HEALTH SECTOR POLICY AND INSTITUTIONAL DEVELOPMENT PROGRAM

(TC-95-03-11-2-GY)

EXECUTIVE SUMMARY

REQUESTER:	Ministry of Finance	
EXECUTING AGENCY:	Ministry of Health (MoH)	
BENEFICIARIES:	Government of Guyana, Ministry of Health	
FINANCING:	IDB:	US$2,500.000 (Net Income FSO)
	Local counterpart funding:	US$250,000
	Total:	US$2,750.000
TERMS:	Execution period:	24 months
	Disbursement period:	36 months

ENVIRONMENTAL CLASSIFICATION: The Committee of Environment and Social Impact (CESI) in its meeting of June 13, 1997, decided that no environmental and social assessment is required. Other suggestions made by CESI members are reflected in the document.

OBJECTIVES: The objective of this operation is to assist the Government of Guyana in the definition and implementation of policies to address institutional, financial, managerial and service delivery problems in the health sector.

DESCRIPTION: The technical cooperation will enable the MoH to access technical consultancy services, to undertake in-service training, to field-test selected options to address the following key policy areas: (a) the reorganization and strengthening of the institutional structure of the health sector; (b) development of plan for integrated service delivery based on a primary care strategy; (c) the preparation of a managerial and human resource development strategy; (d) the identification of health sector financing options and resource allocation mechanisms which enable the MoH to target resources to the most important public health problems, and to those population groups most at risk; and (e) the preparation of a plan to improve the organization, management and financing of the Public Hospital of Georgetown (GPH) as a step prior to addressing further infrastructure development needs. The execution of the project will be the responsibility

of the MoH which will establish a Policy Committee to provide overall policy direction and a Project Management Unit (PMU) headed by a Project Coordinator to manage activities.

BENEFITS: The project is expected to increase the capacity of the MoH to formulate and implement policies for the sector on the basis of sound problem analysis and appraisal of options. This project will also assist the MoH in the implementation of the health sector policy measures contained in the Social Sector Agenda of the HIPC Initiative, currently under development, which in turn will increase the sector's absorptive capacity for the anticipated increases in budgetary allocations to the health sector.

RISKS: There are two main risks. The first concerns the limited institutional capacity available within the MoH, primarily as a result of shortages of qualified personnel. The design of this operation seeks to increase capacity by fostering close collaboration with long-term resident consultants and providing financial incentives for the participation of counterpart staff.

The second risk is that substantial effort will go into the design of policies and procedures, but implementation will not occur due to lack of consensus or a lack of capacity. This risk is mitigated by the inclusion of field tests to pilot alternatives and ease the way for new policies and systems.

THE BANK'S COUNTRY STRATEGY: In the context of preparation of the Social Impact Amelioration Program - Stage II (GY-0025), a social sector strategy for Guyana was formulated, discussed and endorsed by the GoG. It was agreed that in the social sectors the Bank will concentrate on small operations focused on institutional strengthening and organizational changes designed to improve services in a sustainable manner. Once progress is made on strengthening institutional capacity and the implementation of key policy changes, then larger investment programs will become feasible.

SPECIAL CONTRACTUAL CONDITIONS: Prior to first disbursement the GoG/MoH shall present to the Bank: (a) the draft contract to be signed with the selected Project Coordinator; (b) evidence of appointment of the five lead counterparts, one for each project component; and (c) a proposal for selecting and providing additional compensation for counterparts.

I. BACKGROUND

A. The health sector in Guyana

1.1 Guyana's health indicators compare poorly with those of other countries in the Caribbean region reflecting twenty years of economic decline and severe shortcomings in the quality, effectiveness, efficiency and equity of its health services. In 1995, the infant mortality rate was estimated at 45 per 1,000 live births, under-five mortality at 69 per 1,000 and life expectancy at birth at 66 years. While chronic diseases rank among the leading causes of death, other conditions such as malaria, diarrhoea, acute respiratory tract infections and malnutrition remain major contributors to morbidity and mortality. This epidemiological profile suggests that substantial health gains can be achieved through improvements in basic preventive and curative health care provided at lower level facilities.

1.2 The public sector remains the major provider of health services, although there has been a substantial growth of private services in recent years. The structure of facilities in the public health system, consisting of five levels of increasing sophistication, ranging from local health posts staffed by community health workers to the 600-bed Georgetown Public Hospital (GPH), is conceptually well designed for the country's geographical and demographic characteristics, and insures high access to services. However, over the last twenty years there has been a sharp deterioration in the quality of these services, leading to a resurgence of vector-borne diseases and an apparent increase in infant mortality. Much of the burden of economic decline fell on lower level facilities and services outside of Georgetown, leading to a breakdown of the referral system, with patients seeking care directly at GPH, at a substantial cost to the rural poor.

B. Main sectoral problems

1.3 The poor quality of public services at all levels can be attributed to a number of factors, including an inappropriate organizational structure, the Ministry of Health's (MoH) weak capacity to define priorities, manage and monitor the system, acute shortages and inefficient use of trained personnel, equipment, and pharmaceuticals, a dilapidated physical infrastructure, and until recently, a lack of emphasis on primary care services. Many of these problems can be traced to years of economic decline resulting in tight fiscal constraints. Among them, the shortage of qualified staff in certain categories, a product of low salaries and high rates of migration, represents a central constraint as it affects both the delivery of services, especially outside of Georgetown, and the MOH's own capacity to identify sector priorities and formulate a sustainable strategy to address them.

1.4 Despite fiscal constraints, the Government of Guyana (GoG) has continued to provide fully subsidized services, with only nominal charges for private beds at GPH. Since 1991, with economic recovery, the trend of declining budgetary allocations to the health sector has been reversed. Budgeted public expenditures in 1997 represent 2.9% of GDP, a percentage comparable to the average for Latin American and Caribbean countries. However, these resources are insufficient to support the extensive public health infrastructure built during a period of prosperity and the wide range of services offered. GPH alone absorbs one-third of recurrent public expenditures. At the same time, even though public services are provided free of charge, private out-of-pocket expenditures have grown, and are estimated to account for 20% of total health expenditures.

1.5 The decentralized organization of the public health system instituted in the 1980s does not function effectively and hinders solution to sectoral problems. In theory, the MoH is responsible for policy formulation, strategic planning, and monitoring of health indicators, while the delivery of services is largely the responsibility of ten regional administrations. However, the division of responsibilities remains poorly defined and there is a lack of coordination and accountability. Though regions are responsible for service delivery, critical functions remain centralized in the hands of the MoH, including the distribution of drugs and supplies, staffing, and management of vertical programs, such as maternal and child health. At the same time, the MoH has only limited input and control over regional budgets and the implementation of national policies at the regional level. These problems are compounded by limitations in the managerial capacity of regional health officers and the MoH's own lack of capacity to effectively exercise its monitoring role, given shortages of qualified staff, lack of a modern health and management information system, and the use of outdated administrative practices.

C. Bank experience in the health sector

1.6 The IDB has been the major source of funding for health infrastructure in Guyana. In 1978, the Bank approved the Health Care I project (544/SF-GY) in the amount of US$8.8 million to build and equip facilities outside of Georgetown, as well as technical cooperation to train personnel. In 1988, the Bank approved the Health Care II project (822/SF-GY) in the amount of US$27.9 million, designed to carry out the first stage of a complete rehabilitation of the GPH, a set of dilapidated buildings dating to the late 1800s. Two parallel technical cooperation agreements, one for project execution (ATN/SF-3211-GY) and one for the institutional strengthening of the MoH (ATN/SF-3206-GY), were also approved under the project.

1.7 The major components of the loan, the construction of an Ambulatory Care, Diagnostic, and Surgical Center at GPH and the replacement of the laundry, steam generation and power supply for the entire

hospital were completed in 1996. The non-reimbursable technical cooperation for institutional strengthening did not meet all of its stated objectives, given the weaknesses of the Project Execution Unit, the shortage of technical personnel, and the failure to follow through on policy recommendations, but in its final year of execution it resulted in the drafting of the first part of the National Health Plan (NHP), the first systematic attempt in twenty years to identify sectoral problems and define a health policy framework.

D. Government and Bank strategy

1.8 In the context of preparation of the Social Impact Amelioration Program (SIMAP) - Stage II in 1996 (LO-905/SF-GY), a social sector strategy for Guyana was formulated, discussed and endorsed by the GoG. The strategy focuses on the improvement of the quality and efficiency of social services in a sustainable manner. Top priority is given to institutional strengthening activities and organizational changes in the public sector, prior to undertaking major capital investments.

1.9 In the case of the health sector, recent initiatives by the GoG, including the elaboration of the NHP and a renewed emphasis on primary health care demonstrate its strong commitment to address problems in the organization, delivery and financing of services in a comprehensive manner. The NHP has identified many of the constraints affecting the health care system and pointed to possible reforms in several areas, but falls short of defining new policies and an operational strategy for reform. Thus, there is both a need and an opportunity for Bank support to assist in the formulation and operationalization of health sector policies.

1.10 This assistance is also consistent with and will complement the Highly Indebted Poor Countries (HIPC) Initiative, a donor-sponsored debt reduction facility for which Guyana recently qualified. The HIPC Initiative is expected to help Guyana achieve debt sustainability and release significant budgetary resources from debt service starting at its completion point. A substantial portion of these resources are earmarked for spending in the social sectors, including health, education and poverty alleviation, while the balance could be used to sustainably address civil service compensation issues. The proposed technical cooperation will assist the GoG in meeting the targets agreed upon with the donors and expressed in a Health Sector Policy Matrix (see Annex III), and enable it to utilize increased budgetary resources efficiently.

II. OBJECTIVES

2.1 The objective of this operation is to assist the GoG in the definition and implementation of policies to address institutional, financial, managerial and service delivery problems in the health sector, and thus improve the efficiency, equity and quality of health services. Major sectoral problems have been outlined in the NHP and other available studies; the country now requires the development of clear strategies to address each problem area.

III. PROJECT DESCRIPTION

A. The project

3.1 The proposed technical cooperation program will endeavor to accomplish the above objectives through the coordinated provision of technical consultancy services, training, the field testing of options in selected areas and the preparation of plans of action and/or projects that will enable the GoG to adopt and implement successful options on a national scale. These activities will focus on five critical and closely related policy areas: a) reorganization and strengthening of the institutional structure of the sector; b) development of an integrated health service delivery strategy; c) development of managerial capacity and human resources; d) development of health financing options and resource allocation mechanisms; and e) institutional development of the Georgetown Public Hospital.

3.2 A team of long-term resident consultants, complemented by short term expertise, will assist the MOH to identify concrete policy options in the five critical areas, assess their legal, economic, and technical implications, select among alternatives, and draw up implementation plans. The long-term consultants will be employed by a single firm and will work as a team in order to ensure consistency across components. Implementation activities may include pilot tests of new procedures or policies, as a means of evaluating their viability on a small scale, while minimizing risks, prior to nationwide implementation. Field testing will further increase the chances that options developed with project support are eventually adopted and successfully implemented on a national basis.

3.3 The project will also provide resources for training linked to the implementation of the project. It is expected that most of the training will be provided by the resident or short term consultants and take place in country. Training overseas will normally take the form of short (i.e. one month or less in duration) individual or group study visits or, when deemed appropriate, participation in short courses (of one month or less in duration).

3.4 By assisting the MoH in the definition and implementation of policies this project will likely identify new areas where further sector institutional changes or investments might be required. Therefore, resources have been allocated to enable the MoH to generate a portfolio of new projects based on sector priorities which can be funded internally or externally upon completion of the technical cooperation.

B. Project components and activities

1. Reorganization and strengthening of the institutional structure of the health sector

3.5 The objective of this component is to enable the MoH to assume its policy making, regulatory, advocacy and monitoring functions, as outlined in the NHP, while clarifying the roles and responsibilities of the regional authorities and their relationship with the MoH.

3.6 Main activities under this component include the following:

a. Development of options for reorganization of functional responsibilities within the health sector, defining roles and responsibilities, clear lines of reporting and accountability, and functional relationships among the public agencies in the sector, including the MoH, Regional Administrations and parastatals.

b. Preparation and implementation of a strategic plan for reorganization of the MoH to enable it to carry out its policy making functions effectively, as specified in the HIPC's Health Policy Matrix. This plan will draw upon the initial work carried out by the GoG in the context of the HIPC initiative. In order to facilitate its implementation, the plan should provide a clear definition of the nature and sequence of the change to be made, legislative changes required, and key elements involved in the management of change.

c. Development and implementation of a training program for central MOH personnel to enable them to carry out new functions and responsibilities, especially in areas related to policy analysis and implementation as well as setting and monitoring environmental standards in accordance with the new institutional context put in place under the IDB-funded Environmental Management Program (TC-95-04-39-GY).

2. Integrated health service delivery strategy

3.7 The objective of this component is to assist the MoH to improve health services through the development of a comprehensive strategy for integrated service delivery based on primary health care. This

strategy will serve as the basis to guide the allocation of human, financial and other resources among regions, levels of service and facilities, in response to population needs.

3.8 Main activities under this component include the following:

a. Assessment of health needs, patterns of demand and utilization, and available resources (physical and human) in both the public and private sectors. Specific attention should be paid to the unmet needs of vulnerable groups, including children, women and Amerindians.

b. Development of a service organization and delivery strategy which includes the definition of a basic package of services to be provided at each level and mechanisms of referral and counter-referral; a combination of public/private services for the delivery of service packages; the development of treatment/service protocols and the definition of standards of care (quality); determination of human and financial resources required at different levels and facilities; policies for the provision and support of pharmaceuticals, medical and other inputs to health facilities.

c. Design and implementation of a training program covering standards and protocols for priority interventions for health personnel, especially community health workers, nurses and other categories of clinical staff.

d. Identification of investment priorities based on patterns of demand and utilization and service gaps resulting from the current condition of infrastructure and performance of programs.

3. Development of managerial capacity and human resources

3.9 This component will enable the MoH to develop human resources and managerial capacity at all levels of the health system, including the Ministry itself, decentralized levels, public and private facilities. Design activities will focus on the management needs of the sector over the next five years and will include a review of training systems and institutions.

3.10 Main activities under this component include:

a. Assessment of main management gaps at central and regional levels of the MoH as well as individual facilities and development of a strategy to address them, including a training program for Regional Health Officers and facility managers in both public and private sectors.

b. Design of information systems (management, service delivery, epidemiological and other information) to monitor efficiency, effectiveness and quality at service delivery points.

c. Assessment of current practices in the training, recruitment, compensation, and management of public sector personnel at all levels, and definition of a manpower strategy to address these problems.

4. Development of health financing options and resource allocation mechanisms

3.11 This component will focus on the identification, development and testing of options for improved efficiency and equity in the use of public health resources. A health financing strategy which enables better resource allocation and targeting of public sector resources to the most cost-effective interventions and to those population groups most at risk will be developed.

3.12 Main activities under this component include:

a. Comprehensive assessment of sources and uses of funds in the sector, covering the public and private sectors and parastatals; review of current criteria and practices for allocation of resources in the sector; evaluation of equity and efficiency impact.

b. Review of current proposals and establishment of cost recovery mechanisms, including user fees at secondary and tertiary hospitals, with appropriate exemptions for the poor, as well as evaluation and possible extension of existing community financing mechanisms being developed with the assistance of UNICEF.

c. Determination of the costs involved in providing appropriate service packages at each level. Development of a set of cost indicators for different services and types of facilities to use in planning and budgeting.

d. Development of improved budgeting practices which enable the MoH and regional administrations to tie resources to performance of facilities.

e. Development of a proposal to insure that the bulk of budgetary resources made available upon completion of the HIPC Initiative are devoted to high priority preventive and primary care interventions, as specified in the Health Policy Matrix.

5. Institutional development of Georgetown Public Hospital

3.13 This component will enable the MoH to improve the organization, management and financing of the GPH, in order to better utilize previous investments in the facility and lay the basis for future infrastructure needs.

3.14 Main activities under this component include:

a. Assessment of current services provided by the GPH in the context of other services available in the Georgetown area and the hospital's role in the health sector; development of a services plan specifying the type, quality and quantity of services provided, as well as appropriate referral mechanisms.

b. Development of a strategic plan to define and strengthen the organization, management and financing of the facility as a semi-autonomous body.

c. Assessment of the infrastructure and other investment requirements including site appraisal and preparation of a master plan for future hospital investments.

d. Development of a medical waste management plan, which will specify procedures for handling, segregation, packaging, transporting, treatment, and final disposal of wastes. These factors should be incorporated in future investments in the GPH, and will be applied to all future health infrastructure investments.

C. Project execution

3.15 The execution of the project, depicted schematically in Annex II, will be the responsibility of the MoH. In order to ensure that there is a clear and integrated sectoral vision, as well as an identifiable progression from identification of options for policy reform, selection of options, and implementation as part of the technical cooperation, a Policy Committee, comprising the Minister of Health, the Permanent Secretary, the senior management of the MoH, the Project Coordinator and representatives of the Public Service Ministry, the Ministry of Finance and the Regional Administrations, will be established. This committee will be responsible for overall policy direction, decision-making regarding the technical cooperation's outputs, and linkages with other Government agencies, as needed, to implement reforms.

3.16 The MoH will establish a Project Management Unit (PMU) within the Ministry, which will be headed by a Project Coordinator and will be responsible for managing the Technical Cooperation. Technical duties will be exercised by the Project Coordinator, and will include the identification and contracting of consultants, organizing the program of work for consultants and counterparts, sanctioning terms of reference, monitoring the technical quality of outputs, and disseminating them within the MoH. Administrative duties will be carried out by the coordinator with the support of an accountant and an administrative officer. Specific administrative functions, such as procurement and management of funds may be subcontracted to already experienced executing units of other IDB-funded projects such as SIMAP.

3.17 Terms of reference for the Project Coordinator are provided in Annex IV. The selection of the candidate for Coordinator and the draft contract between MoH and the candidate are conditions prior to first disbursement. Given the shortage of technical personnel within the country, the MoH has expressed its desire to seek a Guyanese expatriate for the post, and resources are provided for this purpose. Should a local Project Coordinator be identified, the compensation will be adjusted accordingly.

3.18 The project will be implemented by a team comprising MoH and GPH senior management, a consulting firm, and the Project Coordinator. Given the small size of MoH and GPH management, virtually all of MoH senior staff will have roles in the project, participating in activities as determined by their area of expertise. However, in order to ensure that focus is maintained on each of the project's components, the MoH will appoint a lead counterpart for each of the components, with clear responsibility for its execution in close collaboration with the long-term resident consultants, and coordinate activities within the sector and across other GoG agencies, as needed. Designation of the five lead counterparts will be a condition prior to first disbursement.

3.19 A consulting firm will provide the technical support required for this technical cooperation, including three long-term resident consultants for a total period of 24 months each in the areas of health policy, health planning and facility administration, short-term consultants, and the provision of adequate sources and types of training. The terms of reference for the consulting firm are contained in Annex V. The services of the consulting firm will be secured through procedures acceptable to the Bank. The selection criteria to be used in evaluating bids will place emphasis on securing a team of long-term resident consultants with an optimal skill mix and ensuring that transfer of technology takes place through appropriate on-the-job training of counterparts. The contract with the consulting firm is expected to be for a period of 24 months; the three resident consultants will be identified for an initial period of one year, in order to allow for possible changes in skill mix as the project develops. The contract for consultancy services will specify procedures to be followed by the firm and the GoG/MoH relative to approving terms of reference, candidates, and timing for individual assignments. The proposed contract between the GoG and the firm shall be approved by the Bank prior to signature. Within one month of contracting the consulting firm will present a detailed workplan for the first six months.

IV. REPORTING AND MONITORING

4.1 Monitoring of the project will take place through both regularly scheduled progress reports and technical reports as they are completed.

4.2 Reporting and monitoring will be the primary responsibility of the PMU. The Project Coordinator will prepare quarterly progress reports documenting activities undertaken during the previous three months and a workplan for the following period, based on technical input from the lead counterparts and resident consultants. These reports will be submitted to the IDB and to the Policy Committee within 30 days of completion of each three-month period.

4.3 The consultants and their counterparts will submit to the Bank and to the Policy Committee copies of all technical reports through the Project Coordinator. The Policy Committee and the Bank will review these reports and present recommendations in writing.

4.4 The PMU will also present annual financial statements to the IDB, including one final statement, documenting the uses of Bank and counterpart contributions. These statements will be certified by independent auditors selected by mutual agreement between the GoG and the Bank in accordance with procedures acceptable to the latter. The annual financial statements shall be presented within 90 days of the close of each fiscal year and the final statement within 90 days of the date of the final disbursement.

4.5 A midterm assessment of the technical cooperation will take place one year after the signing of the agreement. This assessment will evaluate progress achieved to date and determine if any adjustments are required, including possible changes in the project design and the skill mix of the long-term consultants. At this time it is expected that all diagnostic and option appraisal will have been completed in all components, and detailed plans for implementation, including field testing, will be made. A second assessment will take place two years from the signing of the agreement, and will be designed to evaluate progress to date as well as identify potential areas for future IDB support. The Project Coordinator will produce a draft final report summarizing the results of the technical cooperation, which will be submitted to the IDB for approval within 30 days of completion of activities.

V. COSTS AND FINANCING

5.1 The cost of this two year technical cooperation agreement is estimated at US$2.75 million, of which U$2.5 million will be provided by the Bank on a nonreimbursable basis and US$250,000 by the GoG. The Bank contribution will finance honoraria and overhead for the consulting firm, transport, per diem, training fees and basic equipment. Notional allocations have also been made to cover the costs of field tests and project preparation. The national counterpart funding will cover the cost of office space, vehicle operating costs, and support staff.

5.2 To ensure ownership by the GoG and that on-the-job training takes place the technical cooperation agreement will require the GoG to

ensure the availability of appropriate counterpart staff to work on project components. The national counterpart contribution makes provision for the payment of additional compensation to selected counterpart staff on account of their increased responsibility and inadequate salary level. The overall issue of public sector salaries is being addressed as part of the HIPC operation for Guyana. New policies to be adopted in that context will provide the needed sustainability in the medium to long term. However, within the next two years an improvement of current compensation levels will provide the counterpart staff incentives to fully participate in the project activities, take advantage of the learning opportunities and enhance Guyanese ownership of the overall effort, while also discharging their current responsibilities. Prior to first disbursement, the GoG will submit a proposal for selecting staff eligible for such increases in salary and a procedure for determining additional compensation levels, modeled on the procedures followed in the Public Administration Project funded by the World Bank and other donor-funded programs. Total counterpart resources for payment of additional compensation under this project will not exceed US$150,000.

5.3 The consolidated budget is presented in the following table. A detailed budget as well as budget assumptions are available in Annex VI in the technical files.

BUDGET OVERVIEW
(In US$000 equivalent)

ACTIVITY	TOTAL	IDB	GoG
Advisory services	1,648	1,648	
Training 1/	172	157	15
Field testing of options	50	50	
Project preparation	200	200	
Project coordinator	144	144	
General support	286	71	215
Contigencies	250	230	20
TOTAL	2,750	2,500	250

1/ Assumes 5 person/months of short-term consultants. On-the-job training provided by long-term resident consultants is not included.

5.4 The disbursements of the Bank's contribution, with the exception of the amount set aside for contingencies, will be administered by the MoH through the PMU. Upon written request of the GoG, the Bank may

establish a revolving fund up to the equivalent of 10% of the Bank contribution.

5.5 Prior to the request for first disbursement of Bank resources, the GoG should present to the satisfaction of the Bank the following: a) a written communication indicating the person(s) who will represent the GoG in all communications with the Bank related to project implementation; b) a written request for disbursement of the revolving fund; c) the draft contract to be signed with the Project Coordinator; d) Evidence of appointment of the five counterpart staff; and e) a proposal for selecting and compensating counterparts.

VI. BENEFITS AND RISKS

A. Benefits

6.1 The project is expected to increase the capacity of the MoH to formulate and implement policies to address critical institutional, managerial, financial and service delivery problems of the sector on the basis of sound problem analysis and appraisal of options. Implementation of these policies will lead to improved effectiveness, efficiency, equity and quality of health services provided. Specifically, by restructuring the organization of the sector, developing an integrated service delivery capacity based on primary care, improving management capacity and resource allocation mechanisms, this operation will also enable a better targeting of resources to the right type of services at the right levels of the health system (i.e. a better working referral system), and to those more in need.

6.2 This project will also enable the MoH to expedite the implementation of the health sector policy measures (strengthening of institutional, human and policy making capacity and establishment of a management and statistical information system) contained in the Social Sector Agenda of HIPC, which in turn will increase the sector's absorptive capacity for the anticipated increases in budgetary allocations to the health sector and lay the groundwork for further reform efforts.

B. Risks

6.3 There are two main risks. The first concerns the limited institutional capacity available within the MoH, primarily as a result of shortages of qualified personnel. The design of this operation seeks to generate capacity without increasing unduly the workload on those few, by prioritising long term support in critical areas and by fostering close working collaboration and team work between MoH staff and long-term resident technical advisors. Such interaction will favor the transfer of skills and

reduce the need for formal training in favor of in-service, hands-on learning. The project will also provide financial incentives to encourage selected counterpart staff to actively participate and fully contribute their expertise and best efforts to project activities.

6.4 The second risk is that substantial effort will go into the design of policies and procedures, but implementation will not occur due to lack of consensus or lack of capacity. This risk is mitigated by the inclusion of field tests to pilot alternatives and ease the way for new policies and systems. Moreover, the strengthening of institutional and management capacity within the sector will also contribute to making the implementation of new policies viable.

GUYANA-HEALTH SECTOR POLICY AND INSTITUTIONAL DEVELOPMENT PROGRAM
LOGICAL FRAMEWORK
TC-95-03-11-2-GY

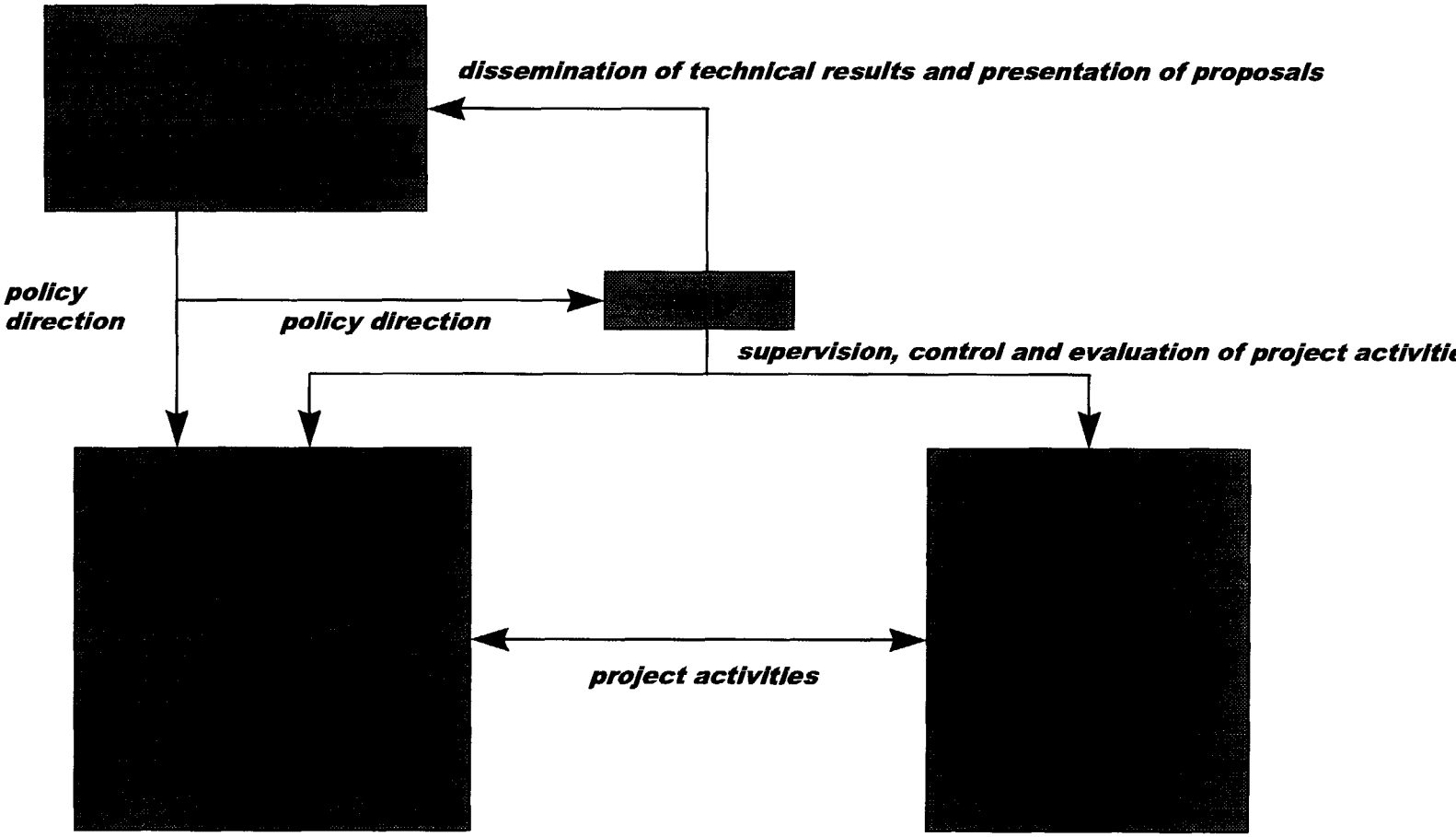
Description	Verifiable Indicators	Means of Verification	Assump
ve the health status of the population in Guyana	Improvement of basic health indicators	Vital and health statistics	Improvements in the and equity of service improvements in hea
: the Ministry of Health to define and implement hat address institutional, financial, managerial and elivery problems identified in the National Health Guyana.	MoH Policy Documents containing specific proposals to address institutional, financial, and managerial problems Proposals reflected in programmed budget	MoH Policy Documents MoH Budget and expenditures Project reports	Problems identified ir represent the key cor improving health serv
organization and strengthening of the institutional ucture of the sector	New organizational structure of MOH prepared Relationship between MoH and Regional Administrations redefined	Project reports MoH Policy Documents Cabinet notes	Options for reform of structure of sector rec support from key gov and Cabinet
velopment of integrated health delivery strategy sed on primary care model	Definition of packages of services to be delivered at each level of system, with emphasis on preventive and primary care Vertical programs integrated into delivery system Criteria for allocating human, financial and other resources among service levels and facilities defined Development of protocols and standards for priority interventions and training of personnel in these areas undertaken Referral system operational	Project reports MoH policy documents Visits to facilities	There is a strong coll relationship between central level, Regiona and Regional Health
velopment of managerial capacity and human ources	Regional Health Officers and facility administrators receive management training Management Information systems designed Manpower strategy elaborated	Project reports	Public sector personn reformed to enable he attract and retain train

Description	Verifiable Indicators	Means of Verification	Assump
velopment of health financing options and resource ocation mechanisms to enable better targeting of blic funds	Detailed study of sources and uses of funds in the sector Design and implementation of cost recovery mechanisms Improved budgeting practices, prioritizing the allocation of resources to primary care	Project reports MoH and facilities' budgets	Government consens increase cost recover primary care
titutional Development of Georgetown Public spital	Plan to improve organization and management of GPH as a semi-autonomous institution elaborated and implemented Site appraisal and master plan for future investments Medical waste management plan elaborated and implemented	Project reports MoH Policy Documents Meetings with GPH Board and Senior Management	MoH willingness to g autonomy to GPH
nputs:		**Project reports**	
oordination	US$144,000 (24 person-months)		
services	US$1,648,000 (88 person-months, including 72 person-months of long-term resident consultants) US$172,000 (5 person-months, 10 workshops and 6 overseas fellowships -study visits)		
ts	US$50,000 (5 field tests)		
reparation	US$200,000		

Annex II

PROJECT EXECUTION AND IMPLEMENTATION

TC-95-03-11-2-GY



HIPC Health Sector Policy Matrix 1/

Objectives	Actions Required	Verifiable Indicators
1. Strengthen institutional capacity of MoH and upgrade human resources	a. Implement restructuring / reorganization of MoH	i. Plan completion in collaboration with the Public Service Commission by April 1998 ii. Plan approval by Cabinet by June 1998 iii. Implementation begins August 1998 and is completed by December 1998.
	b. Develop and implement training plan for MoH personnel	i. Plan completion by April 1998 ii. Allocate resources in FY99 budget
2. Improve health services	a. Increase budgetary allocation on health	i. Total expenditure (current and capital) to reach 3.2% of GDP by 1998 ii. Total expenditure (current and capital) to reach 3.8% of GDP by 2000
	b. Increase proportion of budget spent on drags and medical supplies	i. Expenditure on drugs and medical supplies to reach 27.3% of current health spending in 1998 ii. Expenditure on drugs and medical supplies to reach 30.5% of current health spending by 2000
	c. Increase proportion of budget spent on maintenance	i. Expenditure on maintenance to reach 10% of current health spending in 1998 ii. Expenditure on maintenance to reach 12% of current health spending by 2000
	d. Increase spending on primary and preventive services to increase health impact, improve access to basic services, and increase targeting to the poor.	i. 80% of the increase in expenditures will be devoted to high priority preventive services and primary care, especially at health posts, health centers and district hospitals
	e. Evaluate the role of selective user charges and public/private partnerships to improve targeting of public health spending	i. Prepare evaluation report by August 1998
3. Improve management information system and health statistics	a. Develop a plan to strengthen the management information system and database of health statistics (coverage should include generally accepted health and expenditure statistics following internationally standardized definitions).	i. Plan completion date: July 1998 ii. Implementation begins September 1998

1/ This table was prepared by the Guyanese authorities in collaboration with the staffs of the International Monetary Fund, World Bank, and IDB. The final draft will be presented to the Boards of the three institutions at the end of November. Some of the actions contained in the matrix will be initiated by the Guyanese authorities and supported by the proposed technical cooperation.

PROPOSED RESOLUTION

GUYANA. NON-REIMBURSABLE TECHNICAL COOPERATION FOR A HEALTH SECTOR POLICY AND INSTITUTIONAL DEVELOPMENT PROGRAM

The Board of Executive Directors

RESOLVES:

1. That the President of the Bank, or such representative as he shall designate, is authorized, in the name and on behalf of the Bank, to enter into such agreements as may be necessary with the Co-Operative Republic of Guyana and to adopt such other measures as may be pertinent for the execution of the plan of operations referred to in Document AT- with respect to non-reimbursable technical cooperation for a Health Sector Policy and Institutional Development Program.

2. That up to the sum of US$2,500,000, or its equivalent in other convertible currencies, is authorized for the purposes of this resolution, chargeable to the net income of the Fund for Special Operations.

3. That the above-mentioned sum is to be provided on a non-reimbursable basis.