimination program for lymphatic filariasis, and a review of the extent and spread of dengue and other environmental diseases in Guyana.
- *Prevention and control of non-communicable diseases*: the main priority will be establishment of an evidence base for dealing with injuries. Studies related to diabetes and mental health are also on the agenda.
- *Healthy growth and development*: operational research, establishment of baselines, and monitoring of health systems performance will be crucial to improving the indicators for maternal and child health and for monitoring the EPI and nutrition programmes.
- *Promotion of healthy lifestyles and social environments*: within this area, efforts will be devoted to studies and information generation in relation to risk factors, e.g., tobacco use, physical inactivity, and obesity.
- *Promotion of safe physical environments*: information gathering and analysis will be undertaken in relation to occupational health, sanitation, water, and environmental protection.
- *Ensuring universal access to integrated, equitable, and sustainable health systems*: given the shortage of reliable information, top priority will be given to supporting the establishment and functioning of equity-oriented surveillance and monitoring. Issues of equity of the system, management, productivity, and quality performance will also be given high priority.
- *Promotion of effective health input into social, economic, environmental and developmental policies*: priority in this area will be given to strengthening the public health leadership's capacity to analyse, interpret, and use information in the public debate and opinion formation process.

### *Critical success indicators*

- At least two completed studies that have influenced policy and planning. Verification will be done through review of research reports and policy documents.
- At least one of the information gaps identified in Health in the Americas (HIA) and Health Sector Analysis (HSA) reduced. Verification will be done by comparing different issues of these reports.
- Two components of the health services/system evaluated. Verification will be done through review of evaluation reports.

### **7.3.4 Function 4: Information and knowledge sharing; providing generic policy options; standards; advocacy**

#### *Specific criteria for engagement*

This is a core WHO/PAHO function, and the Organization will apply it to all technical cooperation areas. The following criteria for priority engagement are identified:

- There is a current or potential *threat* to public health.
- There is a need for *defining* or *refining* national health development priorities.

#### *Priority Technical Cooperation Areas*

- *Prevention, control, and reduction of communicable diseases*: highest priority will be given to HIV/AIDS, malaria, dengue, lymphatic filariasis, and food safety.
- *Prevention and control of non-communicable diseases*: diabetes and cancers will be the main foci within this technical cooperation area.
- *Healthy growth and development*: provide generic policy options as needed to support Function 5.
- *Promotion of healthy lifestyles and social environments*: priority will be on risk factors for non-communicable diseases, i.e. tobacco use, physical inactivity, and obesity.
- *Promotion of safe physical environments*: priorities will be sanitation and drinking water quality.
- *Ensuring universal access to integrated, equitable, and sustainable health systems*: the focus will be on international information sharing regarding priority setting, and allocative and technical efficiency.
- *Disaster preparedness, management, and response*: with the exception of flooding, Guyana is not prone to natural disasters and engagement will be maintained at a general level for this technical area.
- *Promotion of effective health input into social, economic, environmental, and developmental policies*: activities within this area will consist mainly of providing opportunities for information sharing among public health leaders within the country and internationally.

### *Critical success indicators*

- National standards have been clearly defined and mechanisms designed for monitoring adherence to them for at least two technical cooperation areas. The achievement will be verified through review of relevant documents.
- An information and knowledge sharing plan developed and implemented to reach more targeted publics, including Regions, in order to fill information and communication gaps. The achievements will be verified through review of the plan and progress reports.

### **7.3.5 Function 5: Providing specific policy advice; serving as broker; influencing policy, action and spending**

#### *Specific criteria for engagement*

This is the prime function of WHO/PAHO's presence in Guyana during the strategic period and the work, including development partner coordination, will be carried out in all the technical cooperation areas. However, the following criteria for specific priority engagements will apply:

- Current or planned policies and strategies are *inadequate* or *inappropriate*.
- Absolute or relative national/international resource allocation is *inappropriate* or *inadequate*.
- Important *funding gaps* exist.
- There are *many* players/actors.
- There are *too few* players/actors.

#### *Priority Technical Cooperation Areas*

- *Prevention, control, and reduction of communicable diseases*: due to the size and complexity of the problem, the large number of partners, and the influx of significant resources, the absolute priority in this area will be given to HIV/AIDS, malaria, and TB. High priority will also be given to zoonoses and food safety.
- *Prevention and control of non-communicable diseases*: Priorities within the area are diabetes, cancer, mental disorders, and oral health conditions.
- *Healthy growth and development*: High priority will be given to influencing specific policies, action, spending among partners, and resource mobilization for Maternal and Child Health, including EPI.
- *Promotion of healthy lifestyles and social environments*: activities will focus on behavioural risk factors for non-communicable diseases.
- *Promotion of safe physical environments*: sanitation, drinking water, and environmental protection are high on the agenda.
- *Ensuring universal access to integrated, equitable, and sustainable health systems*: this will be a main area of activity, including support for priority setting and decision making on allocation of resources; identification of packages of care; support for concerted approaches to surveillance and monitoring systems; establishment of policies and approaches to reduce inequity in access to services; and improving human resources planning and management in the sector.

- *Disaster preparedness, management, and response*: specific advice will be provided on request to support a balanced approach in this area.
- *Promotion of effective health input into social, economic, environmental and developmental policies*: priority will be given to strengthen and support national leadership in bringing public health concerns to an appropriate level of the societal agenda and to creating an environment conducive to implementing the policies required for improving the health situation and system performance.

### *Critical success indicators*

WHO/PAHO will be taking a very proactive role within this function, aiming at influencing policy, action and spending, thus impacting beyond its immediate manageable interest.

- Activities and projects of partners in health guided by relevant national plans and/or a common agenda. Verification will be made through partners' review.
- Resources allocated and/or action taken for local implementation of global/regional strategies in at least three priority technical areas. This will be verified through review of national, regional, and donor budgets.
- Sufficient resources mobilised or brokered for activities in at least two under-funded priority areas, to be verified through review of country office, national, regional, and development partner budgets.

## **8. PERFORMANCE AUDIT**

Having envisioned the future functions in section 7 above, the performance audit evaluates how WHO/PAHO currently stands to achieve the future strategic profile.

### 8.1 SHIFT IN EMPHASIS

The strategy aims at shifting the relative emphasis of the WHO/PAHO presence in Guyana by increasing the efforts in some areas while maintaining involvement at current level in other areas. The shift in emphasis is schematically presented in the table below.

**Table 5:** Shift in emphasis compare to current situation

	Function 1	Function 2	Function 3	Function 4	Function 5
<b>Strategic Direction 1</b>	→	↑↑	↑↑↑	→	↑↑↑
<b>Strategic Direction 2</b>	→	→	↑↑	→	↑↑
<b>Strategic Direction 3</b>	→	↑	↑↑↑	→	↑↑↑
<b>Strategic Direction 4</b>	□	□	↑	→	↑

↑ = increased emphasis; ↓ = decreased emphasis; → = same emphasis; □ = no emphasis

As no area is foreseen to be de-emphasised, it means that additional technical and financial resources will be required, which is in line with the fact that Guyana has been designated one of the five PAHO Key Countries for technical cooperation.

In summary, greater emphasis will be placed on:

- Influencing policy, action and spending
- Strengthening the brokerage role of PAHO among the multiple partners in health, working towards a common agenda
- Improving the quality of technical evidence to support shifts in policies/strategies
- Filling information gaps in areas where effective public health interventions exist
- Monitoring health sector performance
- Building capacity in the Ministry of Health for implementation of evaluation methodologies
- Resource mobilization

## 8.2 STRENGTHS, WEAKNESSES, OPPORTUNITIES AND THREATS

In the following, the current strengths, weaknesses, opportunities, and threats are analysed in the light of the current and the foreseen future functions as described in section 7.

### 8.2.1 Internal strengths and weaknesses

An overview of the strengths and weaknesses internal to the WHO/PAHO Country Office and with respect to implementing the new functional emphases are listed in the table below.

Internal strengths	Internal weaknesses
<ul style="list-style-type: none"> <li>• Influence on general policy through leadership</li> <li>• High credibility and respect for the Organization, which has considerable convening and brokering power</li> <li>• Recognised role in setting norms and standards</li> <li>• Technical capacity of the Organization as a whole, including the expertise available in specialized centres</li> <li>• Values-based Organization</li> </ul>	<ul style="list-style-type: none"> <li>• Lack of specific technical backup in key priority areas of health systems, epidemiology and research, disease prevention and control, and maternal &amp; child health (MCH)</li> <li>• Inadequate capacity and tools for identifying loci of relevant knowledge in the wider organization</li> <li>• Inadequate capacity for public relations and promotion of the Organization and its capabilities</li> <li>• Inadequate activities budget</li> <li>• Not all technical resources in the Country Office accountable to the PWR</li> <li>• PWR over-committed with delivering technical cooperation in disease prevention and control, while trying to establish PAHO/WHO's leadership role in development partner coordination and carry out strategic management duties</li> </ul>

For successful implementation, the strengths are to be built on and the weaknesses removed or minimized. The core strength of the Country Office relates to it being the local presence of the larger WHO/PAHO, with considerable credibility and potential for drawing on the wider expertise of the Organization. The key weaknesses relate to limited technical and financial resources in the Country Office, restricting the ability

to provide on-site technical advice and leadership and to effectively draw on and follow-up with the expertise of the Organization.

### 8.2.2 External opportunities and threats

In implementing the new functions, the external opportunities should be taken and the threats managed in such a way that they are avoided or their effect minimized.

External Opportunities	External Threats
<ul style="list-style-type: none"> <li>• Guyana is the focus of many development partners and there has been a rapid influx of resources for health through bilateral agreements</li> <li>• PRSP being lead by the President, with Theme Group on Health for coordination and influence</li> <li>• National Health Plan and several sub-sectoral plans</li> <li>• Relevant global and regional mandates</li> <li>• PAHO Key Country, HIPC initiative</li> <li>• Possible collaboration with other technical cooperation agencies working in potentially complementary areas</li> <li>• The partners, national and international, are looking to WHO/PAHO to provide technical leadership</li> </ul>	<ul style="list-style-type: none"> <li>• Low national institutional capacity for engagement in health development</li> <li>• Socio-political instability</li> <li>• Attrition of persons trained and difficulty in administering the fellowship program</li> <li>• Significant focus on HIV/AIDS by development partners</li> <li>• Risk of isolated, non-consultative action by development partners</li> <li>• Entry of technical cooperation agencies, working in overlapping areas</li> <li>• No, or slow, response from PAHO regional programs in some areas</li> <li>• Poor coordination among PAHO sub-regional entities in support of the program in Guyana</li> <li>• The unique problems of Guyana, within the Caribbean sub-region</li> </ul>

The opportunities centre on the increased external focus on Guyana by development partners and some key development instruments that are in place, such as the PRSP and the National Health Plan. The threats fall into three main groups: (1) threats intrinsic to Guyana, i.e. related to national capacities and the social and political situation; (2) development partner ‘behaviours and practices’; and (3) the structure and functioning of PAHO, related to the fact that Guyana has a unique set of problems compared to the other Member Countries within the PAHO subregion.

## 9. GAP ANALYSIS

The analysis identifies the gap between the current performance and the performance required for the successful realization of the strategic agenda. The gap analysis addresses the question of whether the skills and resources at hand are sufficient to close the gap. The significant increased emphases, in particular in functions F3 and F5, predict that there are likely to be significant gaps between current and future performance requirements for these functions.

## 9.1 GAUGING THE GAP

The required future performance of the Country Office is compared to its current performance and the gap gauged for each of the five country level functions, F1 to F5, of the strategic agenda defined in section 7. The result of the analysis is summarized in table 6.

**Table 6:** Comparison between required future and current performance of the Country Office of WHO/PAHO

<b>Function</b>	<b>Future performance requirement</b>	<b>Current performance</b>	<b>Gap</b>
<b>F1:</b> <i>Supporting long-term implementation of routine activities.</i>	Provide direct input to routing activities in selected priority areas	Adequate level of financial resources. Inadequate scope and depth of technical support due to time constraints of PWR	<ul style="list-style-type: none"> <li>- Technical capacity in communicable and non-communicable diseases</li> <li>- Technical capacity in EPI and maternal health</li> </ul>
<b>F2:</b> <i>Catalysing adoption and adaptation of technical strategies; seeding large-scale implementation.</i>	Provide advice and funds for adaptation and scaling up of strategies in priority areas of technical cooperation	Lack of depth and span in disease control, MCH, and health systems	<ul style="list-style-type: none"> <li>- Funding and technical capacity in disease control and MCH</li> <li>- Capacity in health systems</li> </ul>
<b>F3:</b> <i>Supporting research and development; monitoring health sector performance.</i>	Provide adequate analytical expertise, guidance, and funding for improving the sectoral evidence base	Current performance is ad hoc and inadequate in all priority areas	<ul style="list-style-type: none"> <li>- Funding and technical capacity for research, data collection and analysis</li> <li>- Analytical capacity: disease control, MCH, and health systems</li> </ul>
<b>F4:</b> <i>Information and knowledge sharing; providing generic policy options; standards; advocacy.</i>	Proactively and on request, provide timely guidance to national and international partners	Adequate level of, and span in, performance; doing less well with respect to timeliness	<ul style="list-style-type: none"> <li>- Timely access to organizational knowledge and response from regional and global levels of the Organization</li> </ul>
<b>F5:</b> <i>Providing specific policy advice; serving as broker; influencing policy, action, and spending.</i>	Proactively influence action of, and provide specific advice to, partners within priority areas	Current performance is reactive, ad hoc, and inadequate in most priority areas. Due to lack of technical support, PWR has to provide direct technical work, rather than influencing high-level policy making	<ul style="list-style-type: none"> <li>- Lack of evidence base (F3)</li> <li>- Technical capacity in disease control and MCH</li> <li>- Technical capacity in health systems</li> </ul>

## 9.2 ASSESSING SUFFICIENCY OF SKILLS AND RESOURCES TO CLOSE THE GAP

The performance gaps are linked to the prevailing situation in Guyana, as the low capacity in the sector results in a relatively weak institutional framework. Further, the influx of new development partners and resources accentuates the demand on the WHO/PAHO Country Office to provide technical leadership for the years to come. The result is a widening gap between the current performance and the required future performance in terms of technical capacity and to a lesser degree in terms of financial resources.

Four areas of gap in technical capacity in the Country Office are identified:

Health systems development – to give WHO/PAHO a strong presence in the development of the sector, in particular addressing issues of equitable access, and cost-effective packages of care. **An international expert recruited for the fixed-term post in this area is required.**

Epidemiology, biostatistics, and research – to guide and support efforts in surveillance and data collection, analysis, and interpretation. The magnitude and depth of the inadequacy of quality evidence for policy in Guyana makes these skills a need in their own right, i.e., it is not a function that can be undertaken as part of another area of technical expertise. **It is suggested that a medium-term international post in this area be established and filled.**

Disease prevention and control (communicable and non-communicable) – to bring together the many initiatives in communicable disease prevention and control and to spearhead addressing the increasing problems of non-communicable diseases. Up to the commencement of the CCS process, this function was undertaken by the PWR in addition to the more strategic tasks of representing the Organization and addressing high-level policy matters. This project is presently being undertaken by a technical position under NPO terms and conditions. Due to the importance of technical leadership in Disease Prevention and Control, and the difficulties in this type of recruitment, **it is recommended that this post be an internationally recruited post in the medium to long term.**

Maternal and Child Health (MCH) – to support efforts to consolidate a response to the continued high levels of maternal and child morbidity and mortality. This function is also currently undertaken by the PWR. Plans to transfer a WHO/PAHO post from another country in the region to Guyana fell through and **alternate mechanisms are being identified to fill this gap.**

Financial resources are insufficient for function F2 in respect of reduction of morbidity and mortality (Strategic Direction 1) and healthy lifestyles (Strategic Direction 2). Further, resources are not enough for the sharply increased emphasis on function F3 in Strategic Directions 1 and 2 as well as for developing health systems (Strategic Direction 3).

The performance gap identified in table 6 above with regards to timely access to knowledge, guidance, and experience exists within the entire Organization and is not specific to the Country Office in Guyana. However, it may be more acute for this office due to the uniqueness of Guyana within the American region, which may call for drawing on lessons learned, e.g. in the African and Asian regions.

## **10. INTEGRATION**

The strategic agenda, shifts in emphases, and gap analysis described above have clear implications for the functioning of WHO/PAHO. The organization can not operate in a “business as usual” mode in fulfilling its commitment to targeted and more efficient and effective technical cooperation in Guyana. The focus on serving country needs is rooted in the WHO/PAHO commitment to country-centered cooperation, evidenced by the Country Focus Initiative and the new definition of a regional program in PAHO.

### **10.1 VERTICAL INTEGRATION - LAUNCHING AND STRENGTHENING COUNTRY LEVEL FUNCTIONS**

Though the Country Office will place main emphasis on the generic function F5 in addressing the strategic directions and technical areas outlined, F3 is the second most important function, being a fundamental function in support of F5. F4 is the third most important function and the Country Office will work in F2 in several technical areas. An explicitly stated PAHO function, implicit in F4 and F5, addresses resource mobilization and partnerships. In order to carry out all of these functions, the Country Office needs relevant resources – human, financial, and infrastructural.

#### **Function 3**

As noted, the development of the evidence base is a key support function and is important for all strategic directions and priority technical areas in the CCS. It is therefore critical that the Country Office possess technical expertise in the collection, analysis, and use of data relevant to the situation and needs of the country, including social and economic data, and their disaggregation to identify inequities.

Given the commitment to addressing the Millennium Development Goals from equity and social inclusion perspectives, the Country Office must be able to offer technical cooperation in the development of indicators of success and the establishment of systems to provide relevant data, and must have adequate resources to carry out related tasks.

#### **Functions 4 and 5**

F4 and, in particular, F5, must be based on valid data; an analysis of pertinent information; and knowledge of cost-effective interventions that would be appropriate to address national and/or regional issues affecting health in Guyana. The Country Office must therefore offer, as far as possible, evidence-based advice and examples of “best practices” from in and outside the subregion. Tailoring of messages for various

audiences, be they national technical counterparts, policy makers at the highest levels, development partners, or the general public, will be necessary. Skills in social communication and advocacy should therefore also be available in the Country Office for success in these functions.

## Function 2

F2 demands not only relevant technical and financial resources, but also that the Country Office be a hub for the management of organizational knowledge regarding technical solutions that are appropriate for use in the respective strategic directions and priority technical areas. Technical cooperation among countries will be a key strategy in carrying out this function. The PWR and technical staff must therefore be aware of relevant initiatives in the priority areas that have been implemented in other member states of WHO, to facilitate identification of those that may be useful for Guyana.

## Function 1

F1 requires limited flexible financial resources, which can quickly be allocated to cover critical gaps. In addition, managerial, analytical, and other technical skills to identify and close gaps as they occur are needed. Financially, the engagement remains at previous levels, while technical support is envisaged to increase.

The Country Office will actively seek opportunities to tap into activities being implemented by development partners that can be of mutual benefit in addressing national health goals, as well as identifying and seeking opportunities internally in the Organization. Adequate financial resources to carry out and sustain the technical coordination program and development partner coordination are pre-requisites for successful implementation of the strategy. Table 7 shows the requirement and distribution of financial resources for technical activities, i.e. other than for management and upkeep of the Country Office itself.

**Table 7:** Proposed strategic activities budget for WHO/PAHO Country Office for 2004-05 biennium, compared to the currently planned budget for the same biennium.

Regular budget	Proposed Strategic Budget for 2004-05						Current 2004-05
	F1	F2	F3	F4	F5	Total	
Communicable diseases	25,000	50,000	50,000	4,000	10,000	<b>139,000</b>	30,500
Non communicable diseases	15,000	15,000	10,000	4,000	6,000	<b>50,000</b>	23,000
Healthy growth and development	20,000	30,000	35,000	4,000	4,000	<b>93,000</b>	44,500
<b>Total Direction 1</b>	<b>60,000</b>	<b>95,000</b>	<b>95,000</b>	<b>12,000</b>	<b>20,000</b>	<b>282,000</b>	<b>98,000</b>
Healthy lifestyles and Physical environment	0	70,000	25,000	5,000	5,000	<b>105,000</b>	71,000
<b>Total Direction 2</b>	<b>0</b>	<b>70,000</b>	<b>70,000</b>	<b>15,000</b>	<b>25,000</b>	<b>180,000</b>	<b>146,000</b>
Universal access	0		80,000	15,000	15,000	<b>110,000</b>	
Disaster preparedness	0			1,000	1,000	<b>2,000</b>	
<b>Total Direction 3</b>	<b>0</b>	<b>0</b>	<b>80,000</b>	<b>16,000</b>	<b>16,000</b>	<b>112,000</b>	<b>97,000</b>
Promotion of health input	0		10,000	5,000	5,000	<b>20,000</b>	
<b>Total Direction 4</b>	<b>0</b>	<b>0</b>	<b>10,000</b>	<b>5,000</b>	<b>5,000</b>	<b>20,000</b>	<b>16,950</b>
<b>Grand Total 2004-05</b>	<b>60,000</b>	<b>165,000</b>	<b>255,000</b>	<b>48,000</b>	<b>66,000</b>	<b>594,000</b>	<b>357,950</b>

The budget foreseen for the 2004-05 biennium, given the strategic shifts and emphases, is higher by about US\$236,000, than what is currently proposed (last column). The largest increase is for Strategic Direction 1, functions F2 and F3, followed by the same functions in Strategic Direction 2. For the 2006-07 biennium, the financial requirements are estimated at a similar level and distribution as for the 2004-05 biennium, in carrying out the WHO/PAHO strategic plan.

## 10.2 HORIZONTAL INTEGRATION

The success of the CCS depends heavily on the recognition that the locus and responsibility for the coordination of all WHO/PAHO technical activities in Guyana lie in the Country Office. It also means that the technical cooperation needs are defined at the country level, which in turn will call upon support and assistance from subregional, regional, and global levels of the Organization.

### 10.2.1 Implications for the Country Office

The strategy relies on the addition to the Country Office of the technical expertise defined in the gap analysis (section 9.2). Therefore, the recruitment for the Health Systems post must be completed and the post of epidemiologist/research scientist established as soon as possible. A MCH Advisor will be required by the beginning of 2004 and a Medical Officer, Disease Prevention and Control by mid-2005.

The mode of operation of the Country Office and its staff will be to proactively seek engagement and influence within the country, i.e., with national and international partners, and to establish networks within WHO/PAHO in order to be better able to draw on expertise and experience existing globally and regionally. This, among other things, will require the establishment of a staff development program that allows staff to maintain and strengthen their skills and reach, including identification of initiatives or interventions in other countries that may provide models for Guyana.

Organizationally, all staff in the Country Office, including subregional staff, should report to the PWR, and all PAHO activities, including those to be implemented by subregional entities, should be captured in the country Biennial Program Budget (BPB). This will facilitate coordination, support, and appropriate attribution.

### 10.2.2 Implications for AMRO/PAHO subregional and regional levels

Implementation of the Country Cooperation Strategy for Guyana requires a mind-set at the subregional and regional levels that acknowledges and internalizes the Country Office as the locus, agenda-setter, and engine for all technical cooperation between the Organization and the country.

For the subregional level, this could mean: joint planning between the Country Office and subregional entities such as CAREC, CFNI, and CPC; subregional staff seconded to the Country Office working with the PWR as first level supervisor; development of systems and mechanisms for information sharing on initiatives in countries in the subregion that may be of benefit to Guyana; and inclusion of Guyana as a specific focus in resource mobilization efforts.

For the regional level, it could mean: establishment of a group, convened through the Country Support Unit (CSU), aimed at rallying regional units around the CCS and facilitating its implementation; accelerated responses from regional units and centres; assistance to identify loci of learning elsewhere in the Organization relevant to Guyana's needs; provision of technical guidance in building capacity to develop and keep current the national health situation analysis; development of systems and mechanisms for information sharing on initiatives in countries in the region and elsewhere that may be of benefit to Guyana; and inclusion of Guyana as a specific focus in resource mobilization efforts.

### **10.2.3 Implications for WHO global level**

An important implication for the global level is the need to continue and possibly accelerate the development of global systems and mechanisms to facilitate intra-organizational networking and information sharing. This will permit the dissemination of experiences and lessons learned in other countries relevant to the situation in Guyana. Further, the global level will need to provide accelerated responses, through the regional office, to specific requests for technical assistance, e.g. in mental and maternal health, and include Guyana as a specific focus in resource mobilization efforts. Finally, to increase the technical capacity in the Country Office in Guyana, will likely be necessary to shift technical resources from the global to the country level.

## **11. CONTINGENCY PLANNING**

A key assumption underlying the strategy is that it will be possible to increase the technical capacity of the Country Office through recruitment of additional international staff. This assumption is judged to be realistic, given the WHO Country Focus Initiative and the decision to make Guyana a PAHO priority focus for technical cooperation. However, in the event that this does not happen or that the capacity is only partially increased, it will have profound implications for the ability to establish WHO/PAHO as the lead technical agency for health development in Guyana and it would be necessary to revise the WHO/PAHO strategic agenda, including its success criteria. A trigger point for whether this will be needed would be the non-recruitment of the health systems expert and the epidemiologist/research scientist by the first half of 2004.

## **12. IMPLEMENTATION**

It is clear that the successful implementation of the CCS will depend on a number of changes which will need to take place at every level of the Organization. Some of these changes will demand a different way of thinking and a clear focus on the country as the centre of technical cooperation.

### **12.1 STRUCTURAL AND FUNCTIONAL CHANGES**

Given the implications of the strategic agenda previously enunciated, structural and functional changes in the WHO operations would be needed, including, but not limited to: ensuring that the lead coordinating function of the Country Office is

observed and respected by all levels of the organization; reviewing the Basic Agreement between the Government of Guyana and WHO/PAHO to clearly outline the lead technical role of WHO/PAHO in public health; providing adequate and appropriate technical resources to ensure that the role of the PWR does not involve the management of specific technical projects; promoting the CCS, in and outside of the Organization, as *the* framework for PAHO/WHO's technical cooperation with Guyana.

## 12.2 POSSIBLE ROAD BLOCKS

There are a number of possible road blocks to implementing the changes required for the success of the CCS, including: insufficient growth in Country Office resources; resistance to change at various levels of the Organization; bureaucratic delays and complications; slow, frustrating, and counterproductive recruitment policies; and management systems that are not responsive to country needs.

## 12.3 PERFORMANCE MANAGEMENT SYSTEM

### 12.3.1 Performance “contract” between levels of WHO

Approval of the CCS signifies a commitment on the part of the entire WHO/PAHO to provide the resources needed for its implementation. If this happens, the Country Office would be obliged to deliver on the success criteria targets as established in section 7.3.

The key instrument for ‘contract’ or mutual commitment among levels of the Organization is joint planning, manifested by all activities reflected in the BPB for Guyana, regardless of the source of funding and the level of the Organization responsible for their execution. The indicators and targets set in the BPB provide a key measure of performance.

The CCS, however, also requires a change in organizational attitude and behaviour to “live” the country focus and it is suggested that systems and performance criteria that encourage timely responses to requests to and from the field be instituted.

### 12.3.2 Staff Performance Management

Successful implementation of the CCS will require organization-wide staff performance management that allows for, encourages, and monitors staff development to:

- maintain technical excellence and strengthen individual skills for alliance building, resource mobilization, effective communication, and knowledge management;
- incorporate country-focused thinking, experience, and behaviour into the career and work objectives of all staff; and
- develop systems encouraging, monitoring, and evaluating the collective performance of regional and global programs and offices in supporting the country level, in addition to evaluating individual performance.