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GUYANA

CONTRACEPTIVE SECURITY IN GUYANA (FINAL DRAFT)

ASSESSING STRENGTHS AND WEAKNESSES



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DELIVER
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CONTRACEPTIVE SECURITY IN GUYANA

ASSESSING STRENGTHS AND WEAKNESSES

DELIVER

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Implemented by John Snow, Inc. (JSI), (contract no. HRN-C-00-00-00010-00) and subcontractors (Manoff Group, Program for Appropriate Technology in Health [PATH], and Crown Agents Consultancy, Inc.), DELIVER strengthens the supply chains of health and family planning programs in developing countries to ensure the availability of critical health products for customers. DELIVER also provides technical management of USAID's central contraceptive management information system.

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Abstract

This assessment documents the current Contraceptive Security (CS) situation in Guyana today and proposes recommendations for improving CS in Guyana in the future. Findings suggest that contraceptive prevalence rates may have stagnated and that certain groups of users demonstrate higher usage rates than others in recent years. The Government of Guyana has taken some first steps towards improving the provision of family planning services in the public sector by identifying family planning and reproductive health as priority programs in the National Health Plan. However, family planning has not been given corresponding special priority attention in recent years which has led to stock-outs of major contraceptives, disparities in contraceptive usage rates, and limited provision of services throughout the public system. Meanwhile, the NGO sector is also struggling with major funding constraints that limit its ability to provide quality services.

Although the Government of Guyana has taken first steps towards prioritizing reproductive health, collecting data, coordinating with the private sector, and allocating funds for family planning, much work needs to be done to ensure family planning services are readily available to those who need and want them. Some of the factors that may have contributed to a slowdown in prevalence rates include limited time and availability of management staff to oversee and prioritize family planning services, weak supply chain, inefficient procurement processes (including limited ability to forecast future needs), personnel shortages at all levels, and few useful data sources for monitoring and evaluating performance both in public and private sectors. The current assessment provides various recommendations for improving data analysis, building an enabling environment for CS, strengthening the supply chain, coordinating and targeting public and private resources, and, finally, efficiently allocating increased funds for the provision of family planning services. The consultants hope that this report will serve as a catalyst for launching efforts to improve the provision of family planning services in Guyana in years to come.

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ACRONYMS

CS	Contraceptive Security
EHSP	essential health services package
FP	family planning
FPAG	Family Planning Association of Guyana
GRPA	Guyana Responsible Parenthood Association
HIV/AIDS	human immune deficiency virus/acquired immune deficiency syndrome
IMCI	integrated management of childhood illnesses
MCH	maternal and child health
MMU	Materials Management Unit, Ministry of Health
MOH	Ministry of Health
NGO	non-governmental organization
NHP	National Health Plan 2003-2007
PHC	primary health care
PMD	Provincial Medical Director
RH	reproductive health
RHA	Regional Health Administration
SCMS	Supply Chain Management Support Project, USAID
SDP	service delivery point
SPARHCS	Strategic Pathway to Reproductive Health Commodity Security
STGs	standard treatment guidelines
STI	sexually transmitted infection
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
VCT	voluntary counseling and testing

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EXECUTIVE SUMMARY

This Assessment Report documents the current Contraceptive Security (CS) situation in Guyana and proposes recommendations for improving CS in the future. The analysis is based on the Strategic Pathway to Reproductive Health Commodity Security (SPARHCS) assessment process, an integrated and comprehensive approach to assessing and improving CS.¹ The assessment team from JSI/DELIVER visited Guyana in late June 2006.

In terms of content, the Report introduces the main family planning providers in Guyana today; evaluates current levels of contraceptive use; explores the enabling environment for reproductive health and family planning; evaluates the supply chain for contraceptives and other health commodities; assesses coordination and information sharing among providers and programs; identifies sources of financing for family planning; evaluates the ability of the MOH health facility network to collect, compile, and use data about family planning services and supplies; and reviews the Ministry's capacities in forecasting and quantification, procurement, distribution, supervision, and monitoring and evaluation.

The assessment included the following specific activities:

- **Literature Review:** A comprehensive literature review was conducted on the situation in the health sector, the Ministry's family planning program, and various other components of CS in Guyana.
- **Key Stakeholder Interviews:** The in-country visit included interviews with approximately twenty representatives of the Ministry of Health (MOH), USAID and UNFPA, non-governmental organizations (NGOs), and private pharmaceutical companies. These interviews provided many of the essential observations that are presented throughout this report.
- **Forecast of Future Contraceptive Needs:** The team also prepared a forecast of contraceptive needs for 2006 to 2008 based on demographic and programmatic information.

The Ministry of Health is the primary provider of family planning (FP) services in Guyana today, coordinating services through the Maternal and Child Health Office (MCH) and Regional Health Officers. Family planning services are typically provided at all public sector facilities, with the majority of clients attending family planning clinics at health centers and posts located throughout the country. In addition to the public sector, many Guyanese turn to the private sector to obtain their contraceptives. Some attend private clinics or purchase contraceptives directly at pharmacies, while others obtain their services from the NGO sector through the Guyana Responsible Parenthood Association (GRPA) or the Family Planning Association of Guyana (FPAG).

While current data is limited, the national contraceptive prevalence rate (CPR) appears to have stagnated recently. The Ministry of Health took a key step towards strengthening family planning services in the public sector by identifying family planning and reproductive health (RH) as priority programs in its 2003-2007 National Health Plan. However, in the years since the Plan was developed, it appears that family planning has not been given the actual programmatic attention that its designation suggests. Key issues have included stock-outs of critical contraceptives, disparities in contraceptive usage rates, and inconsistent provision of services throughout the public system. Meanwhile, key NGOs are struggling with major funding constraints that limit their ability to provide quality services.

¹ Hare, L., Hart, C., Scribner, S., Shepherd, C., Pandit, T. (ed.), and Bornbusch, A. (ed.). 2004.

In addition to listing reproductive health and family planning as priority programs within the National Health Plan, the Ministry of Health has also taken positive steps in designing a system for collecting logistics data, coordinating with the private sector, and allocating funds for family planning. Still, much work needs to be done to ensure that quality family planning services and contraceptives are readily available to every citizen who needs and wants them.

Some of the factors that may have contributed to a slowdown in contraceptive use include limited time and availability of management staff to oversee and prioritize family planning services, a weak supply chain, inefficient procurement processes (including limited ability to forecast future needs), personnel shortages at all levels, and few useful data sources for monitoring and evaluating performance both in public and private sectors.

Recommendations provided within this Report for improving CS in Guyana are as follows:

Family Planning/Reproductive Health

- seek to fully understand the terms, conditions, and limitations of working with UNFPA as a procurement agent and finalize a partnership with UNFPA;
- conduct annual forecasting of contraceptive needs; and address safety stock, lead times, and the GOG/MOH budget cycle throughout the contraceptive procurement cycle;
- create and utilize a multi-sectoral Reproductive Health/Family Planning Coordinating Committee;
- strengthen the Maternal and Child Health program monitoring and evaluation systems and outputs, and consider appointing a Reproductive Health/Family Planning Team Leader within the MCH Office;
- conduct contraceptive demand and use analysis; including the implementation of a comprehensive survey related to Reproductive Health/Family Planning, such as a Demographic and Health Survey (DHS) or similar study;
- assess Maternal and Child Health information management needs and current results;
- ensure that contraceptive logistics data is obtained (preferably through an integrated system);
- continue to institute youth awareness and counseling programs (including contraceptive use);
- consider providing at cost (or free) contraceptives to public service organizations (public-service oriented hospitals and other former MOH entities, as well as public-service oriented NGOs - GRPA, FPAG, and church-affiliated clinics); and
- protect and target public sector funds for procuring sufficient contraceptives and strengthening priority programs, such as family planning.

Health Commodity Supply System, Drug Management, Quality Improvement and Related Issues

- develop an MOH essential health service package (EHSP), standard treatment guidelines (STGs) for all services within the EHSP, and an essential drug and health commodities list(s) (EDL) for these STGs, including family planning and contraceptives;
- further strengthen the Ministry's health commodity supply system;
- streamline data collection and reporting requirements at all health facilities; and
- once an EHSP is developed, ensure that it is fully funded.

With sincere thanks for the warm support they received during their visit, the consultants hope that this CS assessment report will serve as a catalyst for MOH efforts to improve family planning services and contraceptive security in Guyana in the years to come.

INTRODUCTION

In light of a gradual decline in donations and technical assistance towards ensuring Contraceptive Security (CS) in the Latin America and Caribbean Region, most health sectors in the region have begun to increasingly recognize the importance of developing robust and sustainable family planning (FP) programs. Ministries of Health (MOH) throughout the region are faced with, not only assuring the provision of family planning services including a continuous supply of contraceptives, but also responding to increasing demand for contraceptives as the large cohort of youth in the region cross into reproductive age and become more informed about the need to use contraception. At the same time, many countries are also faced with the major challenge of guaranteeing equitable access to family planning services to all their citizens, especially those individuals that are most difficult to reach due to income, socio-cultural, geographic, ethnic, language, age, gender, religious, and educational barriers. As a result of recent efforts to address these challenges, several countries in the region have begun to develop CS committees and subsequent CS strategies that seek to coordinate participation from public, private, and civil society sectors to ensure that all individuals are able to choose, obtain, and use contraceptives whenever they need them.

Contraceptive security (CS) exists when individuals are able to choose, obtain, and use contraceptives whenever they need them.

In Guyana, there are both parallels and notable differences from the trends described above in the Spanish-speaking countries of South and Central America. Regarding donations and technical assistance for family planning and reproductive health (RH), it is reasonable to include Guyana in this group. In recent years, the United States Agency for International Development (USAID) has stopped funding these programs entirely, emphasizing HIV/AIDS support, while the United Nations Population Fund (UNFPA) has emphasized youth programs and HIV/AIDS. Although the Pan American Health Organization (PAHO) has continued to provide support to the Maternal and Child Health (MCH) Office, their assistance has emphasized policy, training, and capacity-building, especially at Regional and District hospitals, and safe motherhood and integrated management of childhood illnesses (IMCI), with little attention being given to family planning. In response, however, the Ministry of Health has not taken on the challenge of building up their family planning program nor directly addressing Contraceptive Security. A lack of useful information also hampers the MCH Office, as current information systems are weak and underemphasized.

Equitable access to family planning and reproductive health services is a major problem in Guyana, compounded by difficult geography, human resource shortages, and income, cultural, language, and educational barriers. Access issues are particularly severe in the “hinterland” regions, where there are few roads and many rivers to cross.

Finally, in regard to efforts to improve coordination among the key actors and develop a plan of action to ensure Contraceptive Security for all Guyanese, there is work to be done. The consultants hope that this report may serve as a catalyst for launching such efforts.

OBJECTIVES AND METHODOLOGY

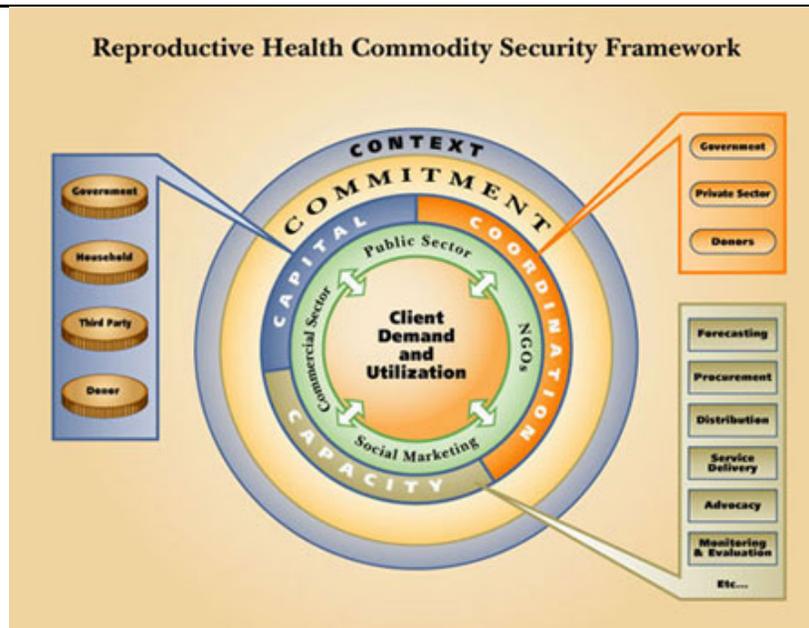
OBJECTIVES

This study aims to document the current Contraceptive Security (CS) situation in Guyana and propose short-term and long-term recommendations for improving CS in the future.

METHODOLOGY

The following framework (see Figure 1), developed by USAID, UNFPA, and various specialists in the field of reproductive health, provides a visual representation of the elements essential to an integrated and comprehensive approach towards improved CS. The SPARHCS framework and assessment tool has been utilized in various countries to guide CS assessment and improvement processes, bearing in mind that the process is cyclical and that each of the essential elements vary in importance depending on the specific situation within each country.

Figure 1 - SPARHCS Framework



Source: SPARHCS -Strategic Pathway to Reproductive Health Commodity Security
A Tool for Assessment, Planning, and Implementation, 2004

Figure 1 above depicts how six essential CS elements impact upon client demand and utilization of contraceptives. In every country, there is a **context** that affects the country's prospects for achieving CS - national policies and regulations that bear on family planning/reproductive health and particularly on the availability of RH supplies, and broader factors like social and economic conditions, political and religious concerns, and competing priorities. Within this context, **commitment**, evidenced in part by supportive policies, government leadership, and focused advocacy, is a fundamental underpinning for CS. It is the basis from which stakeholders invest the necessary **capital** (financing), coordinate for CS, and develop necessary capacities to ensure CS. The boxes in the figure elaborate on each of these three components. **Coordination** involves government, the private sector, and donors to ensure more effective allocation of resources. Households, third parties (e.g., employers and insurers), governments, and donors are all sources of capital. And, **capacities** must exist for a range of functions – policy; forecasting, procurement, and distribution; service delivery; and monitoring and evaluation, to name a few. **Clients**

(women and men) - at the center of the figure - are the ultimate beneficiaries of RHCS as product users, and as shown by the double headed arrows, the drivers of the system through their demand.²

The Guyana assessment focuses on the following CS elements:

- **Context** – Evaluating the status of family planning within Guyana, including donor activities in support of reproductive health, and the country’s prospects for achieving for CS in the coming years.
- **Commitment** – Understanding the enabling environment for reproductive health and family planning, including government leadership, advocacy, and direct and indirect support to ensure product availability and choice for all women and men who want to use modern contraceptive methods.
- **Coordination** – Assessing coordination and information sharing capacity among providers, programs, resources, and activities.
- **Capital** – Understanding sources of financing for family planning generally and contraceptives particularly, and how these services and commodities are being accessed (public, NGO, private, etc...).
- **Information system (LMIS) for contraceptive supplies** – Assessing the ability of the health facility network to provide accurate and timely data on family planning services and supplies and of the regional and national levels of the Ministry of Health to process and use this data.
- **Logistics system capacity** – Evaluating the Ministry’s capacities in forecasting and quantification, procurement, distribution, supervision, and monitoring and evaluation.

ASSESSMENT ACTIVITIES AND PRODUCTS

The assessment visit took place in late June 2006, and included the following specific activities:

- **Literature Review:** A comprehensive literature review was conducted on the health sector situation, the Ministry’s FP program, and various other components of CS in Guyana. All of the documents obtained and reviewed are listed in the Bibliography. In addition, the use and demand analysis drew upon the following quantitative studies: UNICEF. Multiple Indicator Cluster Survey, 2001 and Jagdeo, Tribani. Guyana Contraceptive Prevalence Survey, 1991-92.
- **Key Stakeholder Interviews:** The in-country visit included interviews with approximately twenty representatives from the Ministry of Health, USAID and UNFPA, non-governmental organizations (NGOs), and the private pharmaceutical sector (see Annex 1 for list of interviewees). These interviews provided many of the essential observations that are reported throughout this assessment.
- **Forecast of Future Contraceptive Needs:** The team also prepared a forecast of contraceptive needs for 2006 to 2008 based on demographic and programmatic information.³ Due to limited information, the Ministry is encouraged to develop an annual forecast each year until there is an adequate system for collecting and summarizing logistics (consumption and stock-on-hand) data (see Annex 2 for the 2006-2008 contraceptive forecast).

ASSESSMENT TEAM

The CS assessment team included two JSI/DELIVER consultants, Jeff Sanderson and Nadia Olson. During the week-long visit, they were helped tremendously by Dr. Janice Woolford, MCH / EPI Officer, MOH and Julia Rehwinkel of USAID/Guyana. Preparations for the visit were greatly assisted by Edris George of USAID/Guyana.

² Hare, L., Hart, C., Scribner, S., Shepherd, C., Pandit, T. (ed.), and Bornbusch, A. (ed.). 2004.

³ While 2005 consumption data from Ministry facilities was found during the visit and then compiled, this data proved to be incomplete and was not helpful in producing the contraceptive forecast.

CONTEXT

GENERAL BACKGROUND

Guyana, officially the Co-operative Republic of Guyana is located on the northwestern coast of South America, with a population of approximately 751,000.⁴ Guyanese territory stretches across 83,000 sq miles (214,969 sq km) characterized by a cultivated coastal plain and a forested, hilly interior. The country is divided into ten administrative regions with the majority of the population residing along the coast and in the capital city, Georgetown.⁵ A smaller (28%) proportion of Guyanese live in urban areas than in rural areas (70%); nevertheless, 72% of the population resides along the coastal belt of the country with relatively high population density and easy access to urban centers.

In regards to ethnicity, the largest segments of the population are composed of persons of East Indian and African heritage – 43 and 30 percent respectively; the mixed population forms approximately 17% of the population, Amerindians comprise the next largest group – 10%; and all others (Chinese, Portuguese, White) add up to less than one percent of the populace. More than half of Guyanese practice some form of Christianity, 30% Hinduism, and the remaining people either observe another religious belief (Islam, Rastafarian, Bahai, etc) or do not practice a religion.⁶

Guyana is one of the poorest countries in the world, ranking 107 out of 177 countries in the 2005 Human Development Index Report.⁷ The Guyanese economy has suffered from mismanagement, falling commodity prices, increasing fuel prices, and environmental degradation. According to the Guyana Survey of Living Conditions, 36% of Guyanese were living in absolute poverty (US\$1.40 per day) in 1999, 78% of whom were living in rural interior areas. As a result of economic constraints, many Guyanese leave the country to find opportunities elsewhere. In fact, as many Guyanese live overseas as in the country, and the rate of emigration of skilled workers is among the highest in the region.⁸

Nonetheless, some measures are being taken to help alleviate economic strain on Guyana, especially related to the country's proportionately large international debt. In 1997, the country was declared eligible for debt relief under the Highly Indebted Poor Country Initiative (HIPC) and the Interim Poverty Reduction Strategy Paper (I-PRSP) was accepted in December 2000.⁹ Taking this initiative one step further, in July 2006, the World Bank agreed to write off Guyana's US\$322 million debt as part of a broader initiative to help the world's poorest countries. The recent debt cancellation allows resources to be channeled into education, infrastructure, and health services and helps offset some of the economic challenges that Guyana has faced in recent decades.¹⁰

DEMOGRAPHIC, ECONOMIC, AND HEALTH BACKGROUND

The 2002 Population and Housing Census reported that the population of Guyana had risen to 751,223, higher than the 1991 census by a little more than 27,500. The Census also reported that males (376,000)

⁴ Bureau of Statistics, 2002.

⁵ World Factbook, 2005.

⁶ Bureau of Statistics, 2002.

⁷ UNDP, 2005.

⁸ PAHO and WHO, 2003, pg. 9.

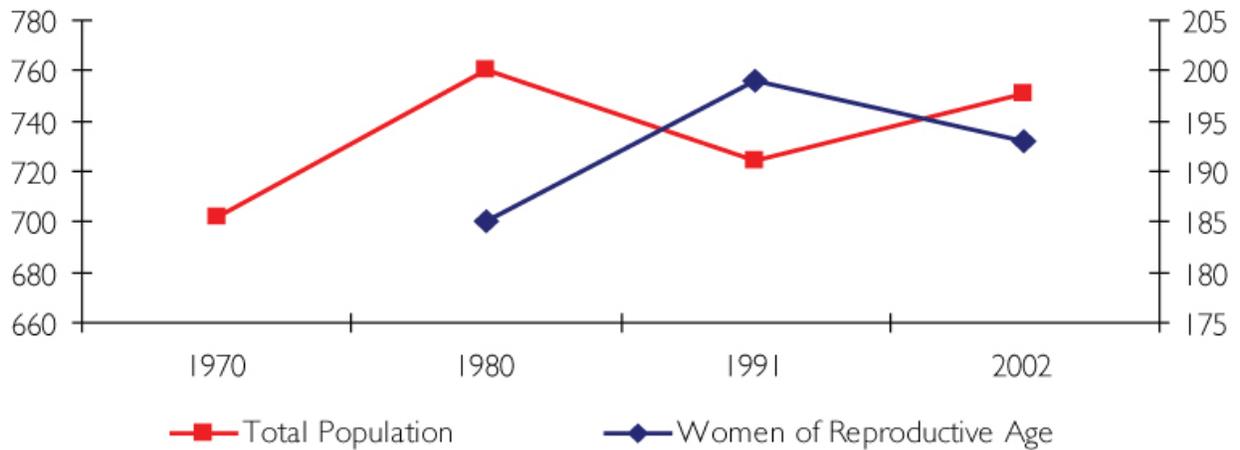
⁹ Ibid., pg. 10.

¹⁰ World Bank, 2006.

outnumbered females (375,000) by a small percent (0.1). Of the 375,000 females, 193,000 were of reproductive age (15-49).

Figure 2 illustrates gradual changes in population between 1970 and 2002. Overall, population has been growing slowly, although there was a slight dip between 1980 and 1991 that has primarily been attributed to emigration. Interestingly, although overall population grew between 1991 and 2002, the total number of women of reproductive age (WRA) decreased by approximately 3%. This recent decrease can also be explained, in part, by a rise in number of women of working age emigrating during the early 2000s.

Figure 2 - Historic Population



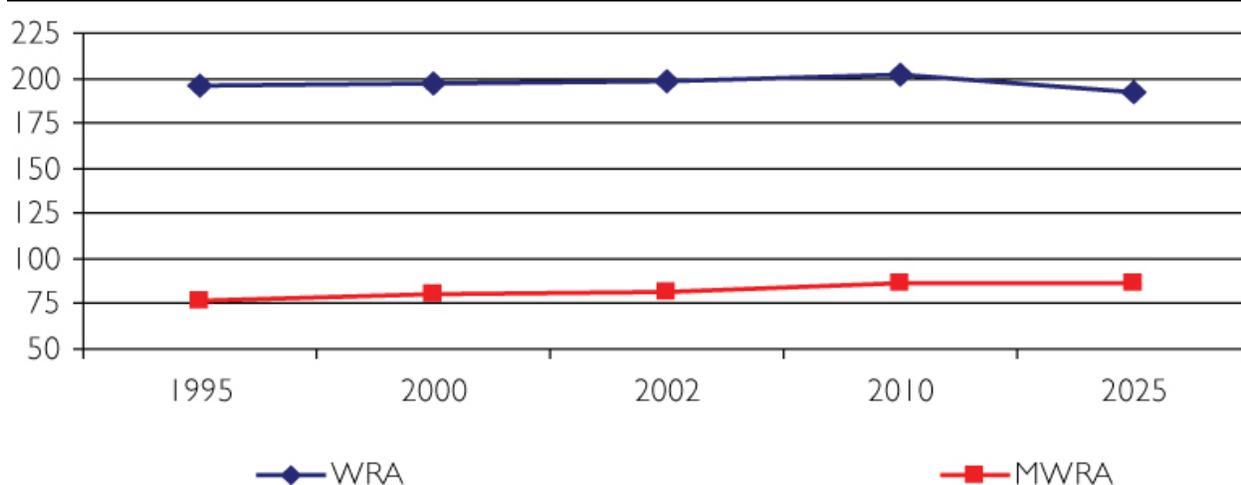
Source: Guyana Census 2002

Although the population was still growing, albeit gradually (0.35% growth rate), between 1991 and 2002, when comparing the 2002 age distribution with that of 1980, there are signs that the population has begun to age. The age-sex distribution depicts that the 0-4 age group was smaller than the 5-9 age group, suggesting a slowdown in number of births. The current fertility rate substantiates this, as 2.3 is approaching replacement level. In addition, age dependency fell from 108 in 1980 to 90 in 2002, and the median age of the population increased to 23 years from 19 in 1980 and 22 in 1991. These changes support the fact that the population has begun to age, although gradually.¹¹

Figure 3 below presents U.S. Census Bureau projected demographic changes through 2025. These projections suggest that the number of WRA will continue to grow slowly until 2010 when, the US Census Bureau predicts, these numbers will begin to decrease slightly, in the case of WRA, and plateau, in the case of MWRA.

¹¹ Bureau of Statistics, 2002.

Figure 3 - Projected Populations (Women of Reproductive Age & Married Women of Reproductive Age)¹²



Source: U.S. Census Bureau, International Programs Center, International Data Base, 2004

In addition to trends in demographic statistics, there are various other background characteristics that help illustrate recent economic and health conditions in Guyana. Table 1 below provides a list of basic statistics to be used as a reference point for socioeconomic conditions in Guyana in recent years.

Table 1 - Development and Health Indicators

Demographic and Family Planning Indicators			
Total Population	2002	751,223	<i>Guyana Census, 2002</i>
Population (men)	2002	376,034	<i>Guyana Census, 2002</i>
Population (women)	2002	375,189	<i>Guyana Census, 2002</i>
Women of Reproductive Age	2002	193,000	<i>Guyana Census, 2002</i>
Percent of Population (rural)	2002	71.6%	<i>Guyana Census 2002</i>
Life Expectancy (men)	2005	60.1 years	<i>UNFPA Country Profile, 2006</i>
Life Expectancy (women)	2005	66.3 years	<i>UNFPA Country Profile, 2006</i>
Total Fertility Rate (TFR)	2002	2.3	<i>World Health Report, 2004</i>
Contraceptive Prevalence Rate (CPR) (any method)	2001	37%	<i>Multiple Indicator Cluster Survey, 2001</i>
Contraceptive Prevalence Rate (CPR) (modern method)	2001	36%	<i>Multiple Indicator Cluster Survey, 2001</i>

¹² U.S. Census Bureau, International Programs Center, International Data Base, 2004. The US Census Bureau projections begin with a slightly higher estimate of WRA than the Guyana Census. Because demographic surveys are infrequent, an up-to-date survey has not been conducted, and migration is highly variable, many sources present varying estimates of demographic data in Guyana. For this reason, these should not be considered exact estimates but a broad depiction of demographic change over time. Data could shift significantly if patterns of migration continue to fluctuate in years to come. Nevertheless, this graph provides a basic understanding of how the population will change if patterns of minimal growth and a stable fertility rate continue to hold.

Economic Indicators			
Gross National Income, PPP (per capita)	2002	US\$ 3,780	<i>World Bank, 2006</i>
Per Capita Total Expenditure on Health	2001-02	US\$ 215	<i>World Bank, 2006</i>
Government Expenditure on Health as % of Total Expenditure on Health	2001	79%	<i>World Health Report, 2004</i>
Rate of Unemployment	2002	12%	<i>Guyana Census , 2002</i>
Rate of Inflation	2005	8.5%	<i>Guyana Statistical Bulletin, 2006</i>
Health and Education Indicators			
Infant Mortality Rate (per 1,000 live births)	2000	45	<i>World Health Report, 2004</i>
Under 5 Mortality Rate (per live births)	2000	58	<i>World Health Report, 2004</i>
Under 5 Severe Malnutrition Rate (<60g)	2004	1%	<i>Guyana Statistical Bulletin, 2006</i>
Maternal Mortality Ratio (per 100,000 live births)	2000	170	<i>World Health Report, 2004</i>
Adult Illiteracy Rate	2003	1.5% women 0.9% men	<i>UNESCO, 2006</i>

MATERNAL AND CHILD HEALTH

When mothers survive and thrive, their children also survive, and the societies in which they live prosper. In 2000, Guyana, and 188 other countries, signed the United Nations Millennium Declaration. Reducing infant mortality and improving maternal health, are two of the stated Objectives of the Millennium Development Goals, which Guyana aims to achieve by 2015.

A quality family planning program is critical to the achievement of these MCH goals, as the ability to plan and space pregnancies reduces maternal and infant mortality, as well as other strains on families, communities, resources, and the environment. In addition, contraceptive use lowers the number of unintended and unwanted pregnancies. Unwanted pregnancies are far more likely to end in abortion, and far less likely to receive adequate prenatal care than wanted pregnancies.

In 2004, the maternal mortality ratio in Guyana was 170 per 100,000 live births. This represents an improvement from previous years, yet the mortality rate remains alarmingly high. The main causes of maternal deaths are hemorrhage (27%), toxemia of pregnancy (21%) and abortion (18%). In addition, complications with abortion have been reported as a frequent cause of admission to the Georgetown Public Hospital. Furthermore, the infant mortality rate (45 per 1,000 live births) in Guyana is also unnecessarily high.

In 2001, 4,977 abortions were conducted in Guyana. In other words, out of approximately 190,000 WRA, 2.6% (26/1,000) may have obtained abortions in 2001.¹³ Although abortion was legalized in Guyana in 1995, and six months later admissions for septic and incomplete abortion dropped by 41%, there are still major issues with capacity to perform safe abortions in Guyana today. As mentioned above, in Guyana, abortions account for approximately one fifth of all pregnancy-related deaths.¹⁴

The following sections provide basic findings about demand and use for contraceptives in Guyana, as well as some discussion of possible areas for improvement in provision of family planning services. Such

¹³ Guyana's abortion rates may be underestimated as they do not gather information from unregistered locations in which abortions may be carried out throughout the country.

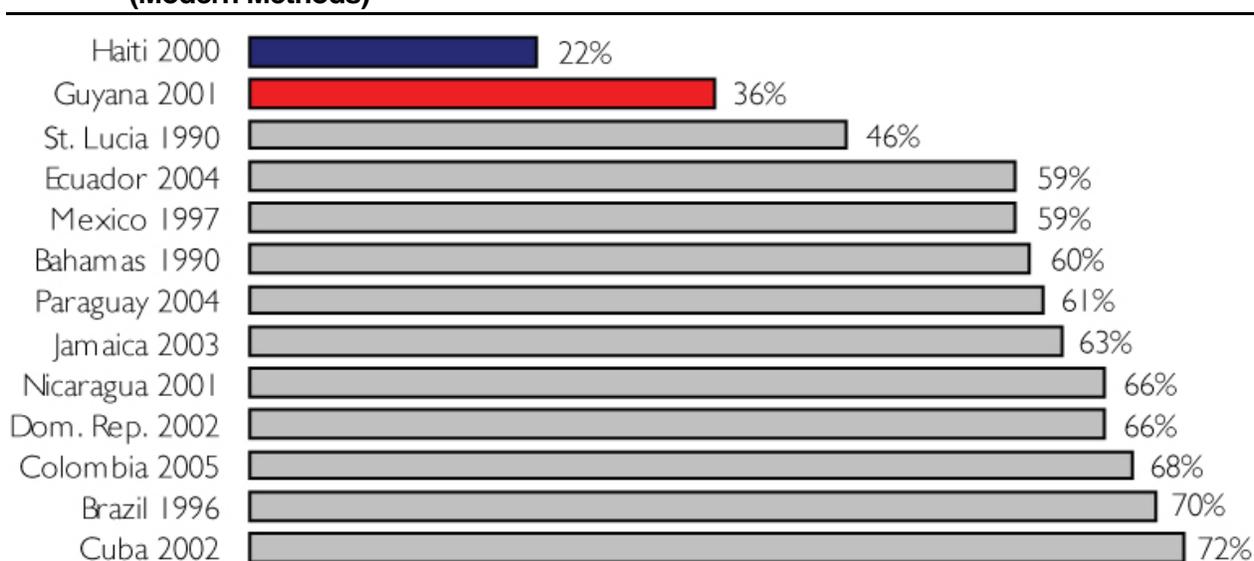
¹⁴ PAHO and WHO, 2003.

improvements can significantly benefit the health of women and their families and reduce the number of unwanted pregnancies. Moreover, improvements in CS can contribute to the achievement of the Millennium Development goals noted above.

DEMAND AND UTILIZATION OF FAMILY PLANNING SERVICES

According to the Multiple Indicator Cluster Survey, carried out in 2000, Guyanese women of reproductive age who were in union (WRAinU) were using modern contraceptive methods at a rate of 36%. When comparing the contraceptive prevalence rate (CPR) in Guyana with other countries nearby, Guyana has one of the lowest prevalence rates in the Latin American and Caribbean region. Figure 4 illustrates that Guyana is one of the few countries in which less than half of women are using modern methods for family planning.

Figure 4 - Contraceptive Prevalence Rate for MWRA in Latin America and the Caribbean (Modern Methods)¹⁵



Source: Demographic and Health Surveys for various countries

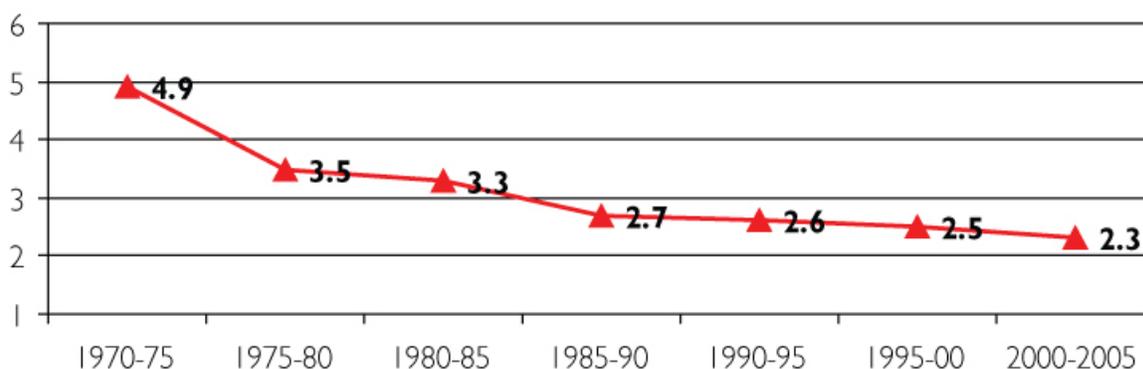
The following section present trends in fertility, contraceptive prevalence, and method mix in recent years.

GLOBAL FERTILITY AND CONTRACEPTIVE PREVALANCE RATE

According to Figure 5, the global fertility rate in Guyana has decreased by over 50% during the last 30 years from approximately 4.9 to 2.3. It appears that the bulk of the drop in fertility took place in the 1970s and 1980s, with a more stable fertility rate in the 1990s and 2000s. In recent years (1990s-2000s) fertility has slowly decreased over time, but these changes have rarely amounted to more than a one to two percent decrease per year.

¹⁵ In the case of Guyana, women in union were considered in addition to married women. In all other countries, only married women were included in estimates of CPR.

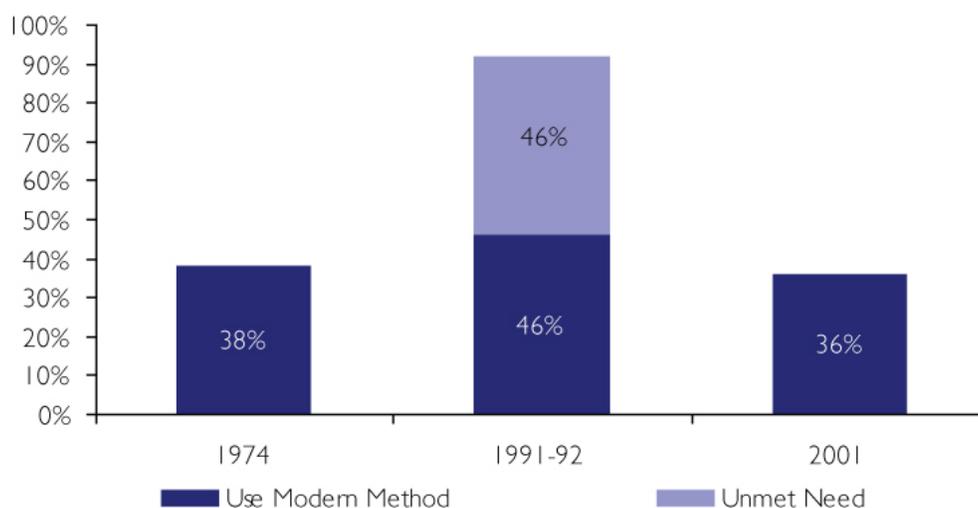
Figure 5 - Total Fertility Rate (births per woman)



Source: United Nations Department of Economic and Social Affairs
Population Division, PRED Bank 4.0 Country Profiles

A reduction in the total fertility rate is often achieved, in part, by an increase in use of contraceptives. In the case of Guyana, the period of time (1970-1990) with the most substantial decrease (33%) in fertility coincides with an increase (21%) in the contraceptive prevalence rate, from 38% in 1974 to 46% in 1991-92 (see Figures 5 and 6).¹⁶ On the other hand, the fertility rate did not increase between 1991-92 and 2001 when the prevalence rate slowed, from 46% in 1991-92 to 36% in 2001 (see Figure 6).¹⁷

Figure 6 - Contraceptive Prevalence Rate and Unmet Need among WRAInU¹⁸



Source: 1974 Guyana Fertility Survey (GFS), 1991-92 Guyana Contraceptive Prevalence Survey (GCPS) and 2001 Guyana Multiple Indicator Cluster Survey (MICS)

¹⁶ Jagdeo, 1993.

¹⁷ Bureau of Statistics, 2002.

¹⁸ There is some variation in sampling between the three surveys presenting CPR. The Amerindian population was not included in the 1974 study while this population was included in subsequent studies. In addition, pregnant women were included in both the 1991-92 and the 2001 surveys but not in the 1974 survey. Nevertheless, all three surveys included modern methods among WRAInU. Thus, the differences in CPR rate observed over time may partly be due to methodological variations. Nevertheless, the data gives a general idea of change over time. For a more detailed understanding of the methodological differences between the three studies please refer to the GCPS (pgs. 60-61) and the MICS (pgs. 13-16 and 43).

Despite the fact that fertility rates have remained stable, the slowdown in contraceptive use is cause for concern, especially when considering that 46% of Guyanese women expressed an unmet need for contraceptives in 1991-92 (see Figure 6). According to the Guyana Contraceptive Prevalence Survey conducted in 1991-92, although almost all women had substantial awareness about contraceptive methods, approximately half were not using despite their desire to either limit (41%) or space (59%) their families.¹⁹ Furthermore, as described above, nearly 3% of all women of reproductive age opted for abortions in 2001, a much higher risk approach to preventing an unwanted pregnancy.

Based on the substantial level of unmet need recorded in 1991-92, one can safely assume that CPR should have, at least marginally, increased throughout the 1990s. The slowdown suggests that there were barriers preventing women from increasingly gaining access to the methods that they needed in 1991-92. Although there is no recent data documenting the current unmet need for contraceptives and whether demand is as high today as it was in the early 1990s, it is clear that the needs of women in the early 1990s were not satisfied in later years. In fact, prevalence rates went down, suggesting that unmet need may have increased since then. An updated version of the MICS will soon be available, providing more current contraceptive prevalence rates and an estimate of unmet need.

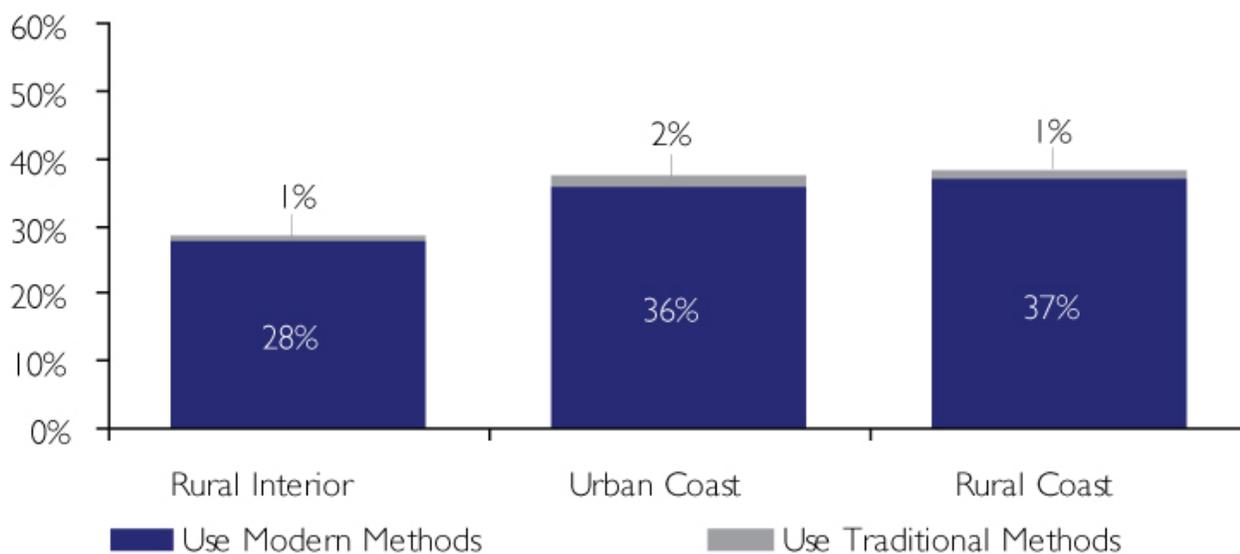
Once new data are available, steps should be taken to assess the barriers to contraceptive use that may have contributed to a slowdown in use of family planning methods in Guyana since the early 1990s. Whether this stagnation can be attributed to lack of access, socioeconomic barriers, cultural obstacles, an overall slowdown in demand, or some combination of all of the above, recent changes illustrate that the family planning program is falling short on some level. Steps must be taken to identify how and why these challenges have arisen and develop targeted measures to prevent further erosion in demand and use of family planning methods in Guyana in years to come.

CONTRACEPTIVE PREVALENCE RATE BY SELECTED CHARACTERISTICS

Figures 7 present contraceptive prevalence rate by geographic location. When disaggregating data for rural interior regions of the country from coastal regions, a distinct disparity in contraceptive usage becomes apparent. Obviously, the less accessible a region, the more difficult and costly it is for residents to gain access to the FP methods they need and for the public sector to reach them. It appears that such geographic barriers may be affecting the rural interior more dramatically than any other region in the country. Thus, this region experiences a lower modern contraceptive prevalence rate (28%) than the urban or rural coastal regions, 36% and 37% respectively (see Figure 7). Unfortunately, data illustrating unmet need or reasons for non-use in these areas is currently unavailable. Unmet need results from the updated MICS will help explore whether these disparities are caused primarily by lack of access or demand or some combination of both factors.

¹⁹ Jagdeo, 1993.

Figure 7 - Contraceptive Prevalence Rate among WRAInU by Geographic Region, 2001



Source: MICS Survey 2001

Beyond place of residence, there are other comparisons of CPR that can be drawn from the MICS 2001 and the GCPS 1991-92. Factors such as age, education level, and ethnicity reveal alarming disparities in use of FP methods, further substantiating the possibility that some women may be facing barriers in access to the methods that they need or want to be using.

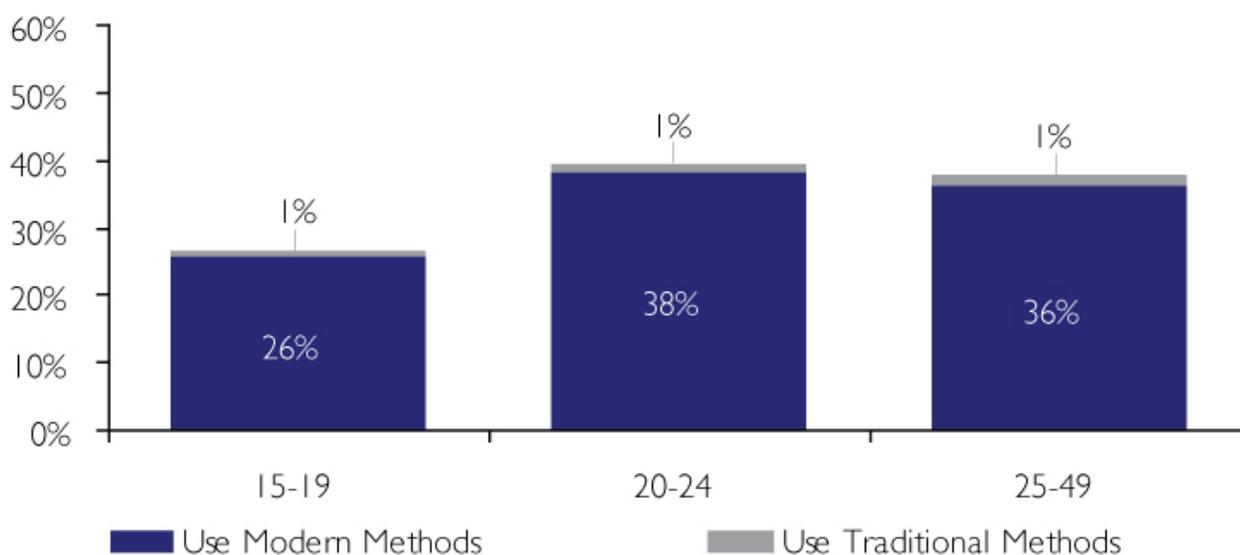
Figure 8 takes a look at CPR by age group, illustrating that adolescents in union are using less contraceptives than their older counterparts. For example, only 26% of young women between the ages of 15 and 19 are using contraceptives in comparison to 38% of slightly older women (20-24). Clearly, women are either becoming more familiar with contraceptives or more readily gaining access to them as they grow older.

Results of the 1998 Adolescent Health Survey showed that 50% of children had had sexual intercourse by age 13, and 90% by age 15.²⁰ The fact that adolescents are sexually active and, not necessarily using contraceptives puts them at high risk of unwanted pregnancy. Special programs that target young women could help bridge the gap in usage rates between age groups and help mitigate the possible negative consequences of unwanted pregnancies.

Additionally, if young women continue to be as sexually active as they were in 1998 and are not often using contraceptives, abortion rates or use of traditional methods may be higher than current estimates suggest. New data is urgently needed to help explore why fertility rate remains low despite a slowdown in contraceptive use, especially among sexually active young women.

²⁰ PAHO and WHO, 2003.

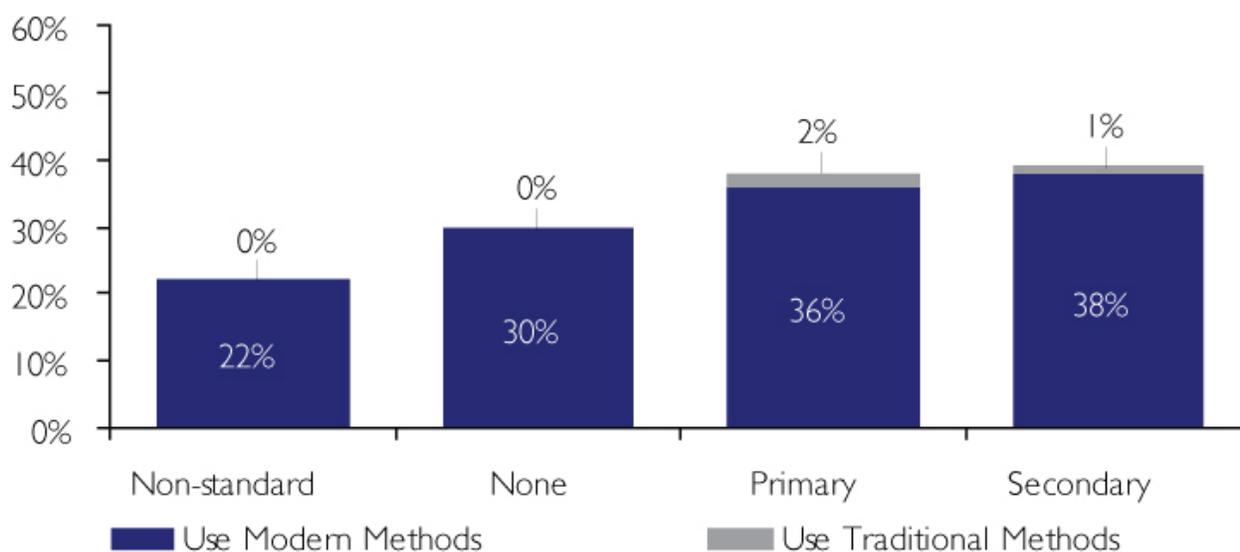
Figure 8 - Contraceptive Prevalence Rate among WRAInU by Age Group, 2001



Source: MICS Survey 2001

In addition to level of maturity, formal education clearly affects women’s rates of contraceptive usage. Figure 9 illustrates that women with non-standard curriculum and no formal education were the least likely to use contraceptives, 22% and 30% respectively, whereas women with primary and secondary education expressed higher rates of contraceptive usage, 36% and 38% respectively. However, the negligible difference in CPR (2%) between the primary and secondary education groups suggests that only a minimal amount of education is necessary to ensure higher contraceptive prevalence rates. In other words, the difference between a primary and secondary education does not necessarily guarantee that a women will have better access or higher demand for contraceptives. In sum, women who are exposed to some level of formal education appear to be much more likely to practice family planning than those women who either have no formal education or a non-standard curriculum.

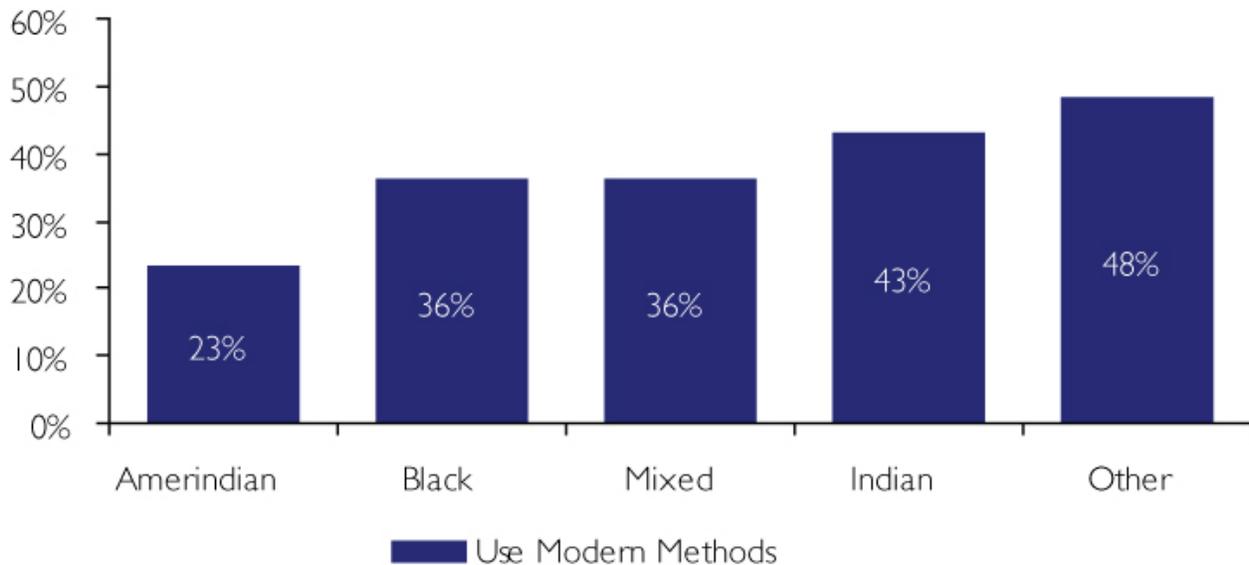
Figure 9 - Contraceptive Prevalence Rate among WRAInU by Level of Education, 2001



Source: MICS Survey 2001

Although there is no recent data available, ethnicity was clearly a differentiating factor for contraceptive use in 1991-92. Figure 10 depicts the level of disparity that existed in 1991-92 between varying ethnic groups. For instance, the Indian population experienced one of the highest rates at 43%, whereas only 23% of Amerindians were estimated to be using contraceptives at this time. The Black and mixed populations reflected the same usage rate of approximately 36%. Finally, the other population, which includes mostly White residents, experienced the highest CPR at 48%.

Figure 10 - Contraceptive Prevalence Rate among WRAInU by Ethnicity, 1991-92

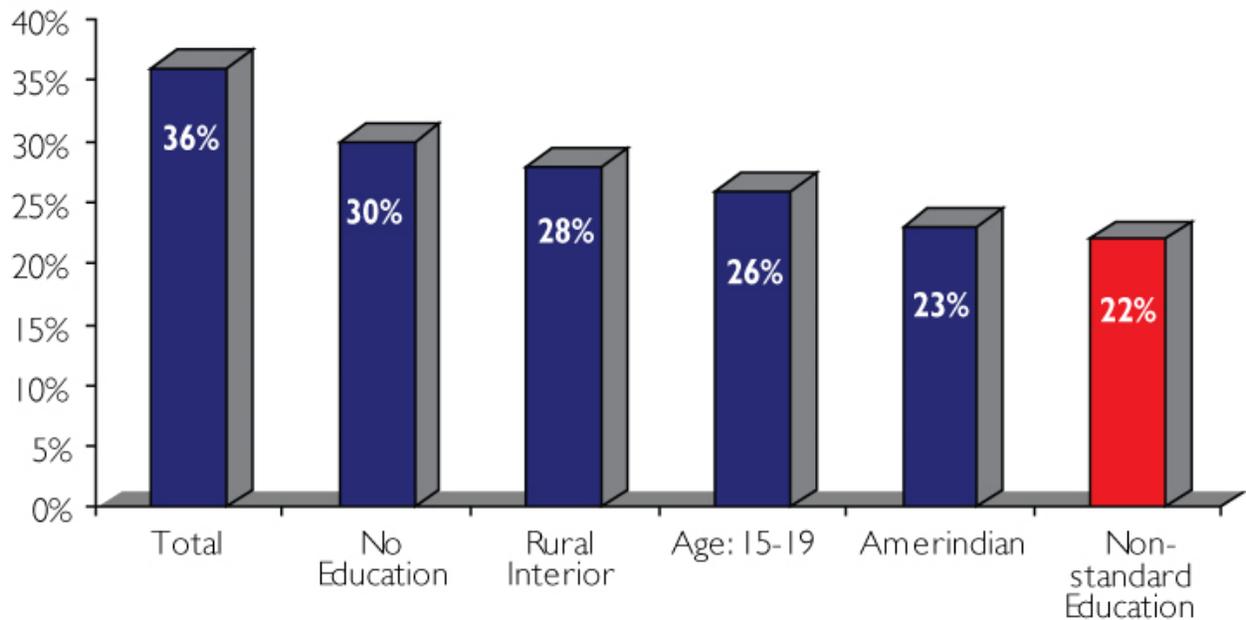


Source: 1991-92 Guyana Contraceptive Prevalence Survey (GCPS)

These results illustrate historic disparities in CPR between ethnic groups in Guyana. The 2001 MICS did not provide an update to this data, and thus it is difficult to determine whether progress has been made in bridging these ethnic disparities in recent years. In order to determine whether this gap has been bridged, the new MICS should analyze and present CPR and unmet need by ethnic group. Assuming gaps still exist, special measures can be taken to target vulnerable groups and ensure that all ethnicities have access to contraceptives as well as the knowledge to use the family planning methods they want and need.

Figure 11 provides a brief summary of certain segments of the population that are experiencing lower contraceptive prevalence rates than the overall CPR and thus may be experiencing additional barriers in access to family planning methods than the rest of the population. As mentioned previously, the Amerindian population, adolescent women, those residing in the rural interior areas, and women with less education appear to have the lowest contraceptive prevalence rates in Guyana. These segments of the population will clearly require special attention to ensure they are able to better choose, obtain, and use contraceptives whenever they need them.

Figure 11 - Contraceptive Prevalence Rates among WRAInU by Selected Characteristics

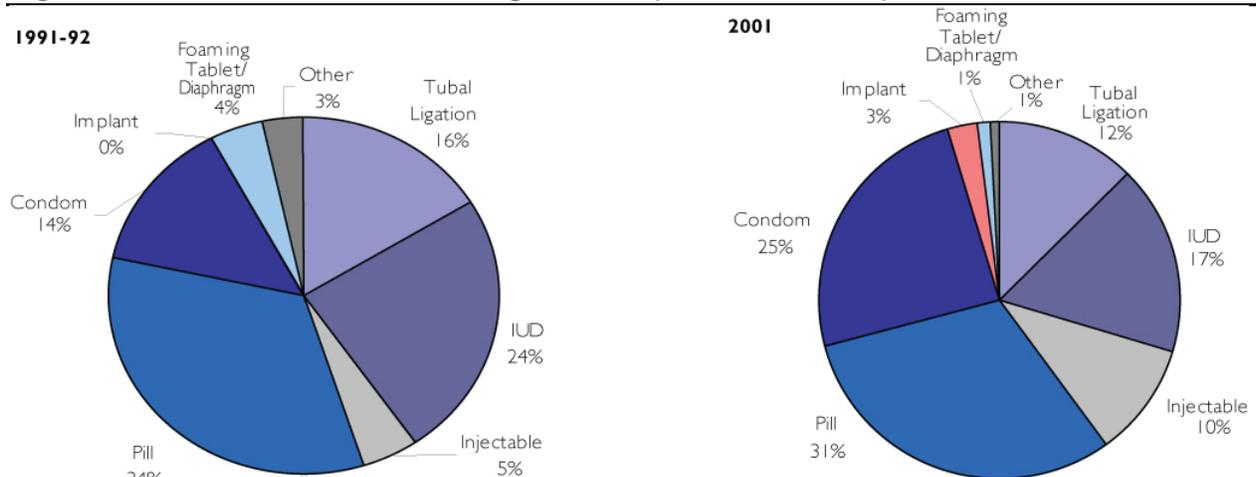


Source: 1991-92 (GCPS) and 2001 (MICS)

METHOD MIX

By observing method mix over time in Figure 12, it becomes apparent that some interesting changes took place throughout the 1990s in Guyana. For instance, permanent methods were preferred in 1991-92 as compared to 2001. There are many possible explanations for this change but perhaps a recent decline in capacity of the public sector to provide these more complicated services contributed to the reduction in use of long-term methods (i.e. tubal ligation and IUD insertion). In contrast, condom and injectable use nearly doubled during the same period and pills remain the most preferred method in Guyana today. Perhaps an increase in use of condoms in recent years can be attributed to awareness campaigns about the benefits of condoms as contraceptives as well as for preventing STIs.

Figure 12 - National Method Mix among WRAInU (Modern Methods)



Source: 1991-92 (GCPS) and 2001 (MICS)

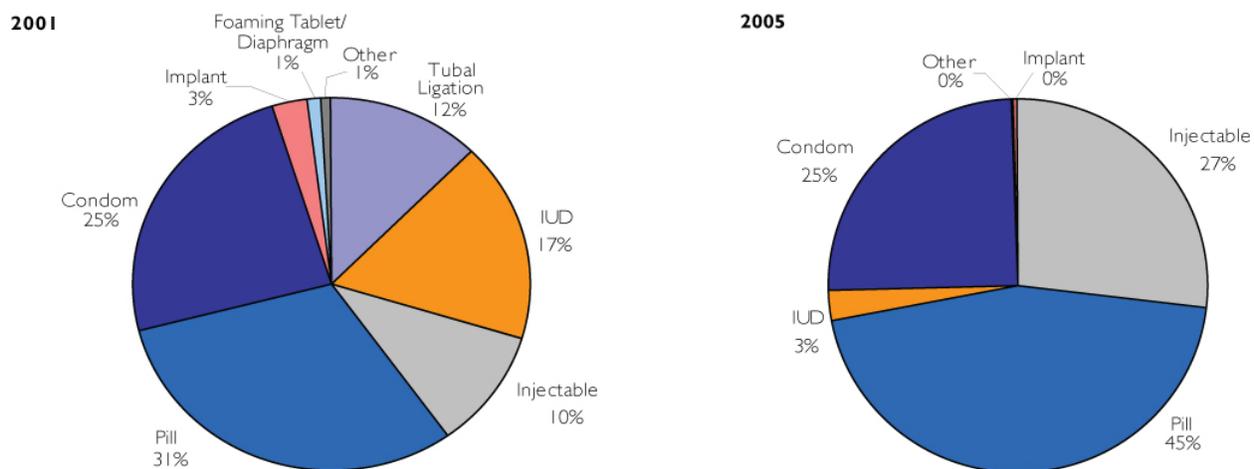
Listed below are some of the changes observed between 1991-92 and 2001:

- significant increase in the use of injectables, from 5% to 10%;
- a slight decrease in the preference for pills, from 34% to 31%;
- a significant decline in the insertion of IUDs, from 24% to 17%;
- a reduction in the proportion of tubal ligation procedures, from 16% to 12%; and
- a dramatic increase in the use of condoms, from 14% to 25%.

Figure 12 above presents data for all FP users in Guyana, irrespective of whether they attend public clinics or obtain their services from the private sector. Unfortunately data is not available to compare method mix by source of supply. Nonetheless, recent analysis of public sector logistics data provides a rough estimate of method mix for those individuals who obtain their services at public facilities.²¹ Figure 13 illustrates some of the differences between the overall method mix and the method mix of public sector FP users. Clearly, the public sector does not provide all the services available in the private sector, limiting methods to those provided at public clinics - pills, injectables, condoms, and IUDs. In addition, current data is not available about the number of tubal ligations performed within the public sector.

Nonetheless, it is clear that oral and injectable contraceptives are most preferred by public sector users. Approximately 70% of all public sector users prefer one of these two short-term methods. In addition, the condom is also a preferred method for public sector users mirroring the high rates of use in the country overall. Finally, many users appear to be obtaining their IUD insertions somewhere other than from public sector facilities. Only 3% of all public sector users are obtaining IUD insertions from the public sector, whereas 17% of all users prefer this method.

Figure 13 - National and Public Sector Method Mix among WRAInU (Modern Methods)



Source: 2001 (MICS) and 2005 MOH Consumption Data

Although data is limited, demand and use information provided above illustrates several possible areas of focus until new data becomes available. Clearly, slowdown in use of contraceptives is cause for concern. In addition, the fact that certain groups demonstrate higher contraceptive prevalence rates than others suggests there may be barriers in the system restricting certain groups from obtaining the contraceptive

²¹ These findings are based on consumption data gathered from the MOH, for 2005. Reporting rates were low and these data should be considered merely a general estimate of MOH method mix in recent years.

methods they need. Finally, method mix is changing, either due to variations in preference and/or the capacity of different facilities to provide adequate services.

Unfortunately, although some groups are using contraception more than others, current data provides no understanding of unmet need and whether certain subgroups are experiencing higher need than others. The new MICS will provide much of the data needed to make these suggested assessments and explore any changes that have taken place since 1991-92 and 2001.

In addition, further analysis needs to be carried out to determine exactly who is using which methods and where they are obtaining these services. Future steps will need to be taken to gather information about and further analyze source of supply. Current data gives us no idea about the proportion of users that are attending the public sector versus the private sector, and the new MICS will not gather this information. These data are essential to estimating the total number of users nationally, how these users are behaving, whether or not different sectors are providing the services that clients need, and exploring ways of segmenting the market by provider.

The following section provides an introduction to the main FP service providers in Guyana, and options for partitioning the market once data is available to further explore such options.

SERVICE DELIVERY

MAIN ACTORS

The following section provides background information about the main FP service providers in Guyana, both from public and private sectors.

Ministry of Health

The MOH is the leading agency in the health sector. It is headed by the Minister of Health who has overall responsibility for sectoral management and regulation. The Minister is assisted by a Permanent Secretary who has responsibility for management, administration and policy analysis and a Chief Medical Officer who oversees all technical functions pertaining to the health sector.

The MOH is responsible for supervising, evaluating and controlling health service delivery provided by various public and private subsectors; formulating health policy and legislation; establishing and enforcing standards; accrediting all facilities; identifying human resource needs of each sector; training, developing and placing health manpower; procuring and distributing pharmaceuticals and medical supplies in all regions; funding and managing vertical health programs; monitoring and evaluating the health sector and its various activities; and promoting healthy lifestyles.

Health Sector Reform and Regional Democratic Councils

In 1986, responsibility for the delivery of health services was devolved from the MOH to the Regional Democratic Councils who receive funding through the Ministry of Local Government. The human and technological resources of the health departments of the Regional Democratic Councils are provided by the MOH. The technical head at the regional level is the Regional Health Officer whose role is to ensure linkages among the various levels and manage service delivery. Because of a combination of economic constraints and organizational weaknesses, the full decentralization envisioned in the 1980s has not successfully taken place and Regions are overburdened, underfunded, and unable to successfully manage the provision of health services as originally anticipated.²²

As a way of benefiting from decentralization while maximizing resources, the Government of Guyana (GOG) has begun to implement additional reform in recent years. According to the National Health Plan,

²² MOH, GRPA and ORC Macro, 2005.

responsibility for service delivery is to be consolidated between four Health Management Committees (reduced from the 10 Regional Administrations) to gain economies of scale and assist in building management capacity. These measures will begin to be put in place in years to come.²³

Family Planning Services

Services to women and children (including maternal and child health, school and adolescent health, family planning/reproductive health, health of the elderly, and nutrition and food security) form part of a National Priority Health Program and MCH activities make up the majority of primary health care services provided in Guyana.²⁴ The provision of family planning services is supervised by the Maternal and Child Health Office and managed by the various Regional Officers. MCH is the largest vertical program in the MOH and its services include antenatal, intranatal, and postnatal care; immunization; education; nutritional advice and supplementation; and family planning.

Under the Family Planning/Reproductive Health Program, MCH aims to promote responsible sexual behavior, reproductive patterns and parenting skills among males and females of reproductive age. MCH aims to monitor the achievement of this overarching goal by tracking the objectives and corresponding indicators presented in Table 2 below.²⁵

Table 2 – Family Planning Reproductive Health Technical Program Objectives

Objectives	Indicators	Timeline
1. Strengthen Family Planning Clinical Services	a) Family Planning Clinic at GPHC headed by full time FP Nurse Practitioner.	2003
	b) FP Clinic in all Regional Hospitals.	2004
	c) FP sessions at 75% of health centers.	2007
	d) Reproductive referral protocols available to all relevant personnel in hospitals and health centers.	2007
2. Strengthen disease-screening programs.	a) Reduce STIs in family planning clients by 25% of the 2002 level.	2006
	b) Introduce annual breast examination for all family planning clients and for all women 40 years and older.	2007
	c) PAP smear (screening for cervical cancer) available in all Regional Hospitals and in 50% health centers.	2007
3. Establish strong RH Promotion Programs	a) Produce and publish a Public Service Announcement relating to reproductive health monthly.	2004 - 2007
	b) Increase use of contraceptive by 25%	2005

Source: National Health Plan 2003-2007, Technical Annex 1, National Priority Technical Programmes Objectives, 2003

There are over three hundred health facilities in Guyana, including the national hospital, regional hospitals, district hospitals, health centers, and health posts. The number of active facilities is constantly in a state of flux as qualified staff is scarce and health sector reform measures are being gradually implemented. These measures intend to redistribute facilities and manpower to maximize the ability of available qualified staff to meet population needs.²⁶

Table 3 below provides the latest estimate of health facilities in which family planning methods should technically be provided. All health posts and centers should provide family planning services but many of these facilities are stocked out of contraceptives or are not adequately staffed to provide services. In addition, the extent to which hospitals are integrated into the family planning program is unclear. It

²³ MOH, 2003.

²⁴ PAHO and WHO, 2003.

²⁵ MOH, 2003

²⁶ PAHO and WHO, 2003.

appears that some hospitals are reporting to and obtaining commodities from the MOH, while others appear to be operating autonomously.

Table 3 - Health Care Facilities in Guyana by Region, 2004-2005

	Health Posts	Health Centers	District Hospitals	Regional Hospitals	National Hospital	Total
Region 1	36	3	3	0	0	42
Region 2	19	11	1	1	0	32
Region 3	21	10	3	1	0	35
Region 4	11	36	0	0	1	48
Region 5	1	15	2	0	0	18
Region 6	4	21	3	1	0	29
Region 7	19	3	2	0	0	24
Region 8	14	4	2	0	0	20
Region 9	53	3	2	0	0	58
Region 10	16	10	2	1	0	29
Total	194	116	20	4	1	336

Source: Bureau of Statistics, 2006

When fully stocked, all health posts and centers provide pills, condoms, injectables, and foaming tablets at family planning clinics held on a weekly basis. In addition to short-term methods, select facilities, namely health centers and hospitals, are equipped with trained staff to provide long-term methods such as IUD insertion and tubal ligation. These more fully equipped facilities tend to be located in urban or more accessible areas of the country.

Human Resources

The main health providers in Guyana are physicians, nurses, medical extension workers (MEDEX) and community health workers.

There were 366 medical doctors and 1738 nurses and midwives in 2000-2004 according to the WHO Global Atlas. Due to manpower shortages, doctors work primarily on a visiting basis in hospitals and big cities along the coastline.

MEDEX have 18 months of clinical training and work in health centers or district hospitals. Community health workers are the main service providers in health posts in rural areas and operate through outreach and home visits. Selected by the community, community health workers attend a 16 week basic training on health promotion; first aid; and managing malaria, common respiratory and diarrheal infections, and all stages of pregnancy. In 2002, there were 57 MEDEX workers and 236 Community Health Workers providing primary health services in public sector facilities.

Existing staff are unevenly distributed throughout rural and urban regions, with 70% of physicians located in Georgetown. In addition, there is a shortage of manpower due to emigration of skilled health workers from Guyana.²⁷

²⁷ Ibid.

Quality of Services

Due to major economic and capacity issues, quality of services has been significantly affected in recent years. According to the National Health Plan, these challenges relate to three major areas of concern:

1) Staffing issues and impact on utilization:

- not enough doctors - specialists and public health staff
- high attrition rate among skilled and experienced professions
- low staff morale and high levels of de-motivation
- low levels of activity at all levels of the system
- recruitment and retention problems
- no incentives to work in hinterland and difficult locations, i.e. outside of Georgetown

2) Planning, management and financing:

- facilities and services added for political reasons rather than technical rationale
- not enough trained and experienced health managers, i.e. lack of managerial capacity at regional levels
- ad hoc planning and crisis management culture, i.e. not able to allocate resources to priority problems
- planning is disease focused and centrally managed, i.e. no regional targets set for health
- devolution of responsibility for health was not matched by authority over all resources
- budgets not focused on needs or performance

3) Data and quality of care issues:

- little formal regional health data available for monitoring and evaluation
- information flows fragmented and not integrated at either facility, regional or central levels
- no systematic approach to data collection from private sector
- no focus on quality and outcomes, only on inputs and shortages²⁸

These capacity constraints have significantly affected the quality of family planning services provided at all levels. Adequately trained staff is not available to provide the necessary counseling and services to ensure clients receive their preferred contraceptive method and appropriate family planning care. More specifically, long-term or more technically complicated services (IUD insertion, tubal ligation, etc...) are not available throughout the country. Finally, many facilities are stocked-out of commodities on a regular basis discouraging women from returning or obtaining services from the public sector.

The Guyana Responsible Parenthood Association (GRPA)

Beyond the public sector, there are various other private entities providing family planning services in Guyana. Founded in the early 70s by the Women's League of Social Services, The Guyana Responsible Parenthood Association (GRPA), with the assistance and guidance from the International Planned Parenthood Federation (IPPF), has played a prominent role in provision and promotion of FP and sexual

²⁸ MOH, 2003.

and reproductive health services. IPPF currently supports one third of GRPA’s annual budget; the remaining amount is covered by service fees and a membership program.

Since its inception, the NGO has collaborated with MCH to provide FP services. Originally, GRPA was contracted by the MOH to manage the provision of FP services in the public sector. Since the late 1990s, GRPA has no longer played this role but continues to provide some basic technical and training-related support and manages the reporting system for the public sector family planning program. Further details about this reporting system are discussed later in the Supply Chain Management section of this report.

Besides its contracts with the GOG, in the early 1980s, GRPA began offering contraceptive and family planning services through its own clinic in Georgetown. Beginning in 1995, GRPA expanded its services beyond the provision of family planning to a range of sexual and reproductive health services. The clinic is currently staffed by a full-time Medical Director, several nurses, and a range of other staff offering a wide range of services, including family practice, infertility, lab, STI care, VCT and HIV testing, outpatient pharmacy, and others.

Additionally, in December 2000, GRPA opened a new, full-service pharmacy near its Georgetown clinic. This project began under a grant from USAID, but with funding no longer available, GRPA aims to develop the pharmacy into a sustainable business and primary source of income for the organization. The pharmacy provides a range of commodities purchased from IPPF and local suppliers and sold to the public, mainly Georgetown residents.

GRPA also provides youth services at a second Georgetown site and assists with several workplace clinics in the city. The youth program involves health care professionals, community volunteers, and youth peer counselors in the sharing of information on sexual and reproductive health care issues.²⁹

Currently, GRPA provides services to approximately 900 FP clients a year (see Table 4). Taking recent estimates of the total number of FP users in Guyana, this adds up to only about two percent of all users.³⁰ Given the unmet need in Guyana, observed in 1991-92 and the ability to pay of certain segments of the population, there is clearly scope for GRPA to expand services and help cover a larger segment of the population.

Table 4 – Family Planning Service Statistics for GRPA, 2004 and 2005

Clients by Method	2004	2005
Oral	289	323
IUD	54	44
Injection	459	434
Condom	181	117
Cream/ foam	7	4
Total	990	922

Source: GRPA, June 2006

Recent declines in donor funds have made it difficult for NGOs like GRPA to keep afloat. Strategies for reducing costs and developing sustainable services may help expand GRPA coverage and consequently allow the public sector to focus on some of the more vulnerable and hard-to-reach segments of the population. Strategies for segmenting the market and alleviating pressure on the public sector may benefit

²⁹ This information is based on conversations with GRPA leader in June, 2006.

³⁰ DELIVER, 2006.

the organization, free up public sector funds, and better serve all Guyanese families in need of family planning services.

Family Planning Association of Guyana (FPAG)

The Family Planning Association of Guyana (FPAG) seeks to improve access to RH services while promoting safe and responsible motherhood. The NGO specifically targets lower income women and those with limited access to services. FPAG provides family planning education, gynecological examinations, contraceptives, emergency contraception, and counseling before and after terminations through its health center located in Georgetown. It also provides abortions up to eight weeks into pregnancy.

The FPAG's reproductive health center was officially opened in 1998 with a community based distribution service, through which field workers went to homes in target areas to sell contraceptives and refer clients to the center. Target areas included Cummings Lodge, Lodge, East La Penitence and Sophia.

In 2001, 3,826 clients attended the center in comparison to 3,468 in 2000. There were 552 termination of pregnancy (TOP) patients, 474 of whom were treated on-site and 78 treated off-site. In addition, in 2001, FPAG ran an adolescent RH program aimed at promoting family life education. At this time, the organization also initiated a collaborative effort with social partners in the health sector, the city council, and women's organizations, through which FPAG agreed to provide counseling, termination and contraceptives to partner clients.

Despite these historical activities, recently FPAG has gone through a series of severe financial and structural setbacks. Like the rest of the health sector, FPAG is dealing with serious capacity issues and a lack of qualified staff to manage the center and provide quality services to clients. For instance, in 2000, the NGO suffered from extreme staff turnover, losing three project coordinators in the span of one year.

Beyond capacity, FPAG no longer has the funding available to purchase commodities (funding ended in March 2005). Historically, FPAG received funding from Planned Parenthood Federation of America – International as well as the International Planned Parenthood Federation - Western Hemisphere Regional Office.³¹ Unfortunately, these funds are no longer available and FPAG has not yet made the successful transition into a self-sustaining organization. As a result of scale back and capacity issues, FPAG, served less than 700 clients, or 1% of all estimated family planning users in the country, in 2005 (see Table 5 below for their service statistics).³²

Table 5 – Family Planning Service Statistics for FPAG, 2005

Clients by Method	2004	2005
Oral	651	379
IUD	136	60
Injection (3 month)	138	80
Injection (2 month)	171	139
Total	1096	658

Source: FPAG, June 2006

Although FPAG is currently serving only a small proportion of the population, historically this NGO had the capacity to serve a larger numbers of clients. For example, in 2004, FPAG served almost twice as many clients as in 2005 (see Table 5). Given the levels of unmet need observed in the early 1990s, one

³¹ Stabroek News, 2001.

³² These numbers are based on conversations with FPAG leaders in June, 2006.

can assume that there are women whose needs are not being met today. Future initiatives should focus on sustainability plans, savings mechanisms, and methods of nurturing and fostering a healthy NGO sector, while alleviating demand on the limited resources of the public sector.

Private Pharmacies, Clinics, and Physicians

Besides the NGO sector, many Guyanese women opt to obtain their FP services and products from the private sector by attending private physicians, clinics, and hospitals or going directly to the pharmacy to purchase their preferred method. Although there is no recent data available estimating the exact proportion of women turning to the private sector, historical data from 1991-92 reported that 39% of contraceptive users were obtaining services and products from either private physicians or pharmacies. Recent consumption data, albeit incomplete, suggests that public sector coverage may have decreased since the early 1990s. This finding coupled with reduced coverage by the NGO sector, suggests that the private sector has either increased its share of services and products, overall use has decreased since 2001, or some combination of these factors has occurred.

Once up-to-date data is available, steps should be taken to further explore the role of the private sector in FP service provision and develop creative ways of coordinating services to maximize and capitalize on the resources and assets of all qualified institutions in the private, NGO, and public sectors. Only through coordinated targeting of services will women in all sectors, strata, and regions of the country gain access to the family planning services they need.

MARKET SEGMENTATION

Role of Public and Private Sectors in the Provision of Services

Because of limited resources in various countries, greater attention is now being paid to a whole-market approach that emphasizes a rational balance between the roles of the public sector, NGOs, and the private sector in providing FP services and contraceptives to clients. Market segmentation analysis (MSA) involves dividing a country's current and potential contraceptive users into subgroups (age cohorts, socioeconomic quintiles, geographic regions, education levels, etc...) each of which has specific characteristics, needs and preferences. This analysis then helps providers develop different strategies for marketing commodities and delivering services to these varying types of clients.

Based on the results of MSA, Contraceptive Security can be improved by reducing duplication of effort among different types of providers. Country examples from recent studies illustrate ways data has been used in different environments to coordinate provision of family planning services between subsectors:

- A 2005 market segmentation study helped the Bolivian government better understand how to target public provision of services and commodities to reach those most in need, while ensuring that proper incentives are created for NGOs and the private sector to participate as well. The analysis highlighted the importance of ensuring poorer rural women have access to publicly provided injectable methods, which are not available in private rural pharmacies.
- In Ghana, where most segments of the population cannot realistically be expected to pay private sector prices, one goal of a 2005 market segmentation study was to identify age groups and geographic areas suffering high levels of unmet need for family planning services and commodities.
- In addition to examining contraceptive use, authors of the 2003 market segmentation study in Bangladesh examined people's ability and willingness to pay for family planning services, primarily as a tool for determining how contraceptives can best be priced and marketed.
- With insufficient funding to meet country-wide contraceptive needs, Romania used market segmentation analysis to plan the targeted expansion of public family planning services primarily by providing free supplies to the rural poor.

- In Nicaragua, market segmentation analysis revealed that NGOs have an enormous opportunity to capture current users of public sector facilities who have the ability to pay for services. Also, the Nicaraguan Social Security Institute, which covers a significant proportion of women of reproductive age in the formal sector, could extend the benefit package to include family planning and, thereby, reduce the burden upon the Ministry of Health.
- In Guatemala, high levels of unmet need at various socioeconomic levels revealed that there are opportunities for all subsectors to increase their market shares simultaneously.

By redistributing family planning services among various sectors and providers, countries can become more efficient, as well as effective, at getting contraceptive products to all users.³³ Although Guyana does not have current data that clarifies the different roles played by the public, commercial, and NGO sectors or the preferences and needs of varying subgroups, the country can still begin to explore ways of targeting resources and coordinating health activities.

Many MOH have formed coordinating bodies, which include representatives of various sectors, in order to share data and information, increase collaboration, and improve the client focus of services. The GOG has already taken steps towards gathering information that could help inform a coordinated group of service providers as the 2006 MICS will provide updated information about behavior and preferences of different subgroups. Future studies could then focus on coupling these data with information about providers and the subgroups that they are currently serving. In addition, the MOH could help take steps to translate these findings into coordinated action among subsectors – NGO, private and public sectors.

³³ Deliver, 2006.

ENABLING ENVIRONMENT

POLITICAL ENVIRONMENT

SOCIO-CULTURAL BACKGROUND

Guyana has been a sovereign nation since 1966 when, as a former colony of Great Britain, it gained full independence. The country became a republic on February 23, 1970, the anniversary of the Cuffy slave rebellion of 1763.

In a multicultural environment, relations have generally been peaceful, except, unfortunately, around politics, as described below:

“Politically inspired racial disturbances between Indo-Guyanese and Afro-Guyanese erupted in 1962-64, and again following elections in 1997 and 2001. The basically conservative and cooperative nature of Guyanese society has usually contributed to a cooling of racial tensions. Racial tensions, however, do constitute Guyana’s greatest ongoing social stress point.

On October 5, 1992, after years of state socialism and one-party control, a new National Assembly and regional councils were elected in the first Guyanese election since 1964 to be internationally recognized as free and fair. Cheddi Jagan was elected and sworn in as president on October 9, 1992. This election began a movement toward a market economy and unrestricted freedom of the press and assembly.

When President Jagan died in March 1997, Prime Minister Samuel Hinds replaced him in accordance with constitutional provisions. President Jagan's widow, Janet Jagan, was elected president in December 1997. She resigned in August 1999 due to ill health and was succeeded by Finance Minister Bharrat Jagdeo, who had been named prime minister a day earlier. National elections were held on March 19, 2001. Incumbent President Jagdeo won reelection with a voter turnout of over 90%.”³⁴

HEALTH POLICY

National Health Goals

Health policy within Guyana begins with the Constitution, as access to health care is established as a right for Guyanese citizens.

The country’s priority health goals are also clearly enunciated within the MOH National Health Plan 2003-2007. Specifically, in the Executive Summary, the text states that “services will target priority problems – the main causes of ill health and the main groups of people affected by them”. The Plan then goes on to define how this will be done, as follows:

- reduce deaths (and illnesses) of mothers and infants – these are vital indicators of performance and achievement to date is inadequate,
- reduce communicable diseases – these are leading causes of death, illness and loss of productivity, particularly HIV/AIDS and malaria,

³⁴ Multi-Educator, Inc., 2006.

- contain chronic non-communicable diseases which are now becoming more important - specifically diabetes, heart disease, cancers, accidents and suicides.³⁵

In the next paragraph, the Plan defines its target populations - families and the poor - through the following statements, “Bad health keeps families in poverty. Better health gives them a chance of working their way to more prosperity. The NHP aims to ensure that poor people have equitable access to quality health services...” The Ministry of Health Annual Report for 2004 reiterates these key points as well.

These are positive and specific policy statements by the Ministry of Health on behalf of important subgroups of the population - mothers and children, families, and the poor.

Financing – MOH Budget Line Item for Contraceptives

Within a habitually tight budget, the consultants were informed that the MOH regularly finds funds to support FP services within the MCH/primary care network and to buy contraceptives. For the 2005 budget cycle, the funding for the purchase of contraceptives was as follows³⁶:

Requested amount	Guy\$45,000,000 (~US\$242,000)
Approved amount	Guy\$25,000,000 (~US\$135,000)
Actual Expenditure	Guy\$68,000,000 (~US\$366,000)

During the time of the visit (June 2006), contraceptive shortages existed, and it was clear that other shortages had occurred in the recent past. It was not clear, however, whether these shortages were the result of poor needs forecasting, a lack of funds, or both.

In relation to procurement, one significant issue the MOH faces is an inability to obtain internationally competitive contraceptive prices. Recent history suggests that even when utilizing a transparent and open competitive bidding process, prices are high. This is likely due to the small quantities being bid (a small number of women of reproductive age), high shipping costs (remote location), and a lack of competition in the market. The Ministry will need to address this challenge in order to expand its purchasing power.

National Drug Policy

The consultants did not find any MOH documents that might be described as either a National Drug (Pharmaceutical) Policy or Pharmaceutical Sector Master Plan, or part thereof.³⁷

In regard to a defined MOH essential health services package (EHSP), the Minister provided the consultants with the framework for Human Resources Development from the NHP³⁸, which includes some basic elements of an EHSP. The Minister referred to it as the “basic package of publicly guaranteed health services”. This framework first defines five levels of service for health care delivery, as follows;

- Level 1 – Health care services delivered at health huts (preventive and primary care only)
- Level 2 – Health care services delivered at health centers (primary care only)
- Level 3 – Health care services delivered at District and Community hospitals (primary care and secondary care)

³⁵ MOH 2003, pg. 6.

³⁶ Information provided by the MCH Office.

³⁷ There is a similarly named document entitled the National Drug Strategy Master Plan for Guyana 2005-2009 prepared by the Ministry of Home Affairs and others, but this plan is focused on anti-narcotics issues rather than legal pharmaceuticals.

³⁸ Dated October 21, 2003.

- Level 4 – Health care services delivered at Regional Hospitals (comprehensive secondary care)
- Level 5 – Health care services delivered at Specialty Hospitals (comprehensive specialty care), e.g. – GPHC, the national Psychiatric Hospital, and the Rehabilitation Hospital

The second step, again following the principles of an essential health services package, is to define in detail the services that the government intends to offer at each of these levels (allowing for minor variations due to geography, seasonality, etc.). This is done quite well for Level 1, and in a more limited way for levels 2, 3, and 4.³⁹ While more details would be needed to complete an explicit EHSP, the basic framework is very good.

The final step taken within this document is to elaborate on the desired, standard staffing pattern (personnel types and approximate titles) for each level (type of facility). This is completed for each level, and for the three types of health centers within Level 2. This completes the primary purpose of the document, guiding HR planning for the National Health Plan.

As a policy document, an EHSP can help the Government define, for both its citizens and public health sector employees, what it is committed to providing through the MOH network, and either by implication or explicit language, what it is not able to provide. In resource limited countries, the EHSP helps define priorities and access, reduce conflicts, clarify expectations, define costs, and focus resources. It can also be used to create dialogue with the private sector about complementary services.

For quality assurance and drug management purposes, there are additional uses for an EHSP. Utilizing a well-written and organized EHSP, standard treatment guidelines (protocols) for preventive, diagnostic, and treatment services can then be developed to reflect modern, appropriate clinical practice protocols for each of the services within the Ministry's EHSP. When provided with clinical training to health care providers, STGs are a valuable quality management tool, as they both define the standards and provide supervisors with a clear way to hold providers accountable to good clinical practices.

When STGs also include the drugs, health commodities, and tests needed by practitioners for prevention, diagnosis, and treatment, the combination of all of these clinical protocols allows for the creation of an essential drugs list, an essential commodities list, and an essential tests list, by level of service. These lists can be extremely useful for commodity management activities, such as procurement, and can also be used to assist in controlling drug and supply costs.

In the case of Guyana, the consultants were informed that an Essential Drug List does exist, with a new edition to come out in July/August 2006, and that contraceptives are included on this list. This list is not, however, the result of the type of comprehensive process described above. The consultants would suggest that the Ministry and the donors that are currently supporting STG development for individual programs⁴⁰ strongly consider this more comprehensive approach. While admittedly not a small effort, this integrated approach [EHSP => STGs => Essential Drug and Commodity List] provides synergistic benefits that will not be gained from a series of independent efforts.

³⁹ Level 2, health centers, is further broken down into Type 1 (polyclinic), Type 2 (week days), and Type 3 (< than five days).

⁴⁰ Some programs are already working on STG development with outside technical assistance (PAHO, Johns Hopkins University, etc.).

GOVERNMENT AND PROGRAMMATIC COMMITMENT TO REPRODUCTIVE HEALTH AND FAMILY PLANNING

Recent history would appear to suggest that family planning, while part of the Ministry of Health's primary health care program, has not been a high priority in relation to other programs and initiatives. Three examples are suggested as supporting this assertion, as follows:

(1) In the National Health Plan 2003-2007,⁴¹ five major components or outputs are defined to meet the Plan's purpose and strategic goals. These include:

- Strengthening management control and capacity to create more responsive and accountable organizations capable of assessing health needs, particularly of the poor and vulnerable, and implementing prioritized action plans.
- Modernizing and rationalizing the public sector health services, with a focus on prevention and health promotion, to improve the utilization of services and the productivity of the available workforce.
- Establishing workforce development and human resource management (HRM) systems so as to achieve the regional staffing targets of the Health Services Strategy and Plan 2003-2007.
- Implementing a national quality framework so as to ensure a high quality of care for consumers and to improve satisfaction in the public and private sectors.
- Directing finance to priority needs, and improving financial accountability and value for money performance for both public and private health expenditure.

Within the Plan, the Ministry also defines priority National Health Programs for the next five years, which are based on an assessment of health needs and the availability of cost effective interventions. They include:

- Maternal and Child Health including Expanded Program of Immunization (EPI), family planning and Integrated Management of Childhood Illnesses (IMCI),
- HIV/AIDs including treatment of STIs and TB,
- Accidents and injuries including suicide,
- Chronic non communicable diseases including heart disease, hypertension, diabetes and nutritional deficiencies, and
- Infectious diseases including malaria, diarrheal diseases, and respiratory infections which dominate the health profile of the hinterland regions.

While family planning is listed as one of three main areas of focus within MCH, family planning is not mentioned again in the document, except in a Table in the descriptive Health Profile section, where it is again suggested that reproductive health and family planning are "health priorities" for both the hinterland and coastal regions. Within the document, there is no summary of family planning needs, no plan of action for addressing FP issues, no targets or defined interventions for family planning. While suggested as a priority area in the Plan, without an action/implementation strategy, it is hard to imagine that family planning program improvements can be expected.

(2) In the Ministry's Annual Report for 2004, the chapter on the year's targets and achievements for their seven (7) primary programs, entitled Policies, Plans, Programs and Projects, includes a total of 71 pages,

⁴¹ Ministry of Health of Guyana, National Health Plan 2003-2007, The Strategic Plan of the Ministry of Health, March 2003, page 20.

21 of which are dedicated to Disease Control accomplishments, 27 to Primary Health Care Services, and the remaining 23 to Ministry Administration, Regional and Clinical Services, Health Sciences Education, Standards and Technical Services, and Rehabilitation Services. However, within the substantial Primary Health Care section and with Maternal and Child Health described as the “largest vertical program in the MOH”, not one of the general objectives for MCH mentions family planning, family planning is not mentioned as one of the key health indicators, and the family planning program is ‘described’ in only two Tables (new acceptors and continuing acceptors) and with no text.

(3) Finally, on several occasions during this short assessment, comments made by interviewees indicated that there may be an “unwritten” view within Government that an increase in the country’s population would not be a bad thing. While this is clearly subjective, similar thinking in the broader environment could negatively influence ongoing commitment to contraceptive security.

FAMILY PLANNING LAWS & POLICIES

As noted above, formal support for maternal and child health is very positive within the National Health Plan. Specifics on family planning, however, is another matter, as it is mentioned only twice in the Plan. The consultants were not able to locate any other documents that might suggest formal policy or legislative support for family planning in Guyana.

ADVOCACY FOR FAMILY PLANNING

As the visit of the consultants was limited in time and scope, it is difficult to generalize about advocacy efforts on behalf of the family planning program. The consultants did not, however, learn of any formal efforts to promote the use of family planning or hear about such campaigns. One well-informed source noted that there is “still a lot of ignorance about family planning” and there is a “need for public education programs”.

OTHER KEY ISSUES

In any report on the public health sector in Guyana, it is important to mention the significant problem of outmigration of qualified professionals and its impact on having staff to provide health services. The drain of human resources is a continuous and stubborn problem, one that negatively affects all health services, both public and private. The Annual Report on the MOH from 2004 provides a ‘snapshot’ of the statistics, as follows:

- Number of physicians per 10,000 = 4.2
- Number of nurses per 10,000 = 3.4
- Staffing – Total MOH - Authorized (913); Filled (616); Vacant (297) = 32.5% vacancy rate
- Within MCH - Authorized (116); Filled (70); Vacant (46) = 39.7% vacancy rate (2nd highest of the seven MOH Programs behind Health Sciences Education at 40.7%)

At the end of 2004, the Ministry had an overall vacancy rate of 32.5%, with individual program rates as high as 40% (MCH and Health Sciences Education). With 3 to 4 out of every 10 positions unfilled, it is easy to imagine that it is quite difficult to provide adequate services throughout the MOH network.

LAWS & REGULATIONS

IMPORT TAXES

One basic issue that can negatively affect commodity prices for consumers is whether suppliers, when they import drugs and related products, are required to pay significant customs duties, fees, and/or taxes to the Government, as suppliers usually pass through these costs on to the client or customer. The consultants learned that the Government of Guyana has provided a duty-free concession to the Ministry of

Health for contraceptives and other products, an important step in keeping MOH costs down and customer prices low. The consultants also found that GRPA has access to this concession. It was not clear whether other NGOs were also provided access to this concession.

SUPPLY CHAIN MANAGEMENT

MINISTRY OF HEALTH SUPPLY CHAIN MANAGEMENT SYSTEM

As noted earlier, Guyana is divided administratively into ten Regions, listed by number. Regions 1 through 6 have coastline on the Atlantic Ocean, whereas 7 through 10 are inland Regions. The MOH organizes itself according to this official administrative structure, using the Regions as coordination and administration hubs for all health services within Regional boundaries. In total, the health facility network of the Ministry is summarized in Table 3 above on page 21.

The Ministry’s supply chain (also called logistics system or health commodity supply system) is managed by the Materials Management Unit (MMU), in combination with the program departments and the Regions. MMU handles most of the products of the Ministry’s programs, although some, such as family planning, seem to have a “partial” status. MMU’s key roles include procurement, inventory management at the central level, order processing, and delivery. Program departments are generally responsible for forecasting, and the Regions are primarily responsible for logistics information, ordering, and product distribution from their warehouses to their health centers and health posts. Regarding distribution, the system consists of a variety of alternative solutions across Regions: in a number of cases, MMU delivers directly to Regional warehouses, hospitals, and even some health centers (and to hospital stores acting as the Regional warehouse); in others, they utilize a “pack, deliver, and collect” (transit) approach; and finally, some Regions must come regularly to Georgetown to collect their supplies. MMU has developed plans to provide delivery to all Regions and their facilities in recent years but this plan has not been fully implemented.

In terms of family planning, all health facilities of the Ministry officially offer family planning counseling services and access to modern methods. In reality, however, the extent and quality of these services is determined by the availability of staff and the training and experience of those available. Because of a ‘brain drain’ of qualified Guyanese to more developed countries, such as the U.S., Canada, and the U.K., health facilities are often understaffed by 50% or more. The result is that the services actually being offered at any given health center or health post are highly dependent on the actual number of staff and the qualifications and experience of the individuals working there.

In addition to the service delivery points of the MOH, the supply chain for contraceptives relies on several other key partners and actors, as follows:

Table 6 – Key Partners and Actors in the MOH Supply Chain for Contraceptives, 2006

Partner/Actor	Primary Roles	Secondary Roles
Maternal Child Health Office, MOH	Program management; quality assurance; commodity forecasting (including contraceptives); MCH health information oversight; monitoring and evaluation	Policy development; capacity-building; resource mobilization; advocacy (choice, long-term method availability, financing, etc.); sector coordination
Regional Health Authorities and Health Facilities	Program management and oversight; quality assurance; collection, aggregation, and reporting of family planning program data and information, including logistics information for contraceptives; monitoring and supervision of services and product availability; monitoring contraceptive orders from facilities	Capacity-building; recruitment

Materials Management Unit, MOH	Procurement of contraceptives with best value-for-money; customs clearance; distribution of contraceptives to RHAs and health facilities on regular schedule; proper inventory management and security	Customs clearance; product quality control (with Bureau of Standards and Food and Drug Administration)
Guyana Responsible Parenthood Association (GRPA)	Contracted by MOH to provide Health Management Information for family planning (service statistics, trend analysis)	Not fully clear whether they are contracted to collect Logistics Management Information (stock-on-hand, consumption, losses and adjustments, stock-out information)
Donors (UNFPA, USAID, others)	In many countries, they provide support to reproductive health and family planning programs through direct RH/FP program support, pre-service and in-service training, and the purchase of contraceptives	They may also provide technical assistance with quality assurance, the development of standards and guidelines (such as STGs and essential drug lists), logistics system improvements, health surveys, and country-specific problems (such as the HR issues in the MOH in Guyana).
Other Family Planning and Contraceptive Providers (FPAG and private commercial sector)	While not actors in the MOH system, GRPA and FPAG, as NGOs, and private physicians and pharmacies also provide contraceptives to those who want and need them. The non-public sector plays an important role in the more populated areas and should be brought into any FP coordination efforts initiated by the MOH and/or donors.	The private sector offers sexual and reproductive health services that are not offered by the public sector.

MATERNAL AND CHILD HEALTH OFFICE

The Maternal and Child Health Office's key roles for contraceptive security including forecasting, LMIS oversight, and monitoring and evaluation. During the visit, the consultants learned that the annual task of forecasting contraceptive needs has moved around quite a bit over the past few years. For some years, starting in the 1980's, GRPA, as the International Planned Parenthood Federation affiliate in Guyana, was viewed as a knowledgeable actor in family planning. They developed forecasts using the IPPF 'formula' and obtained products for themselves and the Ministry through the mid 1990's. For another period, PAHO provided forecasting and procurement support, and Government funds were used to obtain the needed products. Finally, in 2003 or 2004, the Ministry began to buy contraceptives through the MMU and the official government tendering system. At this point, contraceptive forecasting became a task of the MCH Office.

One key problem in producing an accurate contraceptive forecast for the health facilities of the MOH of Guyana is that there is little reliable LMIS or proxy data.

As the box to the right indicates, the best data source for a product forecast is logistics data from the program, as it provides both historical and trend information. In combination with program effort⁴² information, this data can be used to prepare a solid forecast. Even demographic forecasting is a challenge (see Annex 2 for the contraceptive forecast developed by the consultants)

Forecasting Data Sources and Methods

- Logistics data from the FP program (consumption by clients, stock-on-hand, losses & adjustments)
- Services statistics from the FP program (if standards for distribution quantities are developed, distributed, & monitored)
- Population & demographic survey data

⁴² Promotional campaigns for one or more methods, BCC and/or ICC campaigns, and other changes within a national or regional family planning program.

because of the fact that surveys related to key indicators for FP are few and far between. The last comprehensive Contraceptive Prevalence Survey was done by IPPF in 1991/92. Even surveys with the most basic family planning-related information, such as contraceptive prevalence and method mix estimates, are infrequent, as UNICEF sponsored Multiple Indicator Cluster Surveys (MICS) in 2001 and 2006⁴³ appear to be the only surveys obtaining this information. The consultants would strongly urge the Ministry and donors to find the resources needed for the completion of a comprehensive survey on health and family planning, such as the Demographic and Health survey that USAID often supports, as such a snapshot of the health situation is vitally needed for programmatic and strategic planning in the health sector. Key areas of data sparsity include public-private mix, source of family planning services and products by income level, family planning information sources, etc.

Oversight of program information for family planning is another task that has been outsourced to GRPA by the MOH for some time. Findings related to the Family Planning HIS and the utilization of data by the MCH Office/MOH are as follows:

- the basic two-sided data collection form was designed by GRPA, and the reports that health facilities prepare come through the Regions directly to GRPA,
- this report is more complicated than it needs to be and is hard to compile,⁴⁴
- the only data compiled by GRPA for the MCH Office are the service statistics (new and continuing users),
- contraceptive consumption for each method is included on the form but not compiled,
- GRPA provides only minimal analysis of the data for the MCH Office,
- reporting rates (by the health facilities) are generally poor (see Table 7 below),
- there is little or no monitoring by the center or the Regions of data collection and reporting,
- the MCH Office has not taken an interest in ensuring that there is reliable and accurate logistics information for decision-making,
- the MCH Office does not order condoms even though they are most often distributed by family planning nurses at health facilities⁴⁵,
- New GPC, Inc. was recently asked to assist with an emergency procurement of contraceptives after it was realized that shortages were going to occur/occurring, and
- although the Ministry is technically outsourcing the work of MHIS/LMIS reporting to GRPA, and GRPA receives payment for the services provided, there does not appear to be a formal contract that clearly defines responsibilities, requirements, and schedules.

The final role that the consultants see as a priority for the MCH Office is program monitoring and evaluation. As an MOH program, family planning should have defined targets, priority activities, a quality assurance program, standards and guidelines, and basic indicators for monitoring results. It is possible that some of these elements exist on paper. Unfortunately, the consultants did not sense that the

⁴³ Unfortunately, the data from the 2006 MICS survey is not expected to be available until September 2006.

⁴⁴ The consultants compiled all of the consumption data reported to GRPA for 2005 after discovering that it was available. The process proved to be quite cumbersome.

⁴⁵ Condoms are ordered by the Health Sector Development Unit (perhaps because they are purchased with GFATM funds?).

family planning program is being given much attention by the Ministry and did not see evidence that the program has defined targets or indicators. While the personnel shortages of the Ministry have likely contributed to this problem, as does the lack of reliable program and survey information, the consultants would suggest that much more needs to be done and can be done to strengthen the family planning program and enhance contraceptive security.

REGIONAL HEALTH AUTHORITIES AND HEALTH FACILITIES

As the Regional Health Authorities have direct responsibility for primary health care, including family planning, their key roles include program management and oversight; quality assurance; collection, aggregation, and reporting of family planning program data and information (including logistics information for contraceptives); monitoring and supervision of services and product availability; and monitoring contraceptive orders from facilities. Our findings related to these key roles and responsibilities are as follows:

- many health facilities make an effort to complete and send the FP monthly report, however, many others do not (Table 7 below summarizes the reporting rates for 2005),
- Regions may or may not aggregate the information on the FP monthly report before sending the forms to GRPA,
- ensuring that contraceptive stock-outs do not occur does not appear to be a priority of the Regions, in part because there is little or no monitoring by the center or the Regions of data collection and reporting,
- as at the central level, it appears that Regions do not analyze and use the logistics data that is collected by their health facilities,
- there was no evidence that the FP program has defined targets or indicators, or that Regions provide regular monitoring or supervision of services or data collection and reporting,
- health facilities are being overwhelmed by data collection and reporting requirements, and there seems to be little coordination of HMIS and other data efforts across programs,
- contraceptive orders follow a different reporting path than other FP information, going directly to the Materials Management Unit at the central level. In theory, in addition to orders, the Combined Requisition & Issue Voucher (CRIV) includes consumption and stock-on-hand information, but in practice, they are rarely completed, so MMU does not have this important information. On the Regional side, as orders are sent only to MMU, they are often not being received by Regions.

Table 7 – FP Reporting Rates, by Region and Type of Facility, 2005

Regions	Health Post	Health Center	Hospital	% Total
Region 1	0%	33%	44%	6.25%
Region 2	39%	77%	0%	50.69%
Region 3	22%	44%	0%	26.36%
Region 4	17%	57%	0%	47.17%
Region 5	100%	75%	96%	78.75%
Region 6	58%	84%	25%	74.02%
Region 7	7%	0%	38%	8.33%
Region 8	0%	0%	50%	5.56%
Region 9	0%	31%	46%	3.22%
Region 10	52%	67%	17%	53.39%
Totals	15%	62%	30%	33.10%

Source: 2005 MOH FP Reports sent to GRPA

MATERIALS MANAGEMENT UNIT (MMU), MOH

The Materials Management Unit of the MOH serves as the procurement agent and distribution ‘service’ for the network of facilities of the MOH (certain hospitals are expected to manage their own procurement). By design and MOH policy, their distribution responsibility includes the distribution of all drugs and health commodities using an ‘integrated’ approach, in cooperation with the program departments and the Regions and facilities. Perhaps because of the involvement of donors and NGOs in the past (PAHO and GRPA) however, family planning products do not appear to be fully integrated into the MMU system. While MMU handles the orders that it receives from health facilities, they do not monitor contraceptive stock status on behalf of the family planning program.⁴⁶

In relation to the family planning program, MMU has a number of primary roles: procurement of contraceptives (with best value-for-money); customs clearance; distribution of contraceptives to RHAs and health facilities (ideally by delivery and on a regular schedule); and proper inventory management and security. For procurement, as noted above, MMU started procuring contraceptives only about three or four years ago. The following are the findings of the consultants in relation to MMU:

- the procurement process, in combination with the supplier delivery process, appears to take at least six months (the recent order was placed in January and products were scheduled to arrive in July and August),
- the MCH Office is not including this lead time in its forecasting calculations, likely a major contributing factor to the recent contraceptive stock-outs,
- the purchase prices for contraceptives, likely due to small quantities and long shipping distances, are very high, sometimes as much as 5 to 7 times the price that can be obtained directly from international organizations such as UNFPA,
- MMU delivers drugs and health commodities directly to some Regions (2, 3, 4, 5, 6 and 10), but requires others (Regions 1, 7, 8, and 9) to come into Georgetown to pick up their supplies,

⁴⁶ It was not clear to the consultants whether MMU monitors the stock status for any health commodities beyond their own warehouses.

- the distribution of commodities remains a challenge within Guyana due to the lack of roads in some Regions and limited resources for vehicles, fuel, etc.
- the MMU facilitates customs clearance for all products purchased for the MOH, and the process seems to be fairly efficient (up to one month).

GUYANA RESPONSIBLE PARENTHOOD ASSOCIATION (GRPA)

As mentioned above, GRPA, not only supplies its own contraceptives at a clinic in Georgetown, but also provides technical assistance to the MOH in managing its own reporting system.

In regards to its own services, GRPA obtains some contraceptives from IPPF and purchases the rest from the local wholesalers. Almost all are brand names, according to IPPF philosophy. As an NGO with a public-service mission, GRPA is allowed to bring these products into Guyana duty-free by the Government.

While the consultants did not evaluate the quality of GRPA's services in Georgetown, anecdotal evidence suggests that they have a solid reputation and have a high volume of repeat clients. However, as with all IPPF affiliates, they have been facing reductions in funding, which makes the procurement of contraceptives more of a burden than in the past, especially when salaries and other operating expenses come first. Alternative sources for contraceptives, especially at low or subsidized cost, would go a long way in helping them meet their annual budget. As GRPA is a strongly service-oriented non-governmental organization, the question of whether the Ministry of Health would be willing to assist them through access to low contraceptive prices is one that the consultants would like to see discussed.

In relation to the MOH, GRPA has, over the years, provided various types of assistance, especially in the areas of contraceptive forecasting, procurement and information management. Currently, the role is a limited but formal one, as they are contracted by the MOH to organize and report health management information for the family planning program⁴⁷, including service statistics and trend analysis. Key findings related to this activity are as follows:

- the data collection format was designed by GRPA, and the reports prepared by MOH health facilities come through the Regions directly to GRPA,
- this form/report is more complicated than it needs to be and compiling aggregate information is difficult,
- from the forms/reports, service statistics (new and continuing users) are the only items compiled and provided by GRPA to the MCH Office⁴⁸,
- the form/report requests contraceptive consumption by method from health facilities and many facilities are providing this information, however, GRPA is not compiling it,
- GRPA is not providing any trend or other analysis of the FP data to the MCH Office,
- the consultants saw no evidence that GRPA is making efforts to improve the reporting rate of the health facilities, although it was reported that there was some improvement between 2004 and 2005,
- reliable and accurate data on contraceptive security and the FP program is a significant problem.

⁴⁷ It is not clear to the consultants whether a formal agreement exists or whether the 'contract' is based on informal understandings and agreements.

⁴⁸ Whether this is the result of poor performance by GRPA or poor contracting by the MOH is not clear – what is important is that other key information needs to be collected, summarized, and reported.

DONORS (UNFPA, USAID, PAHO, OTHERS)

Current reproductive health and family planning related programs of USAID, UNFPA, and PAHO in Guyana are described briefly below:

UNFPA's current program in Guyana supports youth programs in HIV/AIDS and adolescent health (a three year program since 2003); other programs work with the Women's Affairs Bureau, with Social Security on aging issues; with the Bureau of Statistics on information; and in MCH with a female condom pilot program. Their programs also have a regional focus, with emphasis on Regions 3, 4, 6, 8, and 10. In relation to RHCS, they are interested in improving the coordination mechanisms for RHCS (involvement of all partners and providers) and for data collection. Guyana is part of a six country program in RHCS which is awaiting final approval/funding in New York. This program is expected to include funding for TA for the logistics system⁴⁹ and for a condom promotion program for FP. UNFPA indicated that they are considering future assistance to Guyana in the form of procurement (equipment and contraceptives).

USAID's current program includes only limited for funding for RH and FP activities, including this study. The current HPN Officer is actively seeking additional funding and hopes to obtain the resources for the preparation and completion of a Demographic and Health Survey, likely in 2008.

The PAHO program in Guyana has a wide variety of activities, as they are working in areas of policy, training, and capacity-building, especially at Regional and District hospitals, in the development of STGs for safe motherhood and IMCI (with STGs for FP planned), with the MOH in developing practical solutions for ongoing HR challenges, and various others not related to family planning.

OTHER FAMILY PLANNING AND CONTRACEPTIVE PROVIDERS

Similarly to GRPA, the major issue facing FPAG is the loss of operational funding and products which were previously received from donors, primarily PPAI. The Executive Director, Ms. Maureen Williams, noted that she expects that their stock of contraceptives to run out in November or December. As with GRPA, assistance from the Ministry of Health in regard to access to low priced contraceptives could provide a very significant contribution to FPAG's long term viability.

In terms of contraceptive products (condoms, oral pills, injectables, emergency contraception), both private physicians and pharmacies sell products which are imported by at least seven local wholesalers. While all seven import condoms, it appears that only three or four import pills or injectables. The consultants were informed that local retail prices are roughly G\$100 (US\$0.50) for a pill cycle, G\$700-900 (US\$3.50-4.50) for an injectable vial, and G\$150-300 (US\$0.75-1.50) for a three pack of name brand condoms. Private pharmacies for Regions 4 and 6 combined is estimated at around 110, with an additional 50-60 unlicensed patent shops (OTCs) in Region 4. In other Regions, numbers are dramatically smaller, although no specifics were provided.

⁴⁹ If technical assistance is provided, we would encourage that these program efforts are fully coordinated with the new USAID-funded Supply Chain Management Project's activities.

FINANCING

The importance of establishing enabling policies and efficiently managing the supply chain are essential components of ensuring CS in any country. Other important aspects of CS include identifying sustainable financing for the procurement of RH commodities and ensuring that products are available to the clients who want them. Financing for the purchase of contraceptives, their promotion, supply chain management, and service delivery can come from diverse sources including government, donors, households, and private companies. The following section provides background information about different sources of funding in Guyana, estimated need for future contraceptives and the required financing associated with these estimates, all important aspects of ensuring CS in Guyana in years to come.

SOURCES OF FINANCING

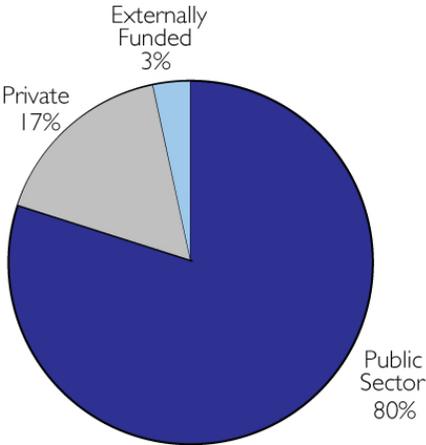
Public health sector expenditures were estimated at US\$37 million for 2004, roughly 80% of the total health expenditures. These estimates can be viewed by source of funding in Table 8 and Figure 14 respectively.⁵⁰ According to the Minister of Health, the public sector’s share of expenditures rose 16% in 2005 to approximately US\$43 million (GY\$8 billion). Of these funds, approximately 23% (US\$9.8 million or GY\$1.8 billion) were drawn from the public sector for the purchase of health commodities, primarily medications.⁵¹

Table 8 - Health Sector Expenditure by Major Sources, 2004

Source of Expenditure	US\$ (millions)	GY\$ (millions)	% Total
Public Sector	37	6,660	80.1%
Private	8	1,372	16.5%
Externally Funded	2	283	3.4%
Total Expenditure on Health	47	8,315	100%

Source: WHO, National Health Accounts, 2006

Figure 14 - Health Sector Expenditure by Major Sources, 2004



Source: WHO, National Health Accounts, 2006

⁵⁰ WHO, 2006.

⁵¹ These numbers are based on conversations with the Minister of Health in June 2006.

Although WHO provides recent estimates for overall health expenditures, detailed health sector expenditure data is unreliable and out of date. In 1999, tax revenues collected through general taxes and insurance contributions constituted the largest proportion of health financing, approximately 62%.⁵² Recent conversations with the Ministry, in June 2006, suggest that the majority of funds are still drawn from tax revenues. Out-of-pocket expenditures by individuals at the service delivery point, primarily within the private sector, constitutes the second largest source of financing for the health sector, accounting for an estimated 17% of total funding to the health sector in 2004.⁵³

Health care costs and financing have been a major concern of the government as it embarks on the Health Sector Reform program. In the past, donor funds contributed substantially to the health sector, reaching as high as about 13% of all health expenditures in 1997. As donor funds become increasingly restricted, especially for family planning services, new strategies must be adopted so that the GOG can sustain its own primary health care services. The focus of the HIPC initiative on primary health care has been a significant source of financing in recent years and has contributed to a gradual increase in health sector funding over time. The HIPC agreement states that the national budgetary allocation for health should have been increased to 4.5% of GDP by 2002 and that 80% of the increase in funds should have been spent on primary health care.⁵⁴ The following sections illustrate that the GOG has progressively made progress towards reaching these goals and that these funds have allowed the GOG to increasingly take responsibility for financing the health sector in recent years.

DONORS

Guyana still receives significant technical cooperation support for the health sector, primarily in the form of grants. In 2004, donors accounted for an estimated 3.4% of public health spending (compared with 3.9% in 2003 and 3.1% in 2002).⁵⁵ The principal sources of external financing in 2000 were the Inter-American Development Bank, UN agencies, USAID and German Technical Cooperation.⁵⁶

Additionally, a recent influx in HIV/AIDS related donor funding from various sources (PEPFAR, Global Fund, etc...) has significantly impacted the provision of health services in Guyana today. Between 1988 and 2000, the Government of Guyana was the main source of financial support for HIV/AIDS programs. Since then, external funding has surpassed domestic sources of funding by approximately 50%.⁵⁷ While HIV/AIDS related funds have helped the government to mitigate effects of the HIV/AIDS crisis in Guyana, other health programs have seen a progressive decline in donor support and have consequently struggled to sustain the provision of adequate services.

Maternal and child health and specifically, family planning programs, no longer receive the same level of support that they did during the 1980s and 1990s. Historically, USAID was one of the main donors to family planning programs in the region, primarily providing donated contraceptives to the public sector and NGOs as well as technical assistance to expand and improve the provision of family planning services to those who need them. Although USAID always intended to gradually decrease its support while helping countries develop the capacity to sustain these programs themselves, in certain cases, economic constraints, deepened poverty, environmental and health related crises and epidemics, and various other political obstacles have led countries, like Guyana, to struggle with this transition.

⁵² Ministry of Health, 2003.

⁵³ WHO, 2006

⁵⁴ PAHO and WHO, 2003.

⁵⁵ WHO, 2006.

⁵⁶ PAHO and WHO, 2003.

⁵⁷ CDC, 2006.

Although the GOG has every intention of fully funding the provision of family planning services, recent problems with the supply chain, limited capacity at all levels, and restricted resources suggest that the Maternal and Child Health Program could benefit from increased donor support in the short-term to ensure that Guyana develops the capacity to successfully sustain its own family planning program in years to come.

PUBLIC SECTOR

As mentioned above, the primary source of funding for the public sector is government taxation. These funds are transferred from the Ministry of Finance to the Ministry of Health, to the Ministry of Local Government (and then to the Regions), and to the Georgetown Public Hospital Corporation. Generally, GOG has maintained a policy of free service provision at the delivery point, but the government has recently introduced limited user charges at select higher level facilities. Revenue generated from charges is minimal – estimated as 0.16% of government health expenditure in 1999. Facilities are not allowed to retain this income and must transfer it to the Regional Treasury. There is no form of public financing of private health insurance for public sector workers.

In recent years, the share of Guyana’s national budget allocated to health has increased, although amounts have fluctuated due to ebbs and flows of external loans (see Table 9). Tax financing of the health sector has increased steadily, reflecting three main factors: 1) sustained economic growth, since the 1990s; 2) GOG focus on health sector expansion as a poverty reduction strategy; 3) and increased government domestic revenues as a result of debt relief policies negotiated through the HIPC initiative.⁵⁸

Table 9 - Public Health Sector Expenditure

	1998	1999	2000	2001	2002	2003	2004	2005*
Public Expenditure on Health (GY\$ millions)	4,328	4,418	5,984	5,982	6,481	6,352	6,947	8,000
Public Expenditure on Health as a % of GDP	4.01%	3.57%	4.60%	4.36%	4.16%	3.97%	4.12%	4.39% (est.)
Public Expenditure on Health as % of Total Public Expenditure	8.91%	8.03%	10.79%	12.29%	12.17%	11.61%	11.61%	12.85% (est.)
Total Per Capita Expenditure on Health in US\$	47	40	52	52	55	53	56	N/A

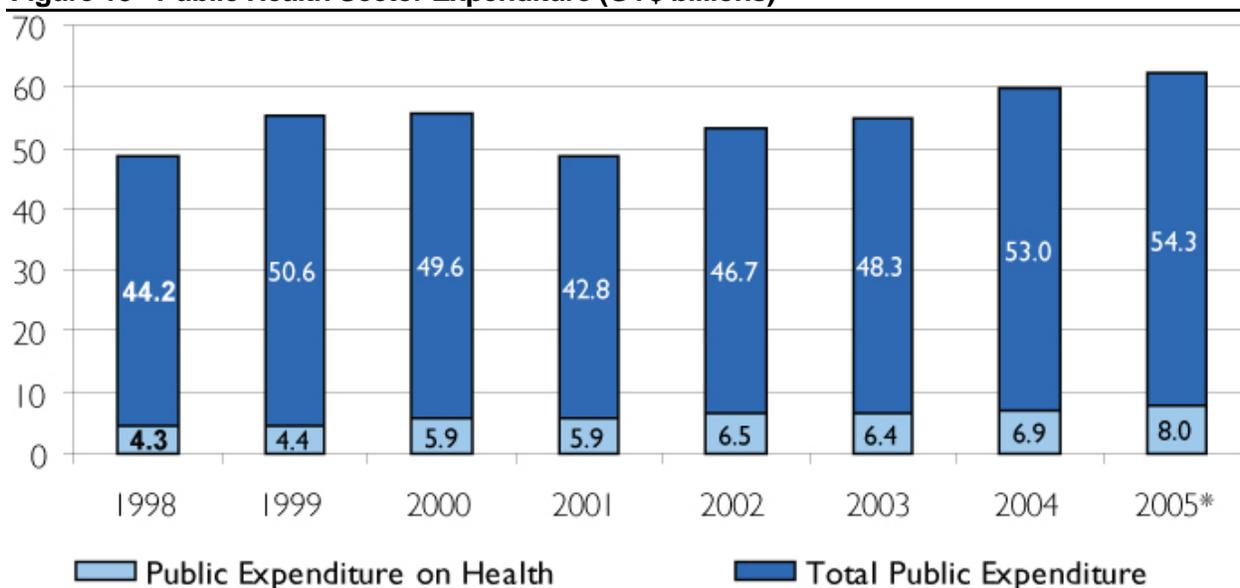
Source: WHO, National Health Accounts, 2006 and Ministry of Health, 2006

*Estimate based on recent conversations with Minister of Health (June, 2006) and trends in economic data in recent years.

Figure 15 below graphically illustrates the fluctuations in public sector funding presented in Table 9. Evidently, public sector funding has gradually increased, with a slight dip in 2001 and some slowdown in 2002 and 2003. Despite these slowdowns, recent expenditures began to accelerate more rapidly beginning in 2004 and continuing into 2005.

⁵⁸ MOH, 2003.

Figure 15 - Public Health Sector Expenditure (GY\$ billions)



Source: WHO, National Health Accounts, 2006 and Ministry of Health, 2006

*Estimate based on recent conversations with Minister of Health (June, 2006) and trends in economic data in recent years.

The public health sector generates insignificant revenues. As mentioned above, revenue generation from user fees and sale of services is minimal. Further, funds allocated from the National Insurance Scheme (NIS) represented only 4% of overall health resources in 1999, with the vast majority of NIS contributions accounted for by pension spending.

Overall, health spending is estimated at less than US\$60 per capita (US\$42 in 1997) below health spending of developed and Caribbean countries with the exception of Haiti. The World Bank estimates the cost of an essential public health clinical service package at US\$12 per capita for low-income countries and US\$22 for middle-income countries. In other words, Guyana appears to have the funds to cover primary health care needs but, current data does not clarify the proportion of funds that are channeled into primary health care.

The extent to which the resources described above flow into the provision of FP services is unclear. Nevertheless, data for 1999 indicates that 34% of resources were allocated to primary health care and primary level facilities. This translates into approximately US\$13.6 per capita spent on primary health care, US\$1 below the estimated 1998 cost of a basic health package (US\$ 14.6 per capita).⁵⁹ Recent HIPC resources have increased the proportion of financing channeled into primary care since 1999 yet, up-to-date data are currently not available to assess whether these are sufficient funds to cover the needs of the population today.

Although data is not available about funds channeled into primary health care or FP, the MOH was able to provide recent expenditure data for the procurement of contraceptives. According to the MCH Officer, US\$366 thousand (GY\$68 million) were spent on contraceptives in 2005, suggesting that approximately 4% of health commodity expenditures (US\$9.8 million or GY\$1.8 billion) went towards contraceptives in Guyana in 2005.⁶⁰ In regards to public sector coverage of the contraceptive market, the most recent data available is from 1991-92 and suggests that 59% of all contraceptive clients were obtaining their methods

⁵⁹ PAHO and WHO, 2003.

⁶⁰ These numbers are based on conversations with the Minister of Health in June 2006.

from the public sector at this time.⁶¹ Unfortunately, no recent data is available to determine whether the public sector continues to cover this proportion of users today.

Finally, no single management unit has overall authority over the financial resources allocated to health. Public sector reform has resulted in the MOH moving from line item budgeting to program budgeting since 1997/98. According to the National Health Plan, this has facilitated the costing of health programs and has given managers more control over resources for their programs. For the most part, however, budgets remain allocated on a historical basis, and no system has been implemented to allocate new resources to priority areas.⁶²

If MCH were to plan to maintain adequate stocks, scale-up provision of services, or institute programs that create demand for contraceptives, resource allocation decisions would have to be based on future need rather than past expenditures. Steps would have to be taken to justify an increase in funding to adequately cover future FP needs.

PRIVATE SECTOR

During the 1980s, the Guyanese economy slowed, leading to deteriorating public health facilities and a growing gap between the supply and demand for health services. Private sources of financing and private provision of services developed because of the government's inability to meet all the health needs of the country and the ability to pay of the middle and high-income segments of the population, for more specialized services.

Reliable information is not generally available on private health expenditures. Studies are carried out infrequently, and secondary sources of this type of information are not readily available. Nevertheless, WHO estimates that the only component of private expenditure is out-of-pocket payments by households for private health care – about 16% of total health expenditure in 2004.⁶³

Historically, additional private sector funds helped fund the health sector. Some employers arranged medical coverage for their employees through direct provision of health services or through non-contributory medical schemes. In addition, in 1997, corporate health expenditures were estimated at about 4.8% of overall health financing. Recent interviews with various health sector representatives suggest that corporate contributions to health financing may have decreased in recent years as many corporations have suspended the provision of health services due to economic constriction. Finally, private individual and group health insurance represented less than 1% of health resources in 1997 and, most likely, continue to represent a relatively insignificant proportion of private health expenditures today.⁶⁴

Finally, in regards to FP, there is no recent data illustrating the proportion of the contraceptive market covered by the private sector. The most recent data available suggests that 39% of all contraceptives clients obtained their contraceptives from the private sector in 1991-1992.⁶⁵ Although there is no current data available these methods were most likely paid for by households at the time of the study and continue to be financed by individual out-of-pocket expenses today. The following section provides some basic information about household expenditures in recent years.

HOUSEHOLDS

As mentioned above, household out-of-pocket expenditures account for most or all private sector expenditures in Guyana. In recent years, WHO estimates that the proportion of household expenditures

⁶¹ Jagdeo, 1993.

⁶² MOH, 2003.

⁶³ WHO, 2006.

⁶⁴ Ministry of Health, 2003.

⁶⁵ Jagdeo, 1993.

has not varied significantly hovering around 17% since 1998 (see Table 10).⁶⁶ Much of these expenses are funded from informal income from overseas remittances, estimated at approximately US\$150 million in 2003.⁶⁷

Table 10 - Household Proportion of Total Health Expenditure

1998	1999	2000	2001	2002	2003	2004
17.25%	17.23%	15.55%	17.38%	16.86%	17.43%	16.45%

Source: WHO, National Health Accounts, 2006

According to the Household Income and Expenditures Survey in 1992, average per capita health expenditures were GY\$465 per month. Spending ranged from GY\$264 for the bottom-decile income group to G\$1,252 for the top decile. These expenditures varied according to geographic location: medical expenditures accounted for 2.05% of total household expenditures in rural and 2.34% in urban households. Furthermore, out-of-pocket expenditures for medical products constituted about 57% of total household health expenditures. Spending for hospitalization and related care were 10% of household health expenditures, but spending was concentrated among families living in urban areas where private hospitals are located.

Finally, the 1999 Guyana Survey of Living Conditions indicated that 2% of monthly household expenditure was spent on medical and health services, the same percentage as found in the Household Income and Expenditure Survey of 1992/1993.⁶⁸ Clearly, more up-to-date data would provide highly valuable information on recent trends in household spending and the characteristics of the populations that have an ability to pay for health services.

Unfortunately, no current data is available describing the extent to which households are financing their own family planning needs, by purchasing contraceptives at the pharmacy or attending private clinics. As mentioned above, at least 39% of contraceptive users were obtaining services from the private sector in the early 1990s. As a result of increased remittances and some gradual improvement in economic conditions since the 1990s, it is likely that the number of users obtaining services from the private sector may have increased beyond the 39% recorded in 1991-92.

FORECASTED NEEDS

The following section provides a forecast of future contraceptive users and associated financial requirements to cover these needs in years to come. The data for this section has been drawn primarily from the National Forecast prepared in early July, 2006. Please refer to Annex 2 for a detailed explanation of the methodology used for the forecast.

ESTIMATED CONTRACEPTIVE USERS

Tables 11 below provides the estimated number of modern method users in the entire country, for women in union of reproductive age (ages 15 to 49) plus sexually active unmarried women for the next several years.

⁶⁶ WHO, 2006.

⁶⁷ Orozco, 2004.

⁶⁸ PAHO and WHO, 2003.

Table 11 - National Estimated Total Modern Method Users (WRAInU & Sexually Active Unmarrieds)

Total Users (WRAInU + Sexually Active Unmarrieds)	2005	2006	2007	2008
Pills	17,757	17,899	18,042	18,185
IUDs	9,087	9,163	9,240	9,318
Injectables	6,392	6,441	6,490	6,539
Condoms	14,901	15,016	15,133	15,250
Implants	1,489	1,502	1,514	1,527
Sterilization (M&F)	6,492	6,548	6,603	6,660
Other (foam, jelly, diaphragm)	540	544	548	553
Total Users	56,660	57,113	57,570	58,031

Table 12 below provides the estimated number of modern method users only in the public sector (MOH), for women in union of reproductive age plus sexually active unmarried women (ages 15 to 49). Table 12 assumes that approximately half of all users are obtaining methods from the public sector, based on a combination of historical data (58.7 MOH in 1991-92)⁶⁹ and MOH new and continuing acceptor data from 2005.

Table 12 - MOH, Estimated Total Modern Method Users (WRAInU & Sexually Active Unmarrieds)

Total Users (WRAInU + Sexually Active Unmarrieds)	2005	2006	2007	2008
Pills	12,407	12,508	12,610	12,712
IUDs	733	738	744	750
Injectables	7,444	7,505	7,566	7,627
Condoms	7,521	7,579	7,638	7,697
Implants	64	65	65	65
Sterilization (M&F)	Not estimated	Not estimated	Not estimated	Not estimated
Other (foam, jelly, diaphragm)	160	161	162	163
Total Users	28,330	28,556	28,785	29,015

ESTIMATED TOTAL CONTRACEPTIVE REQUIREMENTS

Table 13 below provides the *national* annual contraceptive needs for the years 2006 - 2008, using standard usage rates per method. These are annual total national requirements, without accounting for special conditions such as current stock levels, safety stock replenishment, or lead times associated with obtaining future stock.

⁶⁹ Jagdeo, 1993.

Table 13 – National Contraceptive Requirements, 2006-2008

Total Contraceptives (WRA in Union + Sexually Active Unmarrieds)	2006	2007	2008
Pills	268,484	270,623	272,781
IUDs	2,618	2,640	2,662
Injectables	25,763	25,958	26,156
Condoms	1,801,971	1,815,906	1,829,954
Implants	429	433	436

Table 14 below provides the *public sector* annual contraceptive needs for the years 2006 - 2008, using standard usage rates per method. These are the annual total MOH requirements, without special conditions such as safety stock replenishment. Current stock-on-hand or lead times are also not taken into account by these estimated amounts.

Table 14 – MOH Contraceptive Requirements 2006-2008

Total Contraceptives (WRA in Union + Sexually Active Unmarrieds)	2006	2007	2008
Pills	187,620	189,144	190,681
IUDs	738	744	750
Injectables	30,019	30,263	30,509
Condoms	909,526	916,566	923,663
Implants	19	19	19

MOH FINANCING REQUIREMENTS

The following section translates the estimated contraceptive requirements provided above into financial terms. In addition to the cost of procurement, the MOH must consider the costs of supply chain management, such as distribution, transportation, storage, and information management. Furthermore, as discussed throughout this report, the current FP program is struggling with a multitude of challenges that require immediate attention. In order to improve these various elements, MCH must plan for additional funding to, not only cover the procurement of contraceptives, but ensure that all clients of the MOH are able to choose, obtain and use contraceptives when they need them.

CONTRACEPTIVES PRICES

The price paid for contraceptives directly affects CS by limiting or expanding the number of contraceptives that can be procured with a restricted budget. During a recent procurement and pricing study carried out in 14 Latin American countries, contraceptive prices were collected to get a sense of the amount being paid by public, non-profit and private individuals for contraceptives. Table 15 below provides some basic data collected for this study as well as recent prices obtained in Guyana while gathering data for this assessment.

Table 15 - Unit Price for Contraceptives in Guyana, by Source (US\$), 2006

Source	Pill Norgestrel 0.30 mg + Ethinyl Estradiol 0.030 mg	Pill Levonorgestrel 0.15 mg + Ethinyl Estradiol 30 mcg	Injectable (3 months)	Injectable (2 month)	Injectable (1 month)	Condom	IUD
CIF Price							
UNFPA ¹	0.28	0.28	0.73	1.195	0.72	0.04	0.24
Wholesale Price							
Local Price (Emergency Order) ²	8.15	2.42	7.16	3.95	2.33	0.39	5.25
Average Wholesale Price (LAC) ³	N/A	3.41	5.43	4.65	N/A	0.49	4.26
Retail Price							
Average Pharmacy Price (LAC) ⁵	N/A	4.86	10.15	6.69	N/A	0.61	8.68

¹ Reference prices recently given to the MCH Officer by UNFPA in June 2006. These prices do not represent an exact quote.

² Wholesale prices obtained for the emergency order placed through New GPC in March, 2006.

³ Average wholesale prices from 9 LAC countries. Data was collected in December - April, 2005 for the LAC Regional Procurement Options Study.

⁵ Average prices paid by individuals when purchasing contraceptives at the pharmacy level in 9 LAC countries. Data was collected in December - April, 2005 for the LAC Regional Procurement Options Study.

The first two sections of the table above demonstrate significant variation between local wholesale prices paid by the MOH and prices that can be obtained through UNFPA. By procuring for many countries at once and guaranteeing larger volumes, UNFPA obtains significantly lower prices than local suppliers and other international sources. The third section of the table provides average retail prices paid by individuals who purchase their own contraceptives from pharmacies.

ESTIMATED PROCUREMENT COST

In Table 16, the annual MOH contraceptive requirements are converted into financial terms (US\$) for the years 2006 - \$167,292, 2007 - \$112,407, and 2008 - \$113,302, utilizing UNFPA reference prices provided to the MCH Office in June, 2006. These prices may vary once the MCH Office receives an official quotation from UNFPA and the final product list is defined. This table also adds an estimate of safety stock replenishment at the central level, which is assumed to occur in late 2006.

In addition to the cost of commodity, UNFPA charges a 5% administration fee that should be considered when budgeting for the total cost of procurement. The added costs of distribution, transport, and storage should also be taken into consideration when budgeting for procurement. Furthermore, the estimate below provides financial requirements for procuring a limited list of contraceptives. For instance, the consultants only include the cost of procuring a three month injectable, rather than including the one or two month options. The total cost of procurement would significantly increase if the one month injectable is added to the product list. Additionally, the cost of procuring other RH products has not been estimated and should be considered when preparing a complete procurement plan.

Table 16 – Ministry of Health Contraceptive Requirements and Estimated Cost at UNFPA Prices, 2006 - 2008 (Including Safety Stock Replenishment in 2006)

	2006	2007	2008	2006 Estimated Cost (US\$) at UNFPA Prices (CIF)	2007 Estimated Cost (US\$) at UNFPA Prices (CIF)	2008 Estimated Cost (US\$) at UNFPA Prices (CIF)
Pill Requirements	187,620	189,144	190,681	\$52,534	\$52,960	\$53,391
Safety stock for MMU	93,810	0	0	\$26,267	\$0	\$0
Subtotal MOH	281,430	189,144	190,681	\$78,800	\$52,960	\$53,391
IUD Requirements	738	744	750	\$177	\$179	\$180
Safety stock for MMU	369	0	0	\$89	\$0	\$0
Subtotal MOH	1,107	744	750	\$266	\$179	\$180
Injectable Requirements	30,019	30,263	30,509	\$21,914	\$22,092	\$22,272
Safety stock for MMU	15,010	0	0	\$10,957	\$0	\$0
Subtotal MOH	45,029	30,263	30,509	\$32,871	\$22,092	\$22,272
Condom Requirements	909,526	916,566	923,663	\$36,381	\$36,663	\$36,947
Safety stock for MMU	454,763	0	0	\$18,191	\$0	\$0
Subtotal MOH	1,364,289	916,566	923,663	\$54,572	\$36,663	\$36,947
Implant Requirements	19	19	19	\$513	\$513	\$513
Safety stock for MMU	10	0	0	\$270	\$0	\$0
Subtotal MOH	29	19	19	\$783	\$513	\$513
Total MOH				\$167,292	\$112,407	\$113,302

Notes on Table 16:

1. The cost estimates in Table 16 do not include UNFPA's 5% administrative fee.
2. The quantities forecasted for both IUDs and implants are extremely low. Before orders are placed for these contraceptives, the consultants would suggest the MCH Office (or their designee) perform a quick survey of the sites that commonly use these products to determine their needs for the coming period (and existing stocks). In addition, if ordered through UNFPA, they may have minimum order levels based on the sizes of the packing boxes.
3. Table 16 estimates the additional cost of replenishing the supply chain with safety stock at the central level (MMU) only. These estimates do not include safety stock replenishment at the regional levels. The

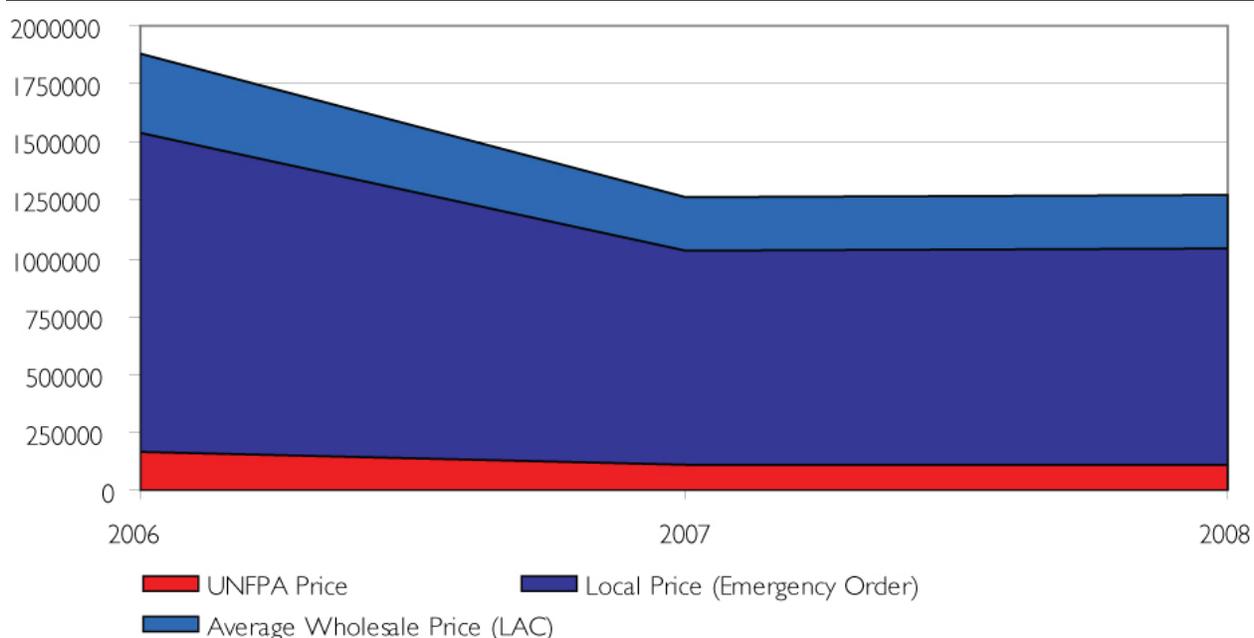
consultants recommend additional safety stock replenishment (4 months) at the regional level if, and when, regional warehouses serve as a storage level within the supply chain distribution system.

It is also important to note that although products have been recently procured from New GPC, there will, most likely, be a short-term need for additional pills, condoms, and injectables before products can be procured from, supplied to, and shipped by UNFPA. Based on yearly estimates provided above, the limited amount of contraceptives procured through New GPC will most likely be consumed in less than one month for pills and condoms and within a three months for injectables. Given various constraints such as the time it takes until funds are available, orders are placed, orders are finalized, products are manufactured and shipped, duties are paid, customs clearance is performed, products are inventoried by the country’s central warehouse, and products are distributed to health facilities, it is very unlikely these products will cover the needs of the public sector until UNFPA supplies arrive in Guyana, are moved to service delivery points, and are available for clients. Assuming there is no additional stock on hand available throughout the supply chain, the MOH will need to address these short-term needs immediately.

POTENTIAL FINANCIAL SAVINGS

According to the estimates provided above, Figure 16 below illustrates the cost of procuring contraceptives through various suppliers. The financial requirements for 2006 are greater than subsequent years due to the estimated cost of replenishing the pipeline with safety stock due to recent stock-outs throughout the supply chain.

Figure 16 – MOH Financial Requirement for Procurement of Modern Methods by Local and UNFPA Prices (US\$)*



	2006	2007	2008
UNFPA Price	\$167,292	\$112,407	\$113,302
Local Price (Emergency Order)	\$1,541,353	\$1,035,778	\$1,044,059
Average Wholesale Price (LAC)	\$1,877,401	\$1,261,596	\$1,271,676

*UNFPA: Reference prices recently given to the MCH Officer by UNFPA in June 2006. These prices do not represent an exact quote. Local Price (Emergency Order): Wholesale prices obtained for the emergency order placed through New GPC in March, 2006. Average Wholesale Price (LAC): Average wholesale prices from 9 LAC countries. Data was collected in December - April, 2005 for the LAC Regional Procurement Options Study.

Based on prices obtained from the MCH Office, local purchases are dramatically more expensive than accessing the prices available to UNFPA. As mentioned previously, by procuring large volumes of commodities on behalf of countries all over the world, UNFPA accesses global economies of scale. According to these figures, procurement will cost the MOH approximately ten times less if GOG were to use UNFPA as a procurement agent rather than to continue to procure from local suppliers. In other words, the MCH Office would be able to procure enough contraceptives (including safety stock) to supply the entire country for a year for less than half of what was spent in 2005 (i.e. US\$167 thousand versus US\$366 thousand).⁷⁰

Although these represent significant savings, additional administrative costs must be taken into consideration in order to ensure an adequate supply of contraceptives in future years. Perhaps these substantial savings could be used to help fund the additional cost of transportation, storage, and supply chain management and avoid some of the stock-out problems that have occurred in the past.

In addition, if the MOH opts to procure through UNFPA, various planning measure must be taken into consideration. For instance, as mentioned above, the MOH will, most likely, need to obtain contraceptives, from another source, to cover the lead times associated with ordering through UNFPA. Secondly, one of the more difficult requirements of the UNFPA agreement is that the MOH must transfer the entire payment for contraceptives being purchased prior to procurement. Following the transfer, UNFPA proceeds with the procurement. The political will and fiscal ability to commit the necessary sums of money upfront for contraceptives is necessary in order to enter into a successful arrangement with UNFPA.

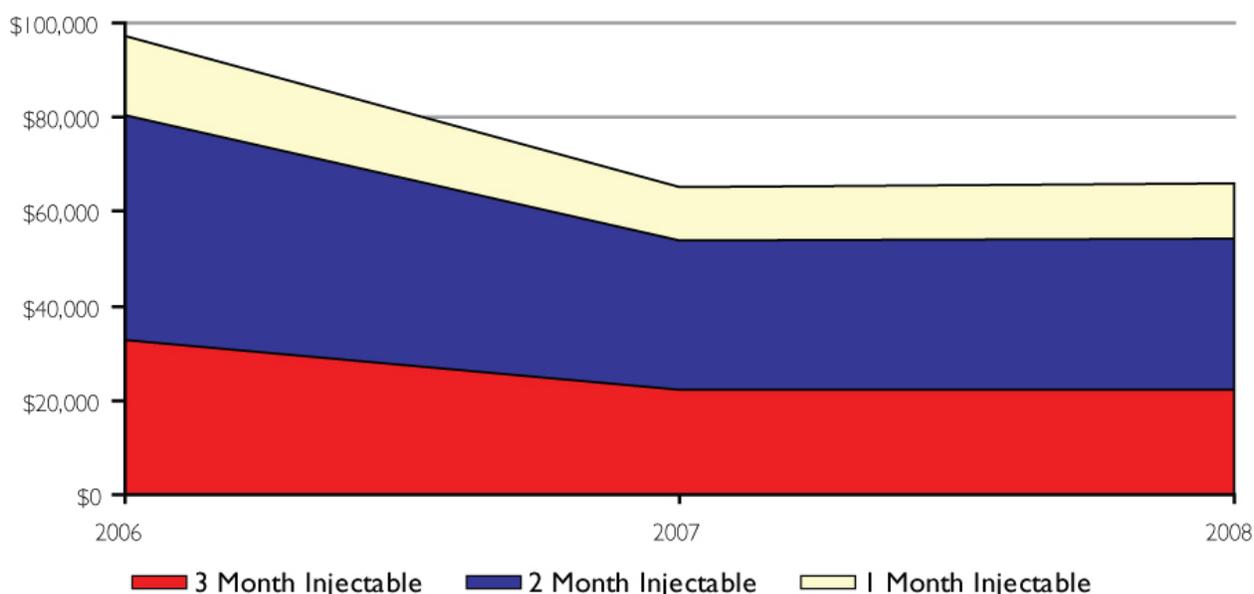
Figure 16 also illustrates that New GPC is able to obtain wholesale prices that are competitive in the Latin American and Caribbean Region. The cost of procuring from New GPC is slightly lower (22%) than average wholesale prices in nine Latin American countries. Unfortunately, although these prices are competitive in the region, they do not compare with the international prices that UNFPA can access on behalf of Guyana. Despite this price difference, New GPC may be the best option for providing additional emergency commodities until new products can be obtained from UNFPA.

In addition to savings that could be obtained by procuring through UNFPA, the following Figure 17 illustrates the difference in cost of procuring a three month injectable than the two and one month options, at UNFPA prices. Currently, the MOH is procuring one month, two month and three month injectables. Figure 17 illustrates that the one and two month injectables cost the MOH significantly more (two to three times) to procure than if the MOH were to only purchase the three month option. In other words, the three month injectable is the most economical option for the GOG, especially given recent issues with stock-outs of injectable contraceptives. For instance, in the case of one month and three months injectables, the cost difference for the MOH is considerable. At current UNFPA prices, Norigynon (one month) is US\$.72, 12 times per year for a total of \$8.64, whereas Megesteron (3 month) would be US\$0.73, 4 times per year for a total of \$2.92, a difference of US\$5.72 per user. The MOH might consider letting the private sector take care of the demand for one month or two month injectables, recognizing that not all Guyanese have access to the private sector. If the MOH were to move towards only procuring the three month injectable, savings could be used to help fund supply chain management strengthening to ensure that the products are getting to the clients that need them.

On the other hand, the current breadth of injectables provides expanded choice for women obtaining products from the public sector, an important aspect of CS. If additional funds are available to procure these various options in addition to funding the cost of effectively distributing these commodities at all levels, the MOH could consider continuing to provide some expanded options to their clients.

⁷⁰ Figures obtained from the MCH Office in June, 2006.

Figure 17 – MOH Financial Requirement for Procurement of Injectables by UNFPA Prices (US\$)



	2006	2007	2008
3 Month Injectable	\$32,871	\$22,092	\$22,272
2 Month Injectable	\$81,175	\$54,536	\$54,958
1 Month Injectable	\$97,262	\$65,368	\$65,900

DIVERSIFIED FUNDING SOURCES

Diversifying funding sources requires several components. Policymakers need to understand what the total needs of their population are. They need to understand the purchasing power of different households, what the national and local government budgets can afford, and what the local private sector can do to maximize domestic sources of revenue. They then need to estimate what share these domestic sources can fund and what external support might be required. Donors need to recognize that national budget constraints and weak local purchasing power will continue to constrain many countries' ability to self-finance their contraceptive needs. Even in some middle income countries, donor support will continue to be necessary for many years to come. Stakeholders need to develop consensus on these issues and develop national financing strategies that both set funding targets and identify actions to ensure the public, private, and donor community can reach those targets.⁷¹

As mentioned throughout this section, a multitude of funding sources in Guyana help cover the FP needs of the entire population. Some individuals have the ability to pay and prefer to obtain their services from the private sector. Others are not in the same economic position and thus must rely on the public sector to provide for their needs. The recent investment of HIPC funds in primary care services is one of the creative ways that Guyana has begun to care for these more isolated and difficult to access populations. In addition, gradual economic growth has steadily increased the amount of financing available through taxes that help cover the services provided by the public sector. Nevertheless, careful coordination must take place to ensure these additional funds are channeled to those who need them the most.

Furthermore, these funds will need to be managed more efficiently to stretch limited budgets further and make immediate improvements towards guaranteeing Contraceptive Security in Guyana. For instance, procurement through UNFPA could free up substantial funds to help improve the provision of family planning services into the future. The following recommendations provide various ideas for strengthening the supply chain and taking steps toward improving Contraceptive Security in Guyana in the coming years.

RECOMMENDATIONS

CONTEXT

Recommendation #1: Contraceptive demand and use analysis - As soon as results from the 2006 UNICEF-sponsored Multiple Indicator Cluster Survey are released, the Ministry should update its contraceptive demand and use analysis to assist in planning family planning program efforts. Key new elements will include method mix, contraceptive prevalence rate, and estimated unmet need.

Rationale: This new information will help reveal whether historic trends are continuing into the present. Historic data shows that CPR slowed down in the 1990s, certain groups of users had higher CPR than others, and that method mix is changing due to modified preference and/or changes in capacity of different facilities to provide services. Historic data provides no understanding of unmet need and whether certain subgroups have higher unmet need than others (ethnic group, age cohort, education level, geographic location and wealth quintile). The new MICS will provide data that will define the current situation and help understanding of changes that have taken place since 2001. By analyzing data by subgroup, the MCH Office can use these results to identify vulnerable groups and implement measures to ensure that these groups have the knowledge and access necessary to obtain and use the FP methods they need. In addition, the new MICS includes open-ended questions that may help identify and explain barriers to contraceptive access. These qualitative results should be compiled, analyzed, and used to assist future programming decisions.

Recommendation #2: Need for data on the state of the reproductive health/family planning program - There is a tremendous need for current data on the state of RH/FP in Guyana (key indicators). The MOH is strongly encouraged to seek support and assistance for a comprehensive survey related to RH/FP, such as a Demographic and Health Survey (DHS) or similar study.

Rationale: Although the 2006 MICS will provide basic data (CPR, method mix, and unmet need), other information is needed, particularly regarding private sector use, contraceptive sources, CPR details by location and subgroup, barriers to access, etc. For instance, recent surveys have not provided information about where users are obtaining services and supplies (public sector versus private sector).⁷² This data is essential for estimating total number of FP users, understanding how these users are behaving, determining whether or not different sectors are providing adequate services to these users, and exploring options for coordinating provision of services between providers. Moreover, new data is needed to explore why fertility rates remain low despite an apparent slowdown in contraceptive use. In other words, if contraceptive use remains low, abortion rates or use of traditional methods may be higher than past estimates suggest. A comprehensive DHS or similar survey will help answer questions surrounding current data and provide the context needed to assess whether Guyanese families are obtaining the FP services they need and where the MCH can focus resources in the future.

SERVICE DELIVERY

Recommendation #3: EHSP, STGs, and the EDHC List - The Ministry should consider taking a more comprehensive approach to developing an essential health service package, standard treatment guidelines (STGs) for all MOH services, and an essential drug and health commodities list(s). Family planning should be included in this process, and a range of contraceptives should be part of the final EDHC List.

⁷² The 2006 MICS will not gather this information either.

Rationale: The Ministry has completed preliminary work on an essential health services package, titled the “basic package of publicly guaranteed health services”, and several donors are currently supporting STG development for individual programs. The essential drug list has also been recently revised. The consultants strongly recommend the Ministry consider organizing a more comprehensive approach to developing these guidelines [EHSP => STGs => Essential Drug and Commodity List (EDHC List)] to ensure these products are fully coordinated and integrated between and amongst programs. This effort, while not small, can provide synergistic benefits for quality of care and drug management that cannot be gained from a series of small, independent efforts.

Recommendation #4: Youth awareness and counseling programs - The Ministry and GRPA should continue developing youth awareness and counseling programs (including contraceptive use), implement creative measures to reach adolescents, and ensure young people are obtaining the information and contraceptive methods they need.

Rationale: Family planning use reduces unintended and unwanted pregnancies. Unwanted pregnancies are far more likely to end in induced abortion, and are far less likely to receive adequate prenatal care, than wanted pregnancies. In 2004, abortions accounted for almost one fifth of all pregnancy-related deaths in Guyana. Currently, adolescent girls are using contraceptives at a much lower rate than their older counterparts (26% versus 38%). The fact that many adolescents are sexually active, are not getting counseling, and are often not using contraceptives, puts them at serious risk of unwanted pregnancy. Special programs that provide counseling and FP services to young women and men can reduce gaps in usage rates between age groups and lessen negative consequences of unwanted pregnancy and unsafe abortion.

ENABLING ENVIRONMENT

Recommendation #5: Creating an RH/FP Coordinating Committee - The MOH would benefit from developing a functioning multisectoral, multipartner RH/FP Coordinating Committee as a mechanism for improving information sharing, data collection and analysis, problem-solving, reporting, and quality of care issues among FP providers and support entities [such as the MMU, UNFPA, other donors, and donor projects (SCMS)].

Rationale: In an effort to improve and focus the provision of services, many countries have formed coordinating bodies to enhance collaboration and data and information sharing. The GOG has already taken steps towards gathering information to help inform a Coordinating Committee, as the 2006 MICS will provide useful information about behavior and preferences of different subgroups. Future studies might then couple this data with analyses of the major providers and the subgroups they are currently serving. This body could then take steps to better coordinate the types of services offered and clients served by each provider.

For example, in order to maintain a healthy and growing private sector that can alleviate demands on the limited resources of the public sector, free or subsidized commodities can be targeted to low-income and hard-to-reach populations. Meanwhile, with lower commodity prices and savings from more streamlined procurement, NGOs and the private sector can help cover contraceptive needs in a cost-efficient manner so that those individuals with a greater ability to pay would begin to look to these other providers for their commodities. By implementing coordinated strategies, leaders in each of the subsectors – public, NGO, and commercial, providers maximize resources and expand market share for each subsector.

Recommendation #6: Strengthening MCH program monitoring and evaluation systems and outputs - The MCH Office should develop stronger program monitoring and evaluation systems and outputs. As an MOH program, family planning should have defined targets, priority activities, a quality assurance program, standards and guidelines, and basic indicators for monitoring results, as well as the

staff to manage these activities. The MOH should consider prioritizing RH/FP by appointing a RH/FP Team Leader responsible for carrying out the planning and monitoring activities mentioned above.

Rationale: While some of these elements do exist, the consultants did not observe that the family planning program is being given priority attention and did not find evidence of well defined and published FP targets or indicators. Although MOH personnel shortages have likely contributed to this problem, as have the lack of reliable program and survey information, the Ministry's family planning program outputs and outcomes can likely be improved with planning, structure (SOPs, etc.), skills development and training, and direct attention. Such willingness to raise family planning in terms of priorities will go a long way towards rebuilding the program and improving the health of Guyanese families. In addition, the MOH could further promote family planning by appointing a Reproductive Health/Family Planning Team Leader who will lessen the burden on the MCH Office Head and help realize the public sector's maternal and child health care goals.

SUPPLY CHAIN MANAGEMENT

Recommendation #7: MCH needs to assess its information management needs and results - The MOH/MCH Office should, as a matter of course, review its options for the management of HMIS and LMIS data (see also Recommendation #8). Collection and aggregation roles are currently contracted out to GRPA. These options include continuing with the status quo, moving these tasks to the MOH statistics department, moving them to the MMU, integrating them back into the MCH Office, and outsourcing through a formal bidding process. In the coming months, the MCH Office should review and update its information management requirements and results.

Rationale: The management of any health program requires that program managers know where they are trying to go (strategies, targets) and where they are in relation to these goals and objectives (monitoring and evaluation of program indicators). Essential program data must be collected, summarized, adjusted, and analyzed before a comparison can be made between targets and results.

Recommendation #8: Developing a system for obtaining contraceptive logistics data - The MCH Office, in coordination with the Regions, the MMU, and the MOH leadership, needs to ensure that an adequate logistics management information system (LMIS) is put in place for recording, reporting, and ordering of contraceptives and FP/RH related products. While it is preferable that these products be incorporated into the comprehensive drug management system, in the absence of an MOH-wide solution, the MCH Office has a responsibility to ensure that the FP program and Regions can obtain timely and accurate LMIS data to plan appropriately and avoid stock-outs. With the USAID-sponsored Supply Chain Management project in Guyana as a technical resource for MOH supply chain issues, it is hoped they can assist the MOH in improving the LMIS for all commodities, including RH/FP related products.

Rationale: Collecting, reporting, and aggregating contraceptive consumption and stock data are vital elements of annual forecasting and procurement processes. Facility data on use and remaining stock allows for easy analysis of the current situation and future needs. As a reporting habit already exists, an effort to revise (and simplify) the forms and strengthen the reporting system could considerably improve the usefulness of data obtained from the current system, potentially with little cost. Additional steps, such as developing standard operating procedures (SOPs), providing training in the new system, and combining reporting of essential logistics data (consumption, stock-on-hand, and losses/adjustments) with ordering, will take more time and effort but also needs to be addressed in years to come.

Recommendation #9: Strengthening the Ministry's health commodity supply system - The Ministry's supply system continues to need improvement. The supply system, and corresponding LMIS, are inconsistent and lack standardization. In addition, family planning products need to be more fully integrated into the MMU supply chain, so that the distribution system ensures product availability for all drugs and health commodities, including contraceptives. As noted above, the consultants encourage the

Ministry to take full advantage of the USAID-sponsored Supply Chain Management project as a technical resource for supply chain and LMIS issues.

Rationale: While some improvements in forms and data collection and reporting procedures have been implemented in recent years by MMU, there is room for further improvement in the LMIS for drugs and health commodities. The distribution system also remains somewhat disjointed, as there is considerable variation in the second level (some Regional warehouses, some hospitals used as warehouses, and some Regions providing transit only) and transport is a mix of delivery and collection, depending on the Region/location. For a commodity logistics system to be effective, it needs a solid design, roles and responsibilities that are clear and reasonable, and consistency in terms of information and response.

Recommendation #10: Annual forecasting of contraceptive needs - The MOH is encouraged to develop an annual contraceptive forecast each year ahead of the GOG budgeting process. The forecast should use the best demographic and program data available until there is an adequate system for collecting and summarizing contraceptive logistics data (consumption and stock-on-hand). The use of consumption data is the preferred forecasting method.

Rationale: The consultants prepared a forecast of contraceptive needs for 2006 to 2008 based on demographic and programmatic information (see Annex 2). However, due to the limited data, the Ministry is strongly encouraged to revise this forecast when new data is available (e.g. 2006 MICS or another health and family planning related survey).

Recommendation #11: Contraceptive safety stocks, procurement lead times, and the GOG/MOH budget cycle – During each contraceptive procurement cycle, the MOH must plan for supplier procurement and shipping “lead times” (UNFPA or other); add time for product testing and customs after arrival; accommodate the GOG/MOH budget cycle schedule into its calculations (timing for budget allocations and release of funds), and consider safety stock replenishment. A preliminary forecast, based on estimated needs for a future period, is likely to need various adjustments as a result of these factors.

Rationale: To ensure a more consistent contraceptive supply, the MOH needs to improve its procurement planning process. This includes understanding the procurement cycle, recognizing and incorporating lead times for procurement processing, shipping, product testing, and customs clearance, and matching the forecasting schedule with the GOG/MOH budget and fund allocation cycles. Factoring in these elements in procurement planning can greatly reduce the chances of significant stock-outs of key products.

Recommendation #12: One time safety stock replenishment of contraceptives at the Regional level – Within the forecast provided in Annex 2, quantity estimates are provided for contraceptive safety stock replenishment at the central level (MMU) in 2006. These estimates do not include the rebuilding of safety stocks at the Regional level (regional warehouses and/or hospitals where contraceptives are stored before moving to lower level facilities). The consultants recommend additional safety stock replenishment (3 to 4 months) at the Regional level as long as Regions remain part of the formal supply chain distribution system.

Rationale: It is always preferable for safety stock to be held as close to the user as possible, as this allows for short ‘replenishment’ trips if a facility is stocked out. However, because there is always a cost for holding supplies (warehouse space, staff, inventory costs, etc.); it is advisable to keep these amounts to a minimum. In addition, the more responsive the ordering-resupply process is, the less the need for holding safety stock at more than one level.

Recommendation #13: Procuring from the private sector – If the MOH elects to continue to procure contraceptives from local wholesalers, the consultants would recommend the MOH implement multi-year framework contracts with these suppliers. The benefits to the MOH are reduced lead times and improved product availability, as more of the burden of the procurement process is placed on the supplier/wholesaler.

Rationale: Framework contracts require suppliers to bring pre-selected products into the country in preparation for orders that have not yet been received. In return, the purchaser provides a longer contract term (generally two or three years), and guarantees that they will purchase a minimum amount over the period. When orders are actually made, the lead time is generally short because supplies are already “in-country”. As part of the contract, suppliers can also be asked to deliver the products to a range of sites, often beyond the central level.

FINANCING

Recommendation #14: Buying contraceptives from UNFPA – The consultants suggest that the MOH immediately seek to fully understand the terms, conditions, and limitations of working with UNFPA as a procurement agent, incorporate these parameters into their forecasting and procurement cycles, and finalize a procurement partnership with UNFPA for the foreseeable future.

Rationale: The MOH needs to identify a reliable, cost-effective and sustainable source of contraceptives for the long-term. Recent history suggests that even when utilizing a transparent and open competitive bidding process, local prices are high. The prices that can be obtained from UNFPA are far lower than any that can be obtained from local wholesalers and/or importers. In addition, UNFPA carefully screens suppliers, thus ensuring the products they offer are of acceptable quality. The value-added for the Ministry from this arrangement far outweighs any disadvantages.

Recommendation #15: Protecting and targeting public sector funds - Although Guyana has increasingly channeled more funds into primary care services, careful planning and coordination should take place to ensure some of these funds are targeted towards procuring contraceptives and strengthening priority programs, such as family planning.

Rationale: A multitude of funding sources in Guyana help cover the country’s FP needs however, the GOG does not guarantee funding to ensure annual strengthening of the RH/FP program. Instead, funding for family planning depends on the discretion of policy makers, the fiscal climate, perseverance of skilled advocates, and the level of historical expenditure. Ensuring CS in an environment of limited public sector resources requires that reproductive health and family planning be elevated in importance, particularly given its links to reducing maternal, neonatal, and infant mortality. Additional funds must be allocated for strengthening the supply chain, improving services, training staff, targeting vulnerable groups, implementing education programs, and carrying out other recommendations provided throughout this assessment.

For procurement specifically, cash flow and treasury management constraints can undermine the ability of the Ministry of Finance to make all necessary procurement funds available at one time. One of the more difficult requirements of the UNFPA agreement is that the MOH must transfer the entire payment for the contraceptives being purchased to UNFPA prior to the actual procurement. Following the transfer, UNFPA proceeds with the procurement. Political will and the ability to commit the necessary funds up front will be necessary to enter into a successful contraceptive procurement with UNFPA.

Recommendation # 16: Ensuring product availability through a fully operational and responsive logistics system - Quality health services require that appropriate drugs, medical supplies, and other commodities are available to providers at service delivery points (SDPs)⁷³. To the best of its capabilities, a Ministry of Health must therefore ensure that these products are available at the SDPs as they are needed by providers and clients. Product availability requires a fully operational and responsive logistics system with a reliable LMIS (see also Recommendation #9). The MOH needs to plan and budget for

⁷³ And that these providers use these products appropriately (see also Recommendation # 5).

additional operational and capital expenditures if they aim to upgrade their health commodity supply system (HCSS).

Rationale: Upgrading the MOH logistics systems will require a design process, staff training, new forms and procedures, new job descriptions, and new distribution capacity (storage and transport). The MOH needs to consider and plan for these additional costs, and should not expect that sufficient changes can be implemented without additional funding.

Recommendation # 17: Providing at cost (or free) contraceptives to public service organizations - If the MOH procures contraceptives from UNFPA, the consultants suggest that the Government/MOH also consider providing contraceptives at cost (or free) to former MOH hospitals (and other former MOH entities) and public-service oriented NGOs such as GRPA⁷⁴, FPAG, and church-affiliated clinics.⁷⁵

Rationale: MOH policy suggests that access to FP is deemed a right for all Guyanese, and that the Ministry of Health is the overseer of this mandate. With access to family planning often being defined by cost, it is in the public health interest to ensure that contraceptives are free or low cost, and that there are alternative service providers for the population to utilize. Unfortunately, as public sector hospitals become more independent, budget challenges often push them to make hard choices, and service compromises can result. With free or low cost products provided to them, the MOH can promote the continuation of family planning services within their outpatient clinics, thus making “one stop” shopping easier for women as they visit the hospital for their children or themselves.

In regard to GRPA and FPAG, both of the long-standing Guyanese family planning NGOs have been negatively affected by lack of planning and funding cuts by their parent organizations in the past year or two, and face severe challenges in the ongoing delivery of family planning services. With their clearly identified public-service oriented missions and long service records, the Ministry might consider “at cost” arrangements with these NGOs. With savings of 50 – 80% on contraceptive purchases, the benefit to these NGOs is clear; while the Ministry would benefit from quality service delivery alternatives and partnership with long-established, well-recognized organizations. If these organizations continue to buy from the commercial market, the consultants would suggest that the Ministry ensure they continue to be allowed access to the Ministry’s duty free concession for contraceptives and other products.

Recommendation #18: Increasing donor support in the short-term - Although the MOH indicates intent to fully funding the provision of family planning services, including supplying contraceptives and addressing recent problems with the supply chain, limited capacity at all levels and competition for resources suggest that the Maternal and Child Health Program could benefit from increased donor support in the short-term. Such support could help ensure that Guyana develops the capacity and focus to successfully sustain the family planning program in the years to come.

Rationale: Donors are often willing to provide financial and technical support to focused program improvement efforts. A two or three year “family planning program initiative” would create valuable focus and should provide enough time to address key issues. Such initiatives might focus on any of the following priority areas:

- logistics system strengthening (forecasting, procurement, distribution, inventory management, etc.),
- health and logistics information system (recording, reporting, streamlining, etc.) improvements,
- coordinating and funding of demographic, health and service-specific surveys,

⁷⁴ Due to internal policies regarding branded products, it is possible that GRPA might not accept such an offer.

⁷⁵ It is possible that this might require UNFPA approval.

- technical assistance for the development of national policies, standards, protocols, and guidelines such as STGs and essential drug lists,
- support to pre-service and in-service training and the institutions that train health professionals,
- direct budget support for other RH/FP program strengthening activities,
- funding and technical assistance for improving the quality of health facilities and services,
- the donation of commodities and equipment, including contraceptives and condoms, and
- addressing country-specific problems (such as the HR issues in the MOH in Guyana).

Recommendation #19: Cost-effective procurement of injectable contraceptives - If the budget for the procurement of contraceptives becomes a limiting factor at any time in the future, the MOH can consider procuring only 3-month injectables (Depo-Provera, Megesteron) and dropping the purchase of one and two month injectables (Norigynon and Noristerat respectively).

Rationale: As the main provider of low cost and/or free contraceptives, Ministries of Health need to find a balance between the resources they have available and the value-added for clients of having a range of products to choose from at Ministry facilities. This is often a difficult choice, as Ministry leaders must always keep in mind the fact that, in some locations, MOH facilities are the only accessible source of family planning services and products. See cost analysis on page 50.

OTHER

Recommendation #20 – Streamline data collection and reporting requirements at health facilities – The Ministry is strongly encouraged to collectively address the burden of time and effort that is being placed on health facilities by information collection and reporting requirements. An organized and coordinated effort to streamline HMIS and LMIS needs would greatly benefit managers and staff in hospitals, health centers, and health posts, allowing them to focus their collective energies on clinical and preventive care.

Rationale: During their visits to several hospitals and health centers, the consultants noticed that each of the various programs of the MOH has implemented its own information recording and reporting procedures. Clearly some of this information is used for program monitoring, annual reports, and other real and perceived ‘requirements’. However, it was also clear that the collective burden on health facility staff of information reporting is overwhelming. Service delivery would benefit greatly from a more streamlined and realistic set of reporting requirements and procedures.

Recommendation # 21 – Funding the essential health services package - If the Ministry accepts the concept of an essential health services package (see Recommendation #3), they should also commit to formally funding the approved health services package, including the implementation of standard treatment guidelines and essential drug and health commodities list. In this way, it will truly be a “basic package of publicly guaranteed health services”.

Rationale: This process, when well-designed and fully implemented, can have very positive impacts on the quality of services in MOH facilities and drug management. This is especially true in countries where providers, especially physicians, have been trained in many different countries and have varied ways of providing care and treatment. The essential drug and commodities list also strengthens the Ministry’s ability to use generic drugs, reduce the number of products being ordered and procured, and manage the distribution systems’ “throughput”.

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ANNEX 1

LIST OF INDIVIDUALS INTERVIEWED

Name	Institution & Comments	Title	Contact Information
Julia Rehwinkel	USAID	HPN Head	USAID/Guyana
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Dr. Leslie S. Ramsammy Sonya Roopnauth Dr. Janice Woolford Omar Shariff Kamene Seepaul Dr. Frank Anthony	Ministry of Health Maternal and Child Health Office Materials Management Unit Health Sector Development Unit	Minister of Health Permanent Secretary MCH/EPI Officer Director of Procurement and Materials Management Executive Director	Ministry of Health, Brickdam Georgetown, T 592-226-1560 F 592-225-4505 www.sdn.org.gy/moh
Dr. Burnadette Theodore-Gandi	PAHO/WHO	PAHO/WHO Representative	8 Brickdam, Georgetown T 592-225-3000 F 592-225-7316
Derven Patrick Shelia McDonald-Miller Patrice LaFleur	UNFPA	Programme Management Advisor (Jamaica) Operations Manager (Jamaica) Representative (Guyana)	42 Brickdam United Nations Place Georgetown, Guyana
Clarence Perry	USAID-Guyana HIV/AIDS Reduction and Prevention Program	Marketing and Distribution Manager	44 High Street, Kinston, Georgetown
June-Ann Fowler	Geddes Grant Guyana, Ltd.		
Bibi Shaw	Mike's Pharmacy Import and Export		
San San Min	USAID Supply Chain Management Project, Guyana	Resident Advisor	
Sandra Manickhan Gandhi	USAID Supply Chain Management Project, Annex Warehouse	Operations Manager	
Dr. Ranjisinghi Ramroop	New GPC, Inc.	Executive Chairman	238 Camp & Quamina Streets, South Cummingsburg, Georgetown

ANNEX 2

NATIONAL CONTRACEPTIVE FORECAST & RESOURCE ANALYSIS FOR 2006 – 2008

Ministry of Health

The Republic of Guyana

August 17, 2006

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During their visit from June 25 – July 1, 2006, the JSI/DELIVER consultants met with the following representatives of the Ministry of Health and other agencies and organizations. The consultants would like to thank each of them for the time and information they provided.

Dr. Leslie S. Ramsammy, Minister of Health
Sonya Roopnauth, Permanent Secretary, MOH
Dr. Janice Woolford, MCH/EPI Officer, MCH Office, MOH
Omar Shariff, Director of Procurement and Materials Management, Materials Management Unit, MOH
Kamene Seepaul, Materials Management Unit, MOH
Dr. Frank Anthony, Executive Director, Health Sector Development Unit, MOH
Frederick A. S. Cox, Executive Director, Guyana Responsible Parenthood Association
Dr. Kampta Prashad, Medical Director, Guyana Responsible Parenthood Association
Sheila Yaw Fraser, Guyana Responsible Parenthood Association
Arlene Harmon, M&E Specialist, Guyana Responsible Parenthood Association
Maureen Williams, Family Planning Association of Guyana
Dr. Ranjisinghi Ramroop, Executive Chairman, New GPC, Inc.
Derven Patrick, Programme Management Advisor, UNFPA, Jamaica
Shelia McDonald-Miller, Operations Manager, UNFPA, Jamaica
Patrice LaFleur, UNFPA, Guyana
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Nezamadeen Naresh, Pharmacist, I.P.A.
San San Min, USAID Supply Chain Management Project, Guyana
Sandra Manichkhan Gandi, Operations Manager, Annex Warehouse
Nurse Henry, Campbellville Health Center
Staff of Linden Hospital and One Mile Health Center, Region 10

SECTION I - National Contraceptive Forecast for 2006 – 2008

I. FORECAST OBJECTIVES AND DATA SOURCES

- a. The Maternal Child Health Office of the MOH (MCH/MOH), with the assistance of JSI/DELIVER, a USAID-funded project, has prepared a three (3) year national forecast for contraceptives for planning, advocacy, and resource mobilization purposes (2006-2008).
- b. The National *Population and Housing Census 2002* served as the primary data source for demographic data (base population, population growth rate estimate, male/female ratios by region, and women of reproductive age).
- c. The Guyana Multiple Indicator Cluster Survey, July 2001 (UNICEF/Guyana Bureau of Statistics), provided the most reliable estimates of national contraceptive prevalence rate and method mix. Unfortunately, neither regional contraceptive prevalence rates nor method mixes could be obtained.
- d. In the short-term, the national forecast for contraceptives also needs to address the rebuilding of safety stocks within the Ministry of Health's central warehouse (MMU) and regional warehouses, particularly for items that have been recently stocked out, such as injectables. In addition, due to the short length of the assessment, the consultants were not able to determine how many of these products, if any, are stocked at the various levels of the supply chain. **Any amount of stock on hand within the supply chain should be considered in relation to the projections of safety stock presented below.**
- e. Until such time as the drug management/contraceptive logistics system (DM/CLS) of the Ministry of Health is producing reliable consumption and stock-on-hand data nationwide, JSI/DELIVER strongly recommends that, at minimum, an annual national contraceptive forecast is completed.

II. FORECAST LIMITATIONS

- a. While the forecast has been prepared for the period 2006-2008, the contraceptive needs provided for the final year, 2008, should be viewed as a rough estimate only, due to the following issues:
 - (1) Reliable data inputs – Ideally, contraceptive forecasts should use consumption or dispensed-to-user data, for forecasting future requirements. Knowing both the historical amounts being used by clients and the trends of this consumption (e.g. upward, steady, downward) allows for fairly accurate forecasting of future needs by method and location (health facility, region, etc.). When consumption data is not available, forecasters must revert to less accurate methods, usually the use of demographic data. Surveys, such as the Multiple Indicator Cluster Survey and Demographic and Health Surveys (DHS), provide 'best guesses' for key assumptions such as the number of users and contraceptive method mix. Limitations include sampling bias, limited regional or district level data, and data becoming out-of-date in a rapidly changing environment.
 - (2) Intensive programmatic efforts can result in rapid changes in the use of modern family planning methods – Upward growth in the use of one or more modern family planning method will have significant impact on the quantities of contraceptives needed nation-wide in future years. Specific educational/awareness campaigns (IEC/BCC) around family planning generally or a specific method; improved provider training in a method (e.g. inserting implants); provider access to appropriate health facilities (e.g. installation of a proper room and equipment for inserting IUDs); and changes in payment mechanisms (e.g. enhanced reimbursement to providers for the promotion of certain methods) can all have an impact on method mix and/or the overall utilization of modern methods.

- b. This national forecast estimates the total national needs and public sector needs for contraceptives, but does not include all products. In addition, the national forecast does not disaggregate the needs of other service providers, such as GRPA, FPAG, or the private commercial sector. For example, the contraceptive needs of private hospitals and private physician offices have not been included - due to a lack of information. In addition, other contraceptives, such as foaming tablets and other reproductive health supplies, are not included. **The Ministry of Health, and contraceptive suppliers and donors, should therefore be aware of the needs of these other programs and products in addition to the estimated needs provided herein and consider how these other suppliers and products relate to and/or affect public sector estimated needs.**
- c. It is also important to note that demographic projections, due to the fact that they must use one of three all-inclusive categories of women (women of reproductive age, women of reproductive age in union, or married women of reproductive age), routinely overestimate the number of family planning users. When forecasting for commodities, this pattern should be recognized and taken into account during the procurement process.

III. FORECAST BACKGROUND

1. This forecast comes at a time when there have been recent stock-outs of key contraceptive products, particularly of Depo-Provera (3-month injectables) and monthly oral pills in Ministry facilities. In some parts of the country, shortages have existed for several months.
2. In addition to quantity problems, the Ministry of Health system also suffers from severe data collection problems and significant distribution challenges. With only limited reporting of consumption data from the health facilities, the MMU and Regional warehouses have a difficult time knowing how much to distribute downward, which means they resort either to a quota approach or they simply don't send out contraceptives until a Region or facility requests them. Over time, the result is that products become mal-distributed or stocked-out, as supply builds up in low demand locations and shortages occur in those locations where demand is higher than the quotas.
3. Contraceptive orders for various contraceptives were recently requested by the MOH through New GPC on an emergency basis. The following quantities were ordered in March, 2006. At the time of the visit of the consultants to Guyana in late June, these amounts had not yet arrived in country:

<u>Product</u>	<u>Quantity</u>	<u>Total Cost</u>	<u>Unit Price</u>
Condoms	40,000 pieces	US\$ 1,560	US\$ 0.39
Nordette	1,000 cycles	US\$ 2,420	US\$ 2.42
Lo-Femenal	500 cycles	US\$ 4,075	US\$ 8.15
Depo-Provera, 3-month injectable	1,250 vials	US\$ 8,950	US\$ 7.16
Noristerat, 2-month injectable	1,000 vials	US\$ 3,950	US\$ 3.95
Norigynon, 1-month injectable	2,000 vials	US\$ 4,660	US\$ 2.33
Copper T 380 A	1000 pieces	US\$ 5,250	US\$ 5.25
Total Cost		US\$ 30,865⁷⁶	

4. It is also useful to note that forecasting is integrally linked with procurement, and vice versa. When a forecast sets out the product needs for a specific period of time, the forecasters are, out of necessity, making important assumptions about procurement and distribution processes; in particular, the number of months needed to ensure that funds are available, orders are placed, orders are finalized, products are manufactured and shipped, duties are

⁷⁶ Information received from MCH Office, June 2006. Additional products were also procured: Neosampoon 500 pieces, cost per unit 8.50, Pregnancy Kits, 8 kits of 20 tests, cost per kit 32.50, IUD removal kits 220, cost per unit 52.00. With these additional items, the total amount cost of the emergency order is \$45,773.40.

paid, customs clearance is performed, products are inventoried by the receiving country's central warehouse, and products are distributed to health facilities. A delay in one or more of these steps by the donor, supplier, or government, in comparison to the anticipated schedule, will negatively affect the arrival of the product and therefore negatively impact product availability for clients.

5. Pipeline monitoring, the careful examination of changes and potential changes in plans and commitments of product suppliers, is therefore crucial for ensuring the steady flow of needed products, in this case, contraceptives for family planning. Equally important for countries that rely on donors as their primary sources for these products are good partnership and regular donor coordination meetings which include specific product discussions.

IV. FORECAST METHODOLOGY AND ASSUMPTIONS

4.1 Consumption-based Forecast

As mentioned previously, when trying to estimate future product needs, the most accurate and reliable forecast method is consumption-based forecasting. Consumption-based forecasting uses consumption data (also called dispensed-to-user data) obtained from service delivery points, for the forecasting of future requirements. Knowing both the historical amounts being used by clients and the trends of this consumption (e.g. upward, steady, downward) allows for fairly accurate forecasting of future needs by method and location (health facility, region, etc.). When consumption data is not available, forecasters must revert to less accurate methods, usually the use of demographic data obtained from surveys, such as the Multiple Indicator Cluster Survey (MICS) and/or Demographic and Health Surveys (DHS). These provide 'best guesses' for key assumptions such as the quantity of users and contraceptive method mix; however, their limitations include sampling bias, limited regional or district level data, and data becoming out-of-date in a rapidly changing environment.

Several key steps should be taken before embarking on a consumption-based forecast:

1. Consumption data for health products should be obtained from service delivery points (anywhere the products are used or distributed) by a logistics management information system (LMIS), and may be referred to as distribution, sales, dispensed-to-user, or dispensed-to-client data. Regardless of the terminology, quantities dispensed to clients *at the lowest level in the distribution system*, when recorded and reported upward to the central level, should be aggregated and used for forecasting, wherever possible. Historical consumption quantities and trends are the best predictors of future requirements.
2. Unfortunately, many programs lack complete and accurate consumption (dispensed-to-client) data. Before embarking on a consumption-based forecast it is essential to determine the quality of the data available. The quality of the data depends on three key factors:
 - Design of the data collection system,
 - Completeness of the data (rate of reporting by service delivery points), and
 - Accuracy of the data.

If consumption data are not gathered or reported regularly, are gathered by a system so flawed that its output is clearly unreliable, or are gathered or reported by personnel without motivation, the reporting system is likely to produce unusable data for forecasting.

After collecting facility data in Guyana, the consultants conducted an assessment of the quality of consumption data and observed the following limitations:

3. In the case of Guyana, the consultants were able to obtain 2005 consumption data from public sector health facilities in all ten regions of the country, as theoretically, reports are being sent to GRPA on a monthly basis from

all MOH primary health facilities. The consultants gathered these data and input all of the 2005 consumption figures in an effort to prepare a consumption-based forecast.

Unfortunately, throughout the compilation, entry, and analysis of the data, the consultants encountered various difficulties with the design, accuracy, and completeness of the available consumption data.

3(a) In terms of the *design of the data collection system*, the following issues became apparent:

- Although consumption data is collected on the GRPA form, this form is quite difficult to interpret for both recorder and end-user. The columns for new and continuing acceptors look very similar to the portion of the form that requests consumption data. For this reason, individuals entering data into the forms are likely to mistake user information for consumption data (see Appendix 1).
- Further, this form does not collect all of the information needed for accurately determining consumption and how much stock will be needed in the future. For instance, there is no place on the form to record losses, transfers, or other adjustments of stock nor places to note when a commodity has been stocked-out, the length of the stock-out period, and/or how many users did not receive the commodity because the facility was stocked-out.
- The methodology for tracking new and continuing acceptors does not provide an accurate reflection of users and/or product consumed. It appears that each client is being recorded as either a new or continuing user every time she/he visits a clinic. As a result, a client is likely counted first as a new acceptor and then several times as a continuing user during each subsequent visit (the second, third, and fourth time she arrives that year). This one user may therefore be ‘counted’ a number of times throughout any given period. The danger with this approach is that new and continuing acceptors are being assumed to be users, when in fact, this tracking system more closely records the number of total visits within a given period.
- The consultants found that individuals at the health posts and health centers are overburdened with the amount of reporting they are expected to produce on a regular basis. As a result, facilities are not reporting family planning data at all, are intermittently reporting data, or are not completely or accurately filling out the report form.
- Lastly, although the central level is receiving consumption data from various facilities on the GRPA forms, this data is not currently being recorded, aggregated, or analyzed by GRPA of the MOH.

3(b) The consultants also found key issues with the *completeness* of the data:

- Once all of the available data for 2005 was entered, the total list of facilities that had provided reports was compared to the total list of facilities that should have reported, and reporting rates were determined for health posts, health centers, and hospitals respectively⁷⁷. These rates illustrate that there were significant reporting challenges in 2005, particularly for health posts:
 - Health Centers – 62% reporting rate
 - Hospitals – 30% reporting rate
 - Health Posts – 15% reporting rate
 - All Health Facilities – 33% reporting rate

3(c) Additional concerns resulted regarding the *accuracy* of the user and consumption data obtained, as follows:

- The MCH Office and several facilities reported that there were stock-outs and expiries at many health facilities during 2005. However, there is no clear available data to estimate the magnitude or impact of these stock-outs on public sector use by family planning clients.

⁷⁷ While the hospital reporting rate is also quite low, it does not seem to be clear as to whether hospitals need to report to the MOH (GRPA) regarding their service statistics.

- Because the methodology used to track new and continuing acceptors may count the same user several times, there is no way to accurately estimate the total number of users in public sector facilities from the available data.
 - As a result of the low reporting rates, there is no accurate way to estimate the total quantities of contraceptives actually dispensed-to-users over the span of the year.
 - Because staff does not have training and/or the motivation to fill out the forms completely and accurately, essential data is not being accurately captured, resulting in errors in the consumption data being reported to the central level.
4. Based on all of the issues and limitations above, the consultants determined that majority of the logistics information was unreliable and was of limited value in estimating the public sector's total future contraceptive needs.
 5. One positive use of this data was its value toward developing an estimate of method mix within the public sector. As noted in the demographic forecast methodology section, this estimate of method mix has been applied to the national forecast of users in order to estimate the Ministry's future requirements for each modern method.
 6. Most of the issues and limitations described above relate to the logistics management information system (LMIS) and its value in providing information to forecasting and procurement. The essential data elements for such an LMIS include consumption, stock-on-hand, and losses/adjustments (pluses and minuses from stock). Suggestions for immediate improvements within the LMIS for family planning are as follows:
 - The fact that the MOH is gathering consumption data from some facilities is a very positive step towards obtaining the essential data needed to accurately forecast contraceptives needs. Immediate steps could be taken to improve reporting rates. In the notes section of the GRPA form, many facilities often request new forms, follow-up from the MOH, and emergency products, etc. By involving the Regions more directly with these facilities, as well as all with those facilities currently not reporting, the MOH would likely see an immediate increase in reporting rates (see Appendix 2 for list of facilities not reporting).
 - In addition to taking steps to improve reporting rates, the MOH can enter and analyze the consumption data being provided and prepare for the eventual use of this data for forecasting future needs.
 - Finally, the MOH should take steps to lessen the reporting burden at the facility-level by stream-lining and revising the GRPA form and reducing the reporting requirements to focus on data that will actually be utilized. The current form is difficult to fill-out, does not collect the essential data necessary to determine contraceptive needs, and does not accurately collect information about the number of users. The current system for tracking new and continuing acceptors is highly unreliable and can not be accurately converted into product needs or users. Attached is a sample form that is already being used for other medicines in Guyana. This form could be used to more accurately track consumption data in the future (see Appendix 3).

4.2 Demographic Forecast

1. The population figures from the National Population and Housing Census 2002 were used for each region. The number of women of reproductive age was also determined from the Census.
2. Population growth was estimated at the national level by calculating the annual change in total population from the 1991 Census to the 2002 Census (0.35% per year).
3. The Guyana Multiple Indicator Cluster Survey, July 2001 (UNICEF/Guyana Bureau of Statistics), was used for the contraceptive prevalence rate (CPR), the percentage of women in union (WRAinU), and the method mix for the national estimate. Respectively, these numbers are:
 - CPR - 36.0% (modern methods),

- WRAinU - 70.6%,
- Method Mix - oral pills - 11.2%; IUDs – 6.3%; injectables - 3.7%; condoms – 8.9%; implants – 1.0%; sterilization (male & female) – 4.6%; and other methods 0.3%.

While this data is roughly six years old, it is unfortunately the best available. As confirmed by UNICEF, a new MICS Survey will be available in the coming months providing up-to-date information. **As soon as this new data is available, it is highly recommended that this forecast be revisited.**

4. The number of total contraceptive users by method (pills, IUDs, injectables, condoms - FP only, sterilization, implants, and other methods) and by region was then determined.
5. A total CPR growth rate of 0.5% per year was then assumed for each year from 2001 to 2008. This number was chosen as a “best guess” for the balance between short-term program achievements and data from other countries.
6. The total number of contraceptive users was increased by a ‘best guess’ estimate of the number of sexually active unmarried women, by method. This was estimated at 3% of all women of reproductive age. Specific data was not available to calculate modern method users or contraceptive needs by region. For method mix for this group of women, our assumptions are as follows: oral pills – 33.3%; IUDs – 3.3%; injectables - 20.0%; condoms – 40.0%; implants – 1.3%; sterilization (male & female) – 0.0%; and other methods 2.0%. These users (sexually active unmarried women) were then added to the totals for women of reproductive age in union, by method, to determine the estimated total users by method.
7. To determine national contraceptive needs, the number of users was then multiplied (or divided) by standard usage rates per method (15 cycles of pills per year, 4 injections per year, 120 condoms per year, 1 IUD per each 3.5 years, 1 implant set per 3.5 years).
8. As the primary purpose of this forecast is to estimate the needs of the Ministry of Health for its Regions and facilities, several additional steps were taken.
 - The first was to try to determine the portion of total users who are actually using MOH facilities (in comparison to other sources such as GRPA, FPAG, and private physicians and pharmacies). The consultants had hoped that 2005 MOH consumption data collected and analyzed would provide an accurate picture of the total use of MOH facilities; unfortunately low reporting rates and concerns about data accuracy eliminated this option. A combination of historical data (58.7 MOH in 1991-92)⁷⁸ and MOH new and continuing acceptor data from 2005 lead the consultants to use an estimate of 50%.
 - The second step was to utilize the MOH new and continuing acceptor data from 2005 to calculate a current method mix for family planning users of the Ministry. This step is important because public sector method mix can differ considerably from other sources due to the availability of and access to services, client perceptions, ability to pay, and other factors. While again, it is important to note that the data quality was low, the calculated method mix for family planning users of the public sector is as follows: oral pills – 45.0%; IUDs – 2.5%; injectables - 27.0%; condoms – 25.0%; implants – 0.1%; sterilization (male & female) – 0.0%; and other methods 0.4%.
 - The third step, as above with the national contraceptive needs, was to multiply (or divide) the number of users of each method by standard usage rates for each method (15 cycles of pill per year, 4 injections per year, 120 condoms per year, 1 IUD per each 3.5 years, 1 implant set per 3.5 years) in order to determine the quantities needed for the Ministry of Health.
9. In addition, two final steps will need to take place in Guyana in order to complete the forecast for 2006:

⁷⁸ Guyana Contraceptive Prevalence Survey 1991-92.

- Adjusting for existing supplies - The first step is to adjust total contraceptive requirements for the MOH downward if there are significant quantities of existing stocks (stock-on-hand) of one or more products. In other words, if the forecast suggests that 100,000 cycles of pills are required for next year, but there are 50,000 cycles in warehouses, the procured amount can be reduced to 50,000 for the one year period.⁷⁹
 - Safety stock replenishment - The second issue to address is the rebuilding of safety (or buffer) stocks for products that have been stocked-out or are nearly stocked out. It is important that the Ministry fully re-supply the 'pipeline' with contraceptives. For the MMU (central level), the consultants suggest a safety stock of a minimum of 6 months and, for the regional level, 4 months. It is important to note that safety stock replenishment should be a one-time event, assuming that it will coincide with better pipeline monitoring and improvements in data collection and distribution that should ensure more balance in the pipeline in the future.
9. The special case of condoms - One additional issue for the Ministry to consider in relation to forecasting and procurement is that most primary health care facilities in Guyana provide 30 condoms to a man or woman who requests them (assuming they are available). This is significantly higher than international averages (standard family planning usage rates) which suggest 120 per year. If the requester returned monthly for a new supply, the total provided over a year would be 360. Of course, what is impossible to determine is how often an individual returns for re-supply. If the average was once per each three months, this would match the international standard; any higher revisit average would indicate that more condoms will be needed.

IV. DEMOGRAPHIC FORECAST

5.1 Contraceptive Prevalence Rates (CPR)

Table 1 below provides contraceptive prevalence rates for all methods and modern methods from the MICS (2000 data).

TABLE 1 - 2000 CONTRACEPTIVE PREVALENCE RATES (CPR) ALL METHODS AND MODERN METHODS		
Source	Women of Reproductive Age (WRA)	Women in Union of Reproductive Age (WRAinU)
MICS (2000) – All Methods	26.3% (est.)	37.3%
MICS (2000) – Modern Methods	25.4% (est.)	36.0%

⁷⁹ As most contraceptives have fairly long shelf lives (4 to 5 years) under acceptable storage conditions, it is generally more prudent to oversupply rather than risk stock-outs.

5.2 Estimated Total Modern Method Users

Tables 2 and 3 below provide the estimated number of modern method users in the entire country, first for women in union of reproductive age (ages 15 to 49), and then for women in union of reproductive age plus sexually active unmarried women.

TABLE 2 – NATIONAL ESTIMATED MODERN METHOD USERS WOMEN IN UNION OF REPRODUCTIVE AGE (WRAinU)				
Users (WRAinU)	2005	2006	2007	2008
Pills	15,808	15,942	16,078	16,215
IUDs	8,892	8,967	9,044	9,121
Injectables	5,222	5,267	5,311	5,357
Condoms	12,561	12,668	12,776	12,885
Implants	1,411	1,423	1,436	1,448
Sterilization (M&F)	6,492	6,548	6,603	6,660
Other (foam, jelly, diaphragm)	423	427	431	434
Total Users	50,810	51,243	51,679	52,119

TABLE 3 – NATIONAL ESTIMATED TOTAL MODERN METHOD USERS (WRAinU & SEXUALLY ACTIVE UNMARRIEDS)				
Total Users (WRAinU + Sexually Active Unmarrieds)	2005	2006	2007	2008
Pills	17,757	17,899	18,042	18,185
IUDs	9,087	9,163	9,240	9,318
Injectables	6,392	6,441	6,490	6,539
Condoms	14,901	15,016	15,133	15,250
Implants	1,489	1,502	1,514	1,527
Sterilization (M&F)	6,492	6,548	6,603	6,660
Other (foam, jelly, diaphragm)	540	544	548	553
Total Users	56,660	57,113	57,570	58,031

Table 4 below provides the estimated number of modern method users in the public sector (MOH), for women in union of reproductive age plus sexually active unmarried women (ages 15 to 49).

TABLE 4 – MINISTRY OF HEALTH (MOH) ESTIMATED TOTAL MODERN METHOD USERS (WRAinU & SEXUALLY ACTIVE UNMARRIEDS)				
Total Users (WRAinU + Sexually Active Unmarrieds)	2005	2006	2007	2008
Pills	12,407	12,508	12,610	12,712
IUDs	733	738	744	750
Injectables	7,444	7,505	7,566	7,627
Condoms	7,521	7,579	7,638	7,697
Implants	64	65	65	65
Sterilization (M&F)	Not estimated	Not estimated	Not estimated	Not estimated
Other (foam, jelly, diaphragm)	160	161	162	163
Total Users	28,330	28,556	28,785	29,015

5.3. Estimated Total Contraceptive Requirements

Table 5 below provides the *national* annual contraceptive needs for the years 2006 through 2008, using standard usage rates per method (step 7 of the methodology outlined above). These are the **annual total national requirements**, without special conditions such as safety stock replenishment.

TABLE 5 – NATIONAL CONTRACEPTIVE REQUIREMENTS 2006-2008			
Total Contraceptives (WRA in Union + Sexually Active Unmarrieds)	2006	2007	2008
Pills (cycles)	268,484	270,623	272,781
IUDs (pieces)	2,618	2,640	2,662
Injectables (vials)	25,763	25,958	26,156
Condoms (pieces)	1,801,971	1,815,906	1,829,954
Implants (sets)	429	433	436

Table 6 below provides the *public sector* annual contraceptive needs for the years 2006 through 2008, using standard usage rates per method (step 7 of the methodology). These are the **annual total MOH requirements**, without special conditions such as safety stock replenishment. **Current stock-on-hand is also not taken into account by these estimated amounts.**

<i>TABLE 6 – MOH CONTRACEPTIVE REQUIREMENTS 2006-2008</i>			
Total Contraceptives (WRA in Union + Sexually Active Unmarrieds)	2006	2007	2008
Pills (cycles)	187,620	189,144	190,681
IUDs (pieces)	738	744	750
Injectables (vials)	30,019	30,263	30,509
Condoms (pieces)	909,526	916,566	923,663
Implants (sets)	19	19	19

In Table 8, the annual MOH contraceptive requirements are converted into financial terms (US\$ dollars) for the years 2006 - \$167,292, 2007 - \$112,407, and 2008 - \$113,302. This table also adds in an estimate of safety stock replenishment at the central (MMU) level, which is assumed to occur in the second half of 2006. For the cost conversion, UNFPA reference prices (see Table 7 below) are used as the standard for contraceptive purchases. These prices may vary when the MCH Office receives an official quotation from UNFPA and the final product list is defined.

TABLE 7 – MOH REQUIREMENTS IN US\$	
Type	UNFPA Reference Prices
Pills (cycle)	\$0.28
IUDs (piece)	\$0.24
Injectables (vial)	\$0.73
Condoms (piece)	\$0.04
Implants (set)	\$23.00-27.00

Source: UNFPA prices provided to the Maternal and Child Health Office by UNFPA, June 2006

In addition to the price of the commodities, UNFPA charges a 5% administration fee that must be included when budgeting for the total cost of procurement. The additional costs of distribution, transport, and storage should also been taken into consideration when budgeting for the cost of procurement and distribution of the commodities, as listed below.

TABLE 8 – MINISTRY OF HEALTH CONTRACEPTIVE REQUIREMENTS AND ESTIMATED COST AT UNFPA PRICES – 2006, 2007, AND 2008 (INCLUDING SAFETY STOCK REPLENISHMENT IN 2006 ONLY)						
	2006 Quantities	2007 Quantities	2008 Quantities	2006 Estimated Cost (US\$) at UNFPA Prices (CIF)	2007 Estimated Cost (US\$) at UNFPA Prices (CIF)	2008 Estimated Cost (US\$) at UNFPA Prices (CIF)
Pill Requirements	187,620	189,144	190,681	\$52,534	\$52,960	\$53,391
Safety stock for MMU	93,810	--	--	\$26,267	\$0	\$0
Subtotal MOH	281,430	189,144	190,681	\$78,800	\$52,960	\$53,391
IUD Requirements	738	744	750	\$177	\$179	\$180
Safety stock for MMU	369	--	--	\$89	\$0	\$0
Subtotal MOH	1,107	744	750	\$266	\$179	\$180
Injectable Requirements	30,019	30,263	30,509	\$21,914	\$22,092	\$22,272
Safety stock for MMU	15,010	--	--	\$10,957	\$0	\$0
Subtotal MOH	45,029	30,263	30,509	\$32,871	\$22,092	\$22,272
Condom Requirements	909,526	916,566	923,663	\$36,381	\$36,663	\$36,947
Safety stock for MMU	454,763	--	--	\$18,191	\$0	\$0
Subtotal MOH	1,364,289	916,566	923,663	\$54,572	\$36,663	\$36,947
Implant Requirements	19	19	19	\$513	\$513	\$513
Safety stock for MMU	10	--	--	\$270	\$0	\$0
Subtotal MOH	29	19	19	\$783	\$513	\$513
Total MOH				\$167,292	\$112,407	\$113,302

NOTES on Table 8:

1. The cost estimates in Table 8 do not include UNFPA's 5% administrative fee.

2. The quantities forecasted for both IUDs and implants are extremely low. Before orders are placed for these contraceptives, the consultants would suggest that the MCH Office (or their designee) perform a quick survey of the sites that commonly use these products to determine their needs for the coming period (and existing stocks). In addition, if ordered through UNFPA, they may have minimum order levels based on the sizes of the packing boxes.

3. Table 8 estimates the additional cost of replenishing the supply chain with safety stock at the central level (MMU) only. These estimates do not include safety stock replenishment at the regional levels. The consultants recommend additional safety stock replenishment (4 months) at the regional level if, and when, regional warehouses serve as a storage level within the supply chain distribution system.

It is also important to note that although products have been recently procured from New GPC, there will, most likely, be a short-term need for additional pills, condoms, and injectables before products can be procured from, supplied to, and shipped by UNFPA. Based on the yearly estimates provided above, the limited amount of contraceptives procured through New GPC will most likely be **consumed in less than one month for pills and condoms and within a three month period for injectables.** Given various constraints such as the time it takes until funds are available, orders are placed, orders are finalized, products are manufactured and shipped, duties are paid, customs clearance is performed, products are inventoried by the country's central warehouse, and products are distributed to the health facilities, it is very unlikely that these products will cover the needs of the public sector until UNFPA supplies arrive in Guyana, are moved to service delivery points, and are available for clients. Assuming there is no additional stock on hand available throughout the supply chain, the MOH will need to address these short-term needs immediately.

II. Issues and Questions for Future Forecasts

1. Two final steps will need to be taken in Guyana in the near future to complete this forecast. The first step is to adjust the total contraceptive requirements for the MOH downward if there are already existing stocks of one or more products throughout the supply chain. These requirements should only be adjusted downward if the existing stocks amount to above and beyond what will be consumed in the short-term or before the UNFPA order arrives and is ready to be dispensed.
2. The second issue to address is the rebuilding of safety (or buffer) stocks for products that have been stocked out or are nearly stocked out. It is important that the Ministry fully re-supply the 'pipeline' with contraceptives. For the MMU (central level), the consultants suggest a safety stock of a minimum of 6 months and, for the regional level, where applicable, 4 months.
3. There is a definite need for a more comprehensive survey of contraceptive prevalence rates in Guyana in order to have a more complete picture of the change in CPR rates and method mix nationally and regionally. During their visit, the consultants learned that the MICS Survey results are to be released shortly. As soon as the results of this survey become available, the annual forecast should be revisited and updated with new demographic and health data.
4. In addition to immediately updating the national forecast as soon as the new MICS survey data becomes available, it is highly recommended that the MOH conduct forecasts on an annual basis in order to regularly update existing estimates with up-to-date and reliable information, as well as to systematically revisit the forecast assumptions in a changing environment.
5. The MOH has already taken some very important steps towards collecting the essential data needed for preparing a consumption-based forecast. Further step must be taken to improve reporting rates, revise and streamline forms, lessen the reporting burden on health staff, and ensure timely and accurate data. The DELIVER consultants have provided more detailed and specific recommendations related to strengthening the

LMIS, improving reporting rates, and preparing for an eventual consumption-based forecast in their Contraceptive Security Assessment Report (August 2006).

6. Finally, as mentioned above, it is very likely that there will be a short-term need for contraceptives in Guyana (period between receipt on New GPC order and arrival and dispersal of contraceptives ordered through UNFPA). It is highly unlikely that the products recently procured from New GPC will last until UNFPA products arrive in Guyana and are ready to be dispensed. These lead times must be estimated and taken into consideration when preparing a forecast. A short-term solution must be sought in order to avoid having a gap in the supply of products once the currently available products (order from New GPC and any stock on hand) have been consumed.

For more information, please visit <http://www.deliver.jsi.com>.

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