TC Document

I. Basic Information for TC

▪ Country:	Co-operative Republic of Guyana through its Ministry of Public Health.
▪ TC Name:	Support for Maternal and Child Health Improvement Program
▪ TC Number:	GY-T1121
▪ Team Leader/Members:	Donna Harris (SPH/CJA); Ian Ho-a-Shu (SPH/CTT); Marcella Distrutti (SCL/SPH); Paula Louis-Grant (FMP/CGY); Martha Guerra (SCL/SPH); Betina Hennig (LEG/SGO); and Leticia Ramjag (CCB/CGY)
▪ Taxonomy:	Operational Support
▪ If Operational Support TC, give number and name of Operation Supported by the TC:	GY-L1058
▪ Date of TC Abstract authorization:	July 1, 2016
▪ Beneficiary:	Co-operative Republic of Guyana through its Ministry of Public Health (MoPH)
▪ Executing Agency	Inter-American Development Bank through the Social Protection and Health Division (SCL/SPH)
▪ Donors providing funding:	Special Program for Employment, Poverty Reduction and Social Development in Support of the Millennium Development Goals (SOF)
▪ IDB Funding Requested:	$350,000
▪ Local counterpart funding, if any:	No
▪ Disbursement period (which includes Execution period):	36 months
▪ Required start date:	January 2, 2017
▪ Types of consultants (firm or individual):	Individuals and firms
▪ Prepared by Unit:	SCL/SPH
▪ Unit of Disbursement Responsibility:	SPH/CGY
▪ TC Included in Country Strategy (y/n):	No
▪ TC included in CPD (y/n):	No
▪ GCI-9 Sector Priority:	Social Inclusion and Equality

II. Description of the Associated Loan/Guarantee

2.1 **Improvements in health indicators.** Guyana has made significant advancements in the health sector in the past two decades, with a decrease in the burden of communicable diseases such as HIV/AIDs, malaria, and tuberculosis, and an increase in life expectancy from 62 years in 1991 to 67 years in 2015.[1] The country met the Millennium Development Goals targets for nutrition, child health (under five

[1] PAHO Basic Indicators.

years of age), and communicable diseases,[2] as well as the goals related to water and sanitation,[3] with positive impacts on health outcomes.

2.2 **Challenges remaining in maternal and neonatal health.** Despite the progress, Guyana continues to experience maternal and infant mortality rates that are among the highest in the Latin America and Caribbean (LAC) region.[4] The maternal mortality ratio is estimated at 121 per 100,000 live births (LB) and the infant mortality rate is estimated at 22 per 1,000 LB.[5] The majority of infant deaths occur in the neonatal period (up to 28 days after birth); in 2014, of all deaths of children less than one year of age, 93% occurred in the neonatal period. In the same year, there were 177 cases of stillbirth. The main causes of maternal mortality are post-partum hemorrhage (PPH) and pregnancy induced hypertension (PIH), while 70% of neonatal deaths are caused by prematurity, followed by respiratory illness (20%).[6] Pregnancy in adolescence is high (about 20% of all LB),[7] representing a higher risk for both mothers and newborns.

2.3 The main factors contributing to maternal and neonatal outcomes in Guyana are related to inadequate access, use, and quality of reproductive, maternal, and neonatal health services, the organization of the health care network and the critical shortage of human resources for health (HRH).

2.4 With respect to HRH, Guyana in 2008 had the lowest number of public sector physicians and the second lowest supply of nurses in the Region of the Americas (ROA).[8] The estimated ratio of the total number of physicians and nurses per 10,000 people in 2010 was 7.25. Even if all public and private physicians, nurses, midwives and nursing assistants are included, Guyana's ratio increases to only 17.7. The comparable figure for the non-Latin Caribbean is 21.7 while the current recommended World Health Organization (WHO) target ratio is 25 per 10,000 members of the population. One of the main reasons for this shortage is the high rates of migration of nurses and doctors. In addition, there is a concentration of remaining health professionals in or near to the capital city of Georgetown which constitutes a challenge for the health system.[9] The available evidence also suggests that the health workforce lacks the appropriate skills, competencies, and motivation,[10] as a result of deficiencies in the educational system[11] and insufficient

---

2 The percentage of children under five who suffer from moderate to mild malnutrition reduced from 12% in 1997 to 6% in 2008. The under-five mortality rate declined from 102/1,000 LB in 1991 to 24 in 2014. HIV incidence decreased and access to antiretroviral drugs increased from 18.4% in 2004 to 83.5% in 2008. Sources: MDG Progress Report 2011, Chief Medical Officer Report 2014, and Health Vision 2020.

3 An estimated 94% of households have access to improved sources of drinking water and 95.4% to improved sanitation facilities. Guyana Multiple Indicator Cluster Survey 2014.

4 In LAC maternal mortality is 62.9 and infant mortality is 15.7 (PAHO Basic Indicators 2014).

5 Chief Medical Officer Report (CMO) Annual Report 2014.

6 CMO Annual Report 2014.

7 MDG Acceleration Framework, Government of Guyana 2014.

8 Pan American Health Organization, Health Information and Analysis Project. Health Situation in the Americas: Basic Indicators 2010. Washington, D.C., United States of America, 2010.

9 Many regional hospitals, district hospitals, and health centers outside of region 4 do not meet the MPH' human resources standards (UNFPA 2010). Region 4 employs 73.6% of Guyana's total physician workforce (PAHO 2010).

10 In the 2010 UNFPA survey, a group of 36 providers scored an average of 75% on how to diagnose asphyxia and on what to do if a newborn is not breathing or breathing slow.

11 In the face of ongoing shortages, nursing enrolments were increased significantly. The country's three nursing schools were under-resourced to accommodate the increase in the number of student; as a result, the quality of programs deteriorated and student course completion and exam pass rates

on-the-job training and poor management practices in human resources. The critical shortages are concentrated in primary care nursing staff, especially in the area of maternal and child health. In 2010, a Health Human Resources Gap Analysis[12] determined that Guyana requires an additional 309 nurses and that over 7,450 Guyanese nurses work abroad, with an expatriation rate of 81.1 percent. In response, Guyana recognizes the urgent need to: (i) design a range of solutions to contribute to closing the human resource gap outside of Georgetown in the short-term, potentially including the use of telemedicine and the development of alliances with non-governmental organizations (NGOs); (ii) review the country's health educational system, including the nursing curricula to better focus on maternal and child health primary care delivery and the midwifery curricula; and (iii) develop employment recruitment and retention incentives for nurses and midwives.[13] While the country has responded to the shortage with increasing pre-service training, there is still an urgent need to squarely address core issues that encourage retention, including strategies to improve the quality of work environments.

2.5 Another area of deficiency is the capacity weakness within the Ministry of Public Health's Maternal and Child Health Unit to effectively manage its program, namely the implementation of the immunization program, the maternal and child health strategy, as well addressing women's health concerns. An institutional assessment of the MCH Unit done in 2016 to support the preparation of GY-L1058 indicated that the MCH Unit has insufficient technical and administrative capacity to run an effective MCH program[14]. Though the structure of the unit has evolved to address some of the service delivery gaps, significant work still remains to be done with respect to setting a clear and defined program with performance targets, assessing the HR requirements and designing an appropriate structure to meet the needs of a well-functioning MCH Unit. While resources from GY-L1058 will be provided to strengthen the MCH unit by financing of additional staff during the life of the project, a more sustainable approach is needed to develop the overall technical capacity in terms of planning, monitoring and evaluation, and execution to improve MCH long term efficiency and effectiveness, as well as to guarantee the results of the loan.

2.6 **Support to improve Maternal and Child Health.** To address the above referenced challenges, the Government of Guyana (GOG) requested the Support to Improve Maternal and Child Health in the form of both loan and technical assistance financing from the Inter-American Development Bank (IDB). The loan (GY-L1058) is currently in preparation and seeks to reduce maternal, perinatal, and neonatal deaths in Guyana by 2020. The Project Profile reached eligibility on April 20, 2016 and approval by the Board is planned for October 26, 2016. This TC will be designed and executed in parallel with the loan and will provide design and operational support to GY-L1058.

---

declined. The lack of employment incentives, performance appraisal, and reward systems, combined with inadequate salaries with no benefits or pay increases have been identified as the main challenges in this area (PAHO 2010).

12 Implementing Guyana's Package of Publicly Guaranteed Health Services (PPGHS): Bridging Health Human Resource Gaps. PAHO. Dubois, Carl A., Ingabire, M-G. February, 2010.

13 Strengthening the Foundation: A Health Human Resources Action Plan for Guyana, 2011 to 2016. PAHO. Ministry of Health, Guyana, December 2010.

14 Institutional Evaluation of the MoPH, GUYANA. Andres Garrett, Institutional and Financial Consultant, July 2016.

2.7 Preparation of GY-L1058 is well advanced with three IDB missions in October 2015 and March and May 2016, along with ERM approval on May 16th. The IDB and the MoPH have jointly: (i) developed a common framework to analyze maternal and child health challenges in Guyana; and (ii) established expected health impacts, outcomes, and potential interventions to support Guyana's maternal and child health programs culminating in the completion of the POD and circulation to QRR. In addition, loan preparation efforts are guided by policy documents developed by the MoPH, namely: (i) the Maternal and Perinatal Health Strategy 2011-2020; (ii) the MDG Acceleration Framework to Improve Maternal Health; and (iii) the National Health Sector Strategy 2013-2020 (Health Vision 2020). The loan will focus on evidence-based interventions that will: (i) improve healthy pregnancy planning and spacing; (ii) increase iron prophylaxis; (iii) increase the detection of early signs of preeclampsia, placenta previa, and other risk factors for PPH, PIH, and prematurity; (iv) improve knowledge, attitudes, and practices related to sexual and reproductive health, pregnancy, safe delivery, and newborn care; (v) improve access to essential and emergency obstetric and neonatal care services (for women and newborns located in the rural interior); (vi) increase institutional delivery (for women located in the rural interior); (vii) increase the quality of skilled birth attendance; (viii) increase the number of complications that are treated according to norms; and (ix) increase the number of mothers and newborns that receive immediate postpartum care according to best practices.

III. Objectives and Justification of the TC

3.1 The general objective of the TC is to support the design and implementation of operation GY-L1058, which seeks to reduce maternal, perinatal and neonatal deaths in Guyana by 2020. To achieve this goal, this TC will finance institutional strengthening activities, focused on the MoPH in general and the Maternal and Child Health Department (MCD) in particular by supporting improvements to the supply of human resources and financing technical studies.

3.2 **Strategic alignment.** This project is consistent with the Update to the Institutional Strategy (UIS) 2010-2020 (AB-3008) and is aligned with the development challenge of social inclusion and equality by increasing access and use of health services and diminishing inequities. It will contribute with the cross-cutting issue of gender equality and diversity, by improving women and indigenous people's access to sexual and reproductive health. Additionally, it will contribute to the Corporate Results Framework 2016-2019 (GN-2727-6) by reducing maternal mortality and increasing the number of beneficiaries receiving health services. It is aligned with the Strategy on Social Policy for Equity and Productivity. It is also consistent with the Sector Framework for Health and Nutrition and its mandate that all people have timely access to quality health services. This project will also support the IDB Country Strategy with the Cooperative Republic of Guyana 2012-2016 (GN-2690) goals of promoting economic growth, enhancing competitiveness, and improving access to basic social services to the indigenous people.

IV. Description of activities/components and budget

4.1 **Component 1. Institutional Strengthening of the Ministry of Public Health (US$180,000).** This component will finance technical assistance to strengthen the Maternal and Child Health Unit within the MoPH, namely, its technical, institutional,

functional and operational capacities to execute the loan and to effectively manage the government's MCH program towards sustaining the results and improving maternal and child health outcomes in Guyana. This component will therefore finance the following: (i) an international consultant to provide technical oversight on the implementation of the project and support capacity building of the MCH;[15] (ii) an assessment of the organizational structure of the MCH Unit and the development of a new organogram in line with the new activities proposed under the loan to guarantee sustainability of the results of the program. This new structure will be used as the basis to staff a reorganized MCH, possibly absorbing some of the specialist staff recruited under the loan; and (iii) review of the evidence and participatory design of solutions to contribute to close the human resource gap in the country's rural interior.

4.2 **Component 2. Technical studies and learning activities (US$120,000).** This component will finance technical studies to support the execution of GY-L1058, including: (i) a supply and demand assessment, which consists of a qualitative analysis and participatory diagnostics conducted at the local level to determine supply and demand barriers to access and use of reproductive, maternal, and neonatal health services. This assessment will include a review of lessons learned from a previous Supply Chain Management Services consultancy funded by USAID. The assessment will also look at the current arrangements in place for procurement of medical supplies at the MOPH Procurement Bond; (ii) the revision of the health educational system, including the nursing curricula with a stronger maternal and child health primary care focus and the midwifery curricula; (iii) a recruitment and retention plan for nurses and midwives which will focus on developing cost-effective incentives, including incentives such as the setting of flexible hours, options to work on a full-time, part-time or casual basis, flexible vacation time and the creation of safe and healthy work environments; and (iv) a knowledge exchange with Costa Rica and Honduras[16] to observe modern methods and approaches in the delivery of child/maternal services under the Mesoamerican Health Initiative.

Indicative Results Matrix

Outcome	Strengthened capacity of the Ministry of Public Health MCH function to deliver maternal and child health services to the population			
Component	**Expected Products**	**Baseline Value**	**Target Value**	**Verification Source**
1	Report on the Institutional functional and human resource requirements for the Maternal and Child Health Unit completed.	0	1	Report approved by MPH and recommendation implemented. (Letter from the Permanent Secretary of MPH approving the report)
2	Report on the supply and demand assessment completed and published	0	1	Key Assessment findings and recommendations used to inform the final design of MCH interventions by JA-L1058 (Letter form the Permanent secretary of MPH

[15] While GY-L1058 will fund staff to execute the project at the MCH Unit, the institutional strengthening activities funded under this TC component will provide technical supervision assistance to serve as the technical link between the components of GY-L1058 and the execution staff of the MCH Unit in order to ensure that technical resources provided through each component of GY-L1058 are working in tandem in terms of timing of input, quality and scope of work. In addition, the technical supervision assistance will provide technical inputs in the recruitment and monitoring of technical consultancy firms and individuals under GY-L1058, as necessary.

[16] Costa Rica and Honduras were selected based on the similarities between these countries and Guyana in terms of GDP, size, socio-economic conditions, and overall development.

Outcome	Strengthened capacity of the Ministry of Public Health MCH function to deliver maternal and child health services to the population			
Component	**Expected Products**	**Baseline Value**	**Target Value**	**Verification Source**
				approving the report)
2	Recruitment and Retention Plan for Nurses completed that includes included a detailed implementation plan, precise timelines, identified partner commitments and defined resource requirements.	0	1	Key findings and recommendations approved by MPH and implemented. (Letter from the Permanent Secretary of MPH approving the key findings and recommendations)
2	Revised Nursing Curricula with a stronger maternal and child health primary care focus completed	0	1	Revised nursing curricula accepted by MoPH. Letter from the Permanent Secretary of MPH
2	Knowledge Exchange and Study Tour to Costa Rica and Honduras completed	0	2	Back-to-Office reports presented to Technical Working Team of the MoPH

Indicative Budget

Component	IDB Funding (US$)
1. Institutional Strengthening of the MoPH	180,000
2. Technical studies and learning activities	120,000
Project Administration/Evaluation	50,000
TOTAL	**350,000**

V. Executing agency and execution structure

5.1 Based on a request from the GOG, the executing agency of this TC is the IDB through SCL/SPH. The project team will contract individual consultants and firms in accordance with the IDB´s procurement policies and procedures. This request was made by GOG on the basis that they wish to avoid delays in contracting consultants and/or managing consultant contracts given that the current MoPH project management and procurement capabilities are insufficient.

5.2 Monitoring the quality and progress of the TC will be carried out directly by the IDB and through IDB institutional systems, under the responsibility of the TC Project Team Leader and with the support of a consultant hired for monitoring and evaluation purposes. The final products will also be reviewed by the Project Team to ensure the quality of products and services funded under this TC. A final evaluation is also planned to assess project success.

VI. Major issues

6.1 For the TC to achieve the aforementioned results, there is a clear need for robust coordination among various administrative and technical departments within the MoPH as well as other key stakeholders, including the Ministry of Finance and the Regional Health Authorities. Based on lessons learned from other projects in Guyana and in the region, an Inter-agency Steering Committee chaired by the MoPH will be established as a condition for disbursement under GY-L1058 as an important mitigation measure to facilitate effective inter-agency coordination. This Inter-agency Steering Committee mechanism will also facilitate coordination between the TC and GY-L1058.

VII. Exceptions to Bank policy

7.1 There are no exceptions to Bank policy.

VIII. Environmental and Social Strategy

8.1 This TC has an ESG classification of “C” as it will not have any negative environmental or social impact (see filters).

Required Annexes:

- Letter of Request
- Terms of Reference
- Procurement Plan

SUPPORT FOR MATERNAL AND CHILD HEALTH IMPROVEMENT PROGRAM

GY-T1121

CERTIFICATION

I hereby certify that this operation was approved for financing under the **Special Program for Employment, Poverty Reduction and Social Development in Support of the Millennium Development Goals (SOF)** through a communication dated July 1, 2016 and signed by Su Hyun Kim (ORP/GCM). Also, I certify that resources from said fund are available for up to **US$350,000** in order to finance the activities described and budgeted in this document. This certification reserves resource for the referenced project for a period of six (6) calendar months counted from the date of eligibility from the funding source. If the project is not approved by the IDB within that period, the reserve of resources will be cancelled, except in the case a new certification is granted. The commitment and disbursement of these resources shall be made only by the Bank in US dollars. The same currency shall be used to stipulate the remuneration and payments to consultants, except in the case of local consultants working in their own borrowing member country who shall have their remuneration defined and paid in the currency of such country. No resources of the Fund shall be made available to cover amounts greater than the amount certified herein above for the implementation of this operation. Amounts greater than the certified amount may arise from commitments on contracts denominated in a currency other than the Fund currency, resulting in currency exchange rate differences, represent a risk that will not be absorbed by the Fund.

Original signed — 10/27/16

Sonia M. Rivera
Chief
Grants and Co-Financing Management Unit
ORP/GCM

Date

Approved: *Original signed* — 10/27/16

Ferdinando Regalia
Division Chief
Social Protection and Health Division
SCL/SPH

Date

IN REPLYING QUOTE DATE HEREOF AND No.....

MINISTRY OF FINANCE
49 Main & Urquhart Streets,
Georgetown,
Guyana.

September 22, 2016.

Ms. Sophie Makonnen
Resident Representative
Inter-American Development Bank
47 High Street
Kingston
GEORGETOWN.

Dear Ms. Makonnen,

Re: Technical Assistance Support to the Ministry of Health

Reference is made to my correspondence dated November 27, 2015 on the subject at caption.

To this end, the Government of Guyana requested technical assistance to support (i) the Ministry of Social Protection in preparing a social protection strategy; and (ii) the Ministry of Health in addressing challenges in reducing maternal, infant and child mortality.

In this regard, the Ministry of Finance requests that the Inter-American Development Bank implements the abovementioned Technical Assistance on the behalf of the Government of Guyana.

Sincerely

Winston Jordan
Minister of Finance

IN REPLYING QUOTE DATE HEREOF AND No.....

MINISTRY OF FINANCE
49 Main & Urquhart Streets,
Georgetown,
Guyana.

November 27, 2015

Ms. Sophie Makonnen
Representative
Inter- American Development Bank
47 High Street
Kingston
Georgetown

Dear Ms. Makonnen,

Re: Technical Assistance Support to the Ministry of Social Protection and the Ministry of Health

As you are aware, the Government of Guyana has been continuously challenged by issues related to maternal, new-born and child health; and social protection.

The Government of Guyana, in aiming to assess social protection systems and address poverty, vulnerability and maternal and child health, requests the Technical Assistance of the Inter- American Development Bank.

In this regard, the Government of Guyana hereby seeks the following:

- Technical Assistance support in the amount of $350,000 to the Ministry of Social Protection to assist in the preparation of a social protection strategy which will identify priorities, resource and institutional strengthening needs; and

- Technical Assistance support in the amount of $350,000 to the Ministry of Health to aid in addressing key challenges in reducing maternal, infant and child mortality.

- Additionally, the Ministry of Finance also seeks the assistance of the Bank in financing a knowledge exchange visit by two officers within the Ministry of Health, Guyana to a Latin American country to observe systems of implementing maternal, neonatal, child, and reproductive health services at the primary as well as at the hospital levels.

I would like to take this opportunity to thank the Inter- American Development Bank for their meaningful assistance and partnership in realising development in Guyana.

Sincerely

Winston Jordan
Hon. Minister of Finance

TERMS OF REFERENCE

AN ASSESSMENT OF THE ORGANIZATIONAL STRUCTURE OF THE MATERNAL AND CHILD UNIT AND DEVELOPMENT OF A NEW ORGANAFRAM

Support for Maternal and Child Health Improvement Program

I. BACKGROUND

1.1 Over the last two decades significant progress has been made within the health sector of Guyana. Life expectancy increased from 62 years in 1991 to 67 years in 2015 and the burden of communicable diseases such as HIV/AIDs, malaria, and tuberculosis decreased.[1] Guyana met the Millennium Development Goals targets for nutrition, child health (under five years of age), and communicable diseases,[2] as well as the ones related to water and sanitation,[3] improving health outcomes.

1.2 Despite this progress, Guyana continues to experience maternal and infant mortality rates (less than one year of age) that are among the highest in the Latin America and the Caribbean (LAC) region. The maternal mortality ratio is estimated at 121 per 100,000 live births and the infant mortality rate is estimated at 23 per 1,000 live births. The majority of infant deaths occur in the neonatal period (up to 28 days after birth). The main causes of maternal mortality are post-partum hemorrhage and pregnancy induced hypertension, while the leading causes of neonatal deaths are prematurity and respiratory illness. The rate of adolescent pregnancy is high (about 20% of all live births), illustrating a gap in services for younger populations.

1.3 Inadequate access, use, and quality of reproductive, maternal, and neonatal health services are some of the main factors negatively impacting maternal and neonatal health outcomes. For instance, the unmet need for contraception in Guyana is 28%, one of the highest in the LAC region. Additionally, only 54% of women initiated antenatal care during the first trimester of pregnancy, posing significant risks to mothers and newborns.

1.4 The main factors contributing to maternal and neonatal outcomes in Guyana are related to inadequate access, use, and quality of reproductive, maternal, and neonatal health services, the organization of the health care network and the critical shortage of human resources for health (HRH).

1.5 With respect to HRH, Guyana in 2008 had the lowest number of public sector physicians and the second lowest supply of nurses in the Region of the Americas (ROA).[4] The estimated ratio of the total number of physicians and nurses per 10,000 population in 2010 was 7.25 and if all public and private physicians, nurses, midwives and nursing assistants are included, Guyana's ratio increases to 17.7. The comparable figure for the non-Latin Caribbean was 21.7 while the current recommended World Health Organization (WHO) target ratio is 25 per 10,000 population. One of the main reasons for this shortage is the high rates of out-migration of nurses and doctors. In addition, there is a concentration of remaining health professionals in or near to the capital city of Georgetown which constitutes a

---

1 PAHO Basic Indicators.

2 The percentage of children under five who suffer from moderate to mild malnutrition reduced from 12% in 1997 to 6% in 2008. The under-five mortality rate declined from 102/1,000 LB in 1991 to 24 in 2014. HIV incidence decreased and access to antiretroviral drugs increased from 18.4% in 2004 to 83.5% in 2008. Sources: MDG Progress Report 2011, Chief Medical Officer Report 2014, and Health Vision 2020.

3 An estimated 94% of households have access to improved sources of drinking water and 95.4% to improved sanitation facilities. Guyana Multiple Indicator Cluster Survey 2014.

4 Pan American Health Organization, Health Information and Analysis Project. Health Situation in the Americas: Basic Indicators 2010. Washington, D.C., United States of America, 2010.

challenge for the health system.[5] The available evidence also suggests that the health workforce lacks the appropriate skills, competencies, and motivation,[6] as a result of deficiencies in the educational system[7] and insufficient on-the-job training and poor human resources management practices. The critical shortages are concentrated in primary care nursing staff, especially in the area of maternal and child health. In 2010, a Health Human Resources Gap Analysis[8] determined that Guyana requires an additional 309 nurses and that over 7,450 Guyanese nurses work abroad, with an expatriation rate of 81.1 percent. In response, Guyana recognizes the urgent need to: (i) design a range of solutions to contribute to closing the human resource gap outside of Georgetown in the short-term, potentially including the use of telemedicine and the development of alliances with non governmental organizations (NGOs); (ii) review the country's health educational system, including the nursing curricula to better focus on maternal and child health primary care delivery and the midwifery curricula; and (iii) develop employment recruitment and retention incentives for nurses and midwives.[9] While the country has responded to the shortage with increasing pre-service training, there is still urgent need to squarely address core issues that encourages retention, including strategies to improve the quality of work environments.

1.6 Another area of deficiency is the capacity weaknesses within the Ministry of Public Health's Maternal and Child Health Unit to effectively manage its program, namely the implementation of the immunization program, the maternal and child health strategy, as well addressing women's health concerns. An institutional assessment of the MCH Unit done in 2016 to support the preparation of GY-L1058 indicated that the MCH Unit lacks the technical and administrative depth and capacity to run an effective MCH program.[10] Though the structure of the unit has evolved to address some of the service delivery gaps, significant work still remains to be done with respect to setting a clear and defined program with performance targets, assessing the HR requirements and designing an appropriate structure to meet the needs of a well-functioning MCH Unit.

1.7 The Inter-American Development Bank aims to address such challenges through the execution of the investment loan "*Support to Maternal and Child Health"* (GY-L1058). This loan will be executed in concurrence with the technical cooperative (TC), *Support for Maternal and Child Health Improvement Program* (GY-T1121). The aim of both the loan and the TC are to reduce maternal, perinatal, and neonatal deaths in Guyana by 2020. The TC will finance institutional strengthening activities, focusing on the Maternal and Child Health Unit (MCH) within the MoPH, by supporting

---

5 Many regional hospitals, district hospitals, and health centers outside of region 4 do not meet the MPH' human resources standards (UNFPA 2010). Region 4 employs 73.6% of Guyana's total physician workforce (PAHO 2010).

6 In the 2010 UNFPA survey, a group of 36 providers scored an average of 75% on how to diagnose asphyxia and on what to do if a newborn is not breathing or breathing slow.

7 In the face of ongoing shortages, nursing enrolments were increased significantly. The country's three nursing schools were under-resourced to accommodate the increase in the number of student; as a result, the quality of programs deteriorated and student course completion and exam pass rates declined. The lack of employment incentives, performance appraisal, and reward systems, combined with inadequate salaries with no benefits or pay increases have been identified as the main challenges in this area (PAHO 2010).

8 Dubois, Carl A., Ingabire, M-G. Implementing Guyana's Package of Publicly Guaranteed Health Services (PPGHS): Bridging Health Human Resource Gaps. PAHO. February, 2010

9 Strengthening the Foundation: A Health Human Resources Action Plan for Guyana, 2011 to 2016. PAHO. Ministry of Health, Guyana, December 2010

10 Institutional Evaluation of the MOPH, GUYANA. Andres Garrett, Institutional and Financial Consultant, July 2016.

improvements to the supply of human resources and financing technical studies. IDB has previously funded projects in Guyana focused on health systems and nutrition.

II. PURPOSE OF THE CONSULTANCY

2.1 The objectives of the study are as follows: (1) access the effectiveness and efficiency of the MCH Unit current organizational structure in achieving its goals in the context of its mandate to implement MoPH's maternal and child health program; (ii) develop a new MCH Unit organogram in line with its mandate and activities proposed under GY-L1058.

III. CHARACTERISTICS OF THE CONSULTANCY

3.1 **Type of consultancy:** Individual consultant

3.2 **Start date and duration:** 40 non-consecutive days, from x to x

3.3 **Location(s) where services are to be provided:** Guyana

3.4 **Qualifications:** The consultant must hold a Master's Degree in human resource management, public health or similar fields of knowledge. The consultant must have demonstrated in-depth knowledge of human resource management in the health sector in the Caribbean and Latin America.

IV. ACTIVITIES OF THE CONSULTANCY

4.1 Conduct a literature review of similar previous studies in the country: a review of all the literature on human resource management and gaps in the MoPH and the Regional Authorities. Consult with the MOPH, MCH Unit, the Public Service Commission, Nurses Association, Nurses training Agencies, etc to determine HR issues and needs.

4.2 Assess human resource needs for the MCH Unit and overall program with particular emphasis on administrative and technical staff and for midwives and propose solutions to bridge the human resource gap.

4.3 Review the organization of the MoPH and the MCH Unit in the context of their mandate and work program and identify the most appropriate and effective organization structure for the MCH Unit. Develop job descriptions for positions in the proposed structure.

V. OUTPUTS, REPORTS AND PAYMENTS

5.1 20% upon execution of the contract and delivery schedule for the completion of the study

5.2 25% upon submittal of report containing methodology, finalized schedule and work plan

5.3 25% upon submittal of the preliminary report with the results of the study focusing on the barriers to demand and supply of health services

5.4 30% upon submittal of final consultancy report and recommendations for interventions

VI. COORDINATION

6.1 The consultant's work will be managed by IDB staff Donna Harris (SPH/CJA) and Marcella Distrutti (SCL/SPH).

TERMS OF REFERENCE

DEVELOPMENT OF RECRUITMENT AND RETENTION PLAN FOR NURSES AND MIDWIVES IN GUYANA

BACKGROUND

1.1 Over the last two decades significant progress has been made within the health sector of Guyana. Life expectancy increased from 62 years in 1991 to 67 years in 2015 and the burden of communicable diseases such as HIV/AIDs, malaria, and tuberculosis decreased.[1] Guyana met the Millennium Development Goals targets for nutrition, child health (under five years of age), and communicable diseases,[2] as well as the ones related to water and sanitation,[3] positively impacting health outcomes.

1.2 Despite this progress, Guyana continues to experience maternal and infant mortality rates (less than one year of age) that are among the highest in the Latin America and the Caribbean (LAC) region. The maternal mortality ratio is estimated at 121 per 100,000 live births and the infant mortality rate is estimated at 23 per 1,000 live births. The majority of infant deaths occur in the neonatal period (up to 28 days after birth). The main causes of maternal mortality are post-partum hemorrhage and pregnancy induced hypertension, while the leading causes of neonatal deaths are prematurity and respiratory illness. Pregnancy in adolescence is high (about 20% of all live births), illustrating a gap in services for younger populations.

1.3 The national health system in Guyana is public, universal, and free for all. Most people depend directly on the public sector; however an estimated 5% of the population utilizes private services through voluntary private health insurance. The Ministry of Public Health (MoPH) is the steward of the system, responsible for policy-setting, regulation and supervision, and health surveillance.

1.4 The public system is financed by general taxation; public health expenditures represented 3.1% of GDP in 2014. Regional Democratic Councils (RDCs) are responsible for service provision, under the guidance and oversight of the MoPH. The health care network includes health posts, health centers, district hospitals, regional hospitals, and national referral hospitals.

1.5 According to a report issued by the Pan-American Health Organization and the MoPH, Guyana maintains the lowest number of physicians in the public sector per 10,000 (2.2), of the 32 countries in the region that reported data on their health workforces in 2008. Guyana has the second lowest ratio of nurses (4.0) in the region.

1.6 External migration of health professionals, especially clinical staff such as nurses and physicians – has created a serious workforce shortage in the health field and placed constraints on health services provision to the population.

1.7 The University of Guyana has a Faculty of Health Sciences with a School of Medicine and other departments which offer Bachelor of Science degrees in medical technology and nursing, and associate degrees in pharmacy, environmental health, and radiography. There are three public nursing schools – one in Georgetown and one each of the country's two other largest towns (Linden and New Amsterdam) – as well as one private school at the St. Joseph Mercy Hospital in Georgetown.

---

1 PAHO Basic Indicators.

2 The percentage of children under five who suffer from moderate to mild malnutrition reduced from 12% in 1997 to 6% in 2008. The under-five mortality rate declined from 102/1,000 LB in 1991 to 24 in 2014. HIV incidence decreased and access to antiretroviral drugs increased from 18.4% in 2004 to 83.5% in 2008. Sources: MDG Progress Report 2011, Chief Medical Officer Report 2014, and Health Vision 2020.

3 An estimated 94% of households have access to improved sources of drinking water and 95.4% to improved sanitation facilities. Guyana Multiple Indicator Cluster Survey 2014.

1.8 The Ministry of Health Department of Health Sciences Education provides training for the lower and mid-level cadres who serve primarily in rural areas. Training lasts 12-18 months and is provided for rural midwives, x-ray technicians, laboratory assistants, rehabilitation assistants, environmental health assistants, and for medex (mid-level physician assistants).

1.9 The Inter-American Development Bank aims to address health challenges in Guyana through the execution of the investment loan "*Support to Maternal and Child Health"* (GY-L1058). This loan will be executed in parallel to the technical cooperation (TC), *Support for Maternal and Child Health Improvement Program* (GY-T1121). The aim of both the loan and program are to reduce maternal, perinatal, and neonatal deaths in Guyana by 2020. The TC will finance institutional strengthening activities, focusing on the Maternal and Child Health Department (MCD) within the MoPH, by supporting improvements to the supply of human resources and financing technical studies. The Bank has previously funded projects in Guyana focused on health systems and nutrition.

II. PURPOSE OF THE CONSULTANCY

2.1 The objective of the consultancy is to develop a recruitment and retention plan for nurses, focusing on cost-effective initiatives.

2.2 Incentives for employment recruitment and retention need to be developed that focus more broadly on quality work environments. Consideration needs to be given to the kinds of incentives that would be the most cost-effective, particularly within the health regions.

2.3 This consultancy consists of a literature review, diagnostic assessment, and final report. A completed recruitment and retention plan for nurses will included a detailed implementation plan, specific timelines, identified partner commitments, and defined resource requirements.

2.4 The assessment will be carried out by means of interviews with the MoPH, cadres of nurses and midwives, and other relevant educational and health sectors. The consultant will evaluate the capacity and gaps in the nursing and midwifery workforce as well as focus on developing cost-effective incentives. Examples of these incentives include the setting of flexible hours, options to work on a full-time, part-time or casual basis, flexible vacation time and creating safe and healthy work environments.

2.5 Use of qualitative methods (focus groups, interviews, or surveys) is recommended in conducting this assessment, and the consultant is expected to make a methodological proposal preliminary to the study that should include data collection methods, as well as data analysis methods. The assessment should help the consultant define clearly stated, concrete recommendations, cost-effective interventions, and aid in the development of an implementation plan.

III. CHARACTERISTICS OF THE CONSULTANCY

3.1 **Type of consultancy:** Individual consultant

3.2 **Start date and duration:** XX non-consecutive days, from MONTH X 20XX- MONTH X 20XX

3.3 **Location(s) where services are to be provided:** Guyana

3.4 **Qualifications:** The consultant must hold a Master's Degree in anthropology, sociology, public health or similar fields of knowledge, and have previous work

experience with health systems and human resources for health. Extensive experience in fieldwork and in conducting rapid diagnostic assessments in the health human resources and health systems fields. The consultant must have demonstrated in-depth knowledge of health systems strengthening from the perspective of health personnel recruitment and retention, as well as experience in participatory diagnoses. Publication of previous works with similar characteristics is desirable.

IV. ACTIVITIES OF THE CONSULTANCY

4.1 Develop a work plan for consultancy, including a schedule of activities, together with the IDB, and the MoPH.

4.2 Review the results of previous consultancies in Guyana related to human resource development and their review of the institutional framework, the system of information and of regulatory mechanisms, monitoring and supervision.

4.3 Conduct a comprehensive situation analysis, a labour market analysis, and an analysis of the factors that influences decisions of health workers to stay or leave remote and rural areas. This should be conducted giving due consideration to broader social, economic, and political factors at the national, subnational and regional level that influence personnel retention.

4.4 Conduct a literature of retention and recruitment plans developed and implemented in similar country contexts; specifically focusing on cost-effective incentives, including the aforementioned setting of flexible hours, options to work on a full-time, part-time or casual basis, flexible vacation time and creating safe and healthy work environments.

4.5 Conduct a rapid diagnostic assessment, analyzing the capacities and gaps in human resources and competencies/skills pertaining to nurses and midwives. The assessment will include both current nurses and midwives, relevant MoPH staff, and health educational staff

4.6 Organize and conduct meetings with MoPH and relevant sectors to discuss options for promotion and training in recruitment and retention of nurses and midwives, identifying priorities.

4.7 Develop a preliminary recruitment and retention plan for nurses and midwives, included a detailed implementation plan, precise timelines, identified partner commitments and defined resource requirements. Consider the following when developing the plan: relevance, acceptability, affordability, effectiveness, and impact.

4.8 Hold meetings for reviewing and discussing the proposed plan. This will help determine relevance to national health priorities and the expectations of health workers and their communities, as well as, facilitate the engagement of stakeholders.

4.9 Prepare implementation plans and end of the consultancy report, with recommendations and lessons learned. Submit finalized recruitment and retention plan.

V. OUTPUTS, REPORTS AND PAYMENTS

5.1 20% upon execution of the contract and delivery schedule for the completion of the assessment

5.2 25% upon submittal of report containing methodology, finalized schedule and work plan

5.3 25% upon submittal of the preliminary report with the results of the rapid diagnostic assessment focusing gaps and capacity of nurses and midwives. The report will also

include results for the literature review on cost-effective incentives for health personnel recruitment and retention.

5.4 30% upon submittal of final consultancy report and recommendations for institutional capacity building within the MCH Unit.

VI. COORDINATION

6.1 The consultant's work will be coordinated and managed by IDB staff in XX.

TERMS OF REFERENCE

REVISION OF THE HEALTH EDUCATION SYSTEM IN GUYANA

BACKGROUND

1.1 Over the last two decades significant progress has been made within the health sector of Guyana. Life expectancy increased from 62 years in 1991 to 67 years in 2015 and the burden of communicable diseases such as HIV/AIDs, malaria, and tuberculosis decreased.[1] Guyana met the Millennium Development Goals targets for nutrition, child health (under five years of age), and communicable diseases,[2] as well as the ones related to water and sanitation,[3] positively impacting health outcomes.

1.2 Despite this progress, Guyana continues to experience maternal and infant mortality rates (less than one year of age) that are among the highest in the Latin America and the Caribbean (LAC) region. The maternal mortality ratio is estimated at 121 per 100,000 live births and the infant mortality rate is estimated at 23 per 1,000 live births. The majority of infant deaths occur in the neonatal period (up to 28 days after birth). The main causes of maternal mortality are post-partum hemorrhage and pregnancy induced hypertension, while the leading causes of neonatal deaths are prematurity and respiratory illness. Pregnancy in adolescence is high (about 20% of all live births), illustrating a gap in services for younger populations.

1.3 The national health system in Guyana is public, universal, and free for all. Most people depend directly on the public sector; however an estimated 5% of the population utilizes private services through voluntary private health insurance. The Ministry of Public Health (MoPH) is the steward of the system, responsible for policy-setting, regulation and supervision, and health surveillance.

1.4 The public system is financed by general taxation; public health expenditures represented 3.1% of GDP in 2014. Regional Democratic Councils (RDCs) are responsible for service provision, under the guidance and oversight of the MoPH. The health care network includes health posts, health centers, district hospitals, regional hospitals, and national referral hospitals.

1.5 According to a report issued by the Pan-American Health Organization and the MoPH, Guyana maintains the lowest number of physicians in the public sector per 10,000 (2.2), of the 32 countries in the region that reported data on their health workforces in 2008. Guyana has the second lowest ratio of nurses (4.0) in the region.

1.6 External migration of health professionals, especially clinical staff such as nurses and physicians – has created a serious workforce shortage in the health field and placed constraints on health services provision to the population.

1.7 The University of Guyana has a Faculty of Health Sciences with a School of Medicine and other departments which offer Bachelor of Science degrees in medical technology and nursing, and associate degrees in pharmacy, environmental health, and radiography. There are three public nursing schools – one in Georgetown and one each of the country's two other largest towns (Linden and New Amsterdam) – as well as one private school at the St. Joseph Mercy Hospital in Georgetown.

---

1 PAHO Basic Indicators.

2 The percentage of children under five who suffer from moderate to mild malnutrition reduced from 12% in 1997 to 6% in 2008. The under-five mortality rate declined from 102/1,000 LB in 1991 to 24 in 2014. HIV incidence decreased and access to antiretroviral drugs increased from 18.4% in 2004 to 83.5% in 2008. Sources: MDG Progress Report 2011, Chief Medical Officer Report 2014, and Health Vision 2020.

3 An estimated 94% of households have access to improved sources of drinking water and 95.4% to improved sanitation facilities. Guyana Multiple Indicator Cluster Survey 2014.

1.8 The Ministry of Health Department of Health Sciences Education provides training for the lower and mid-level cadres who serve primarily in rural areas. Training lasts 12-18 months and is provided for rural midwives, x-ray technicians, laboratory assistants, rehabilitation assistants, environmental health assistants, and for medex (mid-level physician assistants).

1.9 The Inter-American Development Bank aims to address health challenges in Guyana through the execution of the investment loan "*Support to Maternal and Child Health"* (GY-L1058). This loan will be executed in parallel to the technical cooperation (TC), *Support for Maternal and Child Health Improvement Program* (GY-T1121). The aim of both the loan and program are to reduce maternal, perinatal, and neonatal deaths in Guyana by 2020. The TC will finance institutional strengthening activities, focusing on the Maternal and Child Health Department (MCD) within the MoPH, by supporting improvements to the supply of human resources and financing technical studies. The Bank has previously funded projects in Guyana focused on health systems and nutrition.

II. PURPOSE OF THE CONSULTANCY

2.1 The objective of the consultancy is to develop nursing and midwifery curriculums with a stronger focus on maternal and child health and primary care.

2.2 This consultancy consists of a literature review, diagnostic assessment, nursing and midwifery curriculums, curriculum training materials, and a final report. The training materials will enable facilitators to implement the curriculum in educational settings.

2.3 The assessment will be carried out by means of interviews with the MoPH, cadres of nurses, midwives, and other relevant educational and health sectors. The consultant will evaluate the capacity and gaps in nursing and midwifery education and skills, as well as, focus on maternal and child health and primary care.

2.4 Use of qualitative methods (focus groups, interviews, or surveys) is recommended in conducting this assessment, and the consultant is expected to make a methodological proposal preliminary to the study that should include data collection methods, as well as data analysis methods. The assessment should help identify gaps in nursing and midwifery education and training and provide insight on recommendations for implementation.

III. CHARACTERISTICS OF THE CONSULTANCY

3.1 **Type of consultancy:** Individual consultant

3.2 **Start date and duration:** XX non-consecutive days, from MONTH X 20XX- MONTH X 20XX

3.3 **Location(s) where services are to be provided:** Guyana

3.4 **Qualifications:** The consultant must hold a Master's Degree in health education, sociology, public health, nursing or similar fields of knowledge, and have previous work experience with maternal and child health, primary care, and the development of nursing and/or midwifery curriculum. Extensive experience in fieldwork and in conducting rapid diagnostic assessments in the health education and health worker curricula. The consultant must have demonstrated in-depth knowledge of MCH and its intersection with primary care in the context of curriculum for health personnel, as well as experience in participatory diagnoses. Publication of previous works with similar characteristics is desirable.

IV. ACTIVITIES OF THE CONSULTANCY

4.1 Develop a work plan for consultancy, including a schedule of activities, together with the IDB, and the MoPH.

4.2 Review the results of previous consultancies in Guyana related to curriculum development for nursing and midwifery staff and other clinical professionals. Additionally, review medical education standards, policies, and procedures in Guyana and those of countries with a similar development profile.

4.3 Conduct a literature of nursing and midwifery curriculums focusing on maternal and child health as well as primary health implemented in similar country contexts.

4.4 Conduct a rapid diagnostic assessment, analyzing the capacities and gaps in competencies/skills in the context of maternal and child health and primary care, pertaining to nursing and midwifery education. The assessment will include current nurses and midwives, relevant MoPH staff, and health educational staff.

4.5 Organize and conduct meetings with MoPH and relevant sectors to discuss options for a new nursing and midwifery curriculums, identifying priorities.

4.6 Develop nursing and midwifery curriculums that have a strong emphasis on primary health care as well as maternal and child health. Also develop materials to facilitate trainings on the new curriculums.

4.7 Hold meetings for reviewing and discussing the proposed new curriculums and their implementation. This will help determine relevance to national health priorities and the expectations of nurses, midwives, and their communities, as well as, facilitate the engagement of stakeholders.

4.8 Prepare an end of the consultancy report, with recommendations and lessons learned. Submit finalized nursing and midwifery curriculums.

V. OUTPUTS, REPORTS AND PAYMENTS

5.1 20% upon execution of the contract and delivery schedule for the completion of the assessment

5.2 25% upon submittal of report containing methodology, finalized schedule and work plan

5.3 25% upon submittal of a nursing and midwifery curriculums with a strong maternal and child health primary care focus.

5.4 30% upon submittal of final consultancy report and recommendations for the implementation of the curriculums.

VI. COORDINATION

6.1 The consultant’s work will be coordinated and managed by IDB staff in XX.

TERMS OF REFERENCE

KNOWLEDGE EXCHANGE WITH COSTA RICA AND HONDURAS

BACKGROUND

1.1 Over the last two decades significant progress has been made within the health sector of Guyana. Life expectancy increased from 62 years in 1991 to 67 years in 2015 and the burden of communicable diseases such as HIV/AIDs, malaria, and tuberculosis decreased.[1] Guyana met the Millennium Development Goals targets for nutrition, child health (under five years of age), and communicable diseases,[2] as well as the ones related to water and sanitation,[3] positively impacting health outcomes.

1.2 Despite this progress, Guyana continues to experience maternal and infant mortality rates (less than one year of age) that are among the highest in the Latin America and the Caribbean (LAC) region. The maternal mortality ratio is estimated at 121 per 100,000 live births and the infant mortality rate is estimated at 23 per 1,000 live births. The majority of infant deaths occur in the neonatal period (up to 28 days after birth). The main causes of maternal mortality are post-partum hemorrhage and pregnancy induced hypertension, while the leading causes of neonatal deaths are prematurity and respiratory illness. Pregnancy in adolescence is high (about 20% of all live births), illustrating a gap in services for younger populations.

1.3 The national health system in Guyana is public, universal, and free for all. Most people depend directly on the public sector; however an estimated 5% of the population utilizes private services through voluntary private health insurance. The Ministry of Public Health (MoPH) is the steward of the system, responsible for policy-setting, regulation and supervision, and health surveillance.

1.4 The public system is financed by general taxation; public health expenditures represented 3.1% of GDP in 2014. Regional Democratic Councils (RDCs) are responsible for service provision, under the guidance and oversight of the MoPH. The health care network includes health posts, health centers, district hospitals, regional hospitals, and national referral hospitals.

1.5 The Inter-American Development Bank aims to address health challenges in Guyana through the execution of the investment loan "*Support to Maternal and Child Health"* (GY-L1058). This loan will be executed in parallel to the technical cooperation (TC), *Support for Maternal and Child Health Improvement Program* (GY-T1121). The aim of both the loan and program are to reduce maternal, perinatal, and neonatal deaths in Guyana by 2020. The TC will finance institutional strengthening activities, focusing on the Maternal and Child Health Department (MCD) within the MoPH, by supporting improvements to the supply of human resources and financing technical studies. The Bank has previously funded projects in Guyana focused on health systems and nutrition.

II. PURPOSE OF THE CONSULTANCY

2.1 The objective of the consultancy is to facilitate a knowledge exchange with Costa Rica and Honduras to observe modern methods and approaches in the delivery of child/maternal services under the Salud Mesoamerica Initiative.

---

1 PAHO Basic Indicators.

2 The percentage of children under five who suffer from moderate to mild malnutrition reduced from 12% in 1997 to 6% in 2008. The under-five mortality rate declined from 102/1,000 LB in 1991 to 24 in 2014. HIV incidence decreased and access to antiretroviral drugs increased from 18.4% in 2004 to 83.5% in 2008. Sources: MDG Progress Report 2011, Chief Medical Officer Report 2014, and Health Vision 2020.

3 An estimated 94% of households have access to improved sources of drinking water and 95.4% to improved sanitation facilities. Guyana Multiple Indicator Cluster Survey 2014.

2.2 This consultancy consists of literature review, program plan, study tour reports, and final report. The program plan will include platforms for the exchange of ideas as well as an itinerary for study tours for MoPH staff and programmatic activities.

III. CHARACTERISTICS OF THE CONSULTANCY

3.1 **Type of consultancy:** Individual consultant

3.2 **Start date and duration:** XX non-consecutive days, from MONTH X 20XX- MONTH X 20XX

3.3 **Location(s) where services are to be provided:** Guyana

3.4 **Qualifications:** The consultant must hold a Master's Degree in development, sociology, public health, or similar fields of knowledge, and have previous work experience with maternal and child health, capacity building, and planning/implementing health-related study tours. The consultant must have demonstrated experience arranging and designing technical tours and the corresponding programing. Documentation of previous works with similar characteristics is desirable. Fluency in spoken and written English and Spanish is required. Previous work experience in Guyana, Costa Rica, and/or Honduras is preferred. Familiarity with the Salud Mesoamerica Initiative is desired.

IV. ACTIVITIES OF THE CONSULTANCY

4.1 Develop a work plan for consultancy, including a schedule of activities, together with the IDB, and the MoPH.

4.2 Review the results of previous consultancies in Guyana related to study tours for government and MoPH officials. Additionally, review official health documents on maternal and child health service delivery under the Salud Mesoamerica Initiative for Honduras and Costa Rica.

4.3 Conduct a literature of previous study tours for government officials in the field of health service delivery, maternal and child health if possible. Look at study tours that occurred in countries with a similar development profile.

4.4 Utilize the results of previous rapid diagnostic assessment analyzing the capacities and gaps in competencies/skills in maternal and child health service delivery in Guyana. The assessment will guide the planning of activities and themes of discussion for the study tours.

4.5 Organize and conduct meetings with MoPH and relevant sectors to discuss expectations and options of activities for the study tours.

4.6 Coordinate with partners in Costa Rica and Honduras to organize activities and set an agenda for the study tours.

4.7 Develop itinerary and corresponding activities that facilitate a knowledge exchange between Guyana and representatives from Costa Rica and Honduras to observe modern methods and approaches in the delivery of child/maternal services under the Salud Mesoamerica Initiative. This includes providing a detailed schedule for study-tour activities which includes liaison with resource persons to deliver presentations in briefing sessions, and with hosting organizations for visiting maternal and child health agencies/departments and NGOs.

4.8 Work with necessary parties, IDB and the MoPH to identify criteria for participating in the study tour.

4.9 Hold meetings for reviewing and discussing the proposed itinerary and programmatic plan.

4.10 Conduct study tour. This includes logistic arrangements and itinerary which include accommodation arrangements, and in-country travels in visiting country, interpretation when needed.

4.11 Prepare an end of the consultancy report, with recommendations and lessons learned. A preliminary update report should be written for each study tour completed.

V. OUTPUTS, REPORTS AND PAYMENTS

5.1 20% upon execution of the contract and delivery schedule for the completion of the assessment

5.2 25% upon submittal of report containing methodology, finalized schedule and work plan

5.3 25% upon submittal of a Back-to-office study tour reports.

5.4 30% upon completion of knowledge exchange and submission of final report.

VI. COORDINATION

6.1 The consultant's work will be coordinated and managed by IDB staff in XX.

TERMS OF REFERENCE

QUALITATIVE STUDY ON SUPPLY AND DEMAND BARRIERS TO ACCESS AND USE OF REPRODUCTIVE, MATERNAL, AND NEONATAL HEALTH SERVICES IN GUYANA

I. BACKGROUND

1.1 Over the last two decades significant progress has been made within the health sector of Guyana. Life expectancy increased from 62 years in 1991 to 67 years in 2015 and the burden of communicable diseases such as HIV/AIDs, malaria, and tuberculosis decreased.[1] Guyana met the Millennium Development Goals targets for nutrition, child health (under five years of age), and communicable diseases,[2] as well as the ones related to water and sanitation,[3] positively impacting on health outcomes.

1.2 Despite this progress, Guyana continues to experience maternal and infant mortality rates (less than one year of age) that are among the highest in the Latin America and the Caribbean (LAC) region. The maternal mortality ratio is estimated at 121 per 100,000 live births and the infant mortality rate is estimated at 23 per 1,000 live births. The majority of infant deaths occur in the neonatal period (up to 28 days after birth). The main causes of maternal mortality are post-partum hemorrhage and pregnancy induced hypertension, while the leading causes of neonatal deaths are prematurity and respiratory illness. Pregnancy in adolescence is high (about 20% of all live births), illustrating a gap in services for younger populations.

1.3 Inadequate access, use, and quality of reproductive, maternal, and neonatal health services are some of the main factors negatively impacting maternal and neonatal health outcomes. For instance, the unmet need for contraception in Guyana is 28%, one of the highest in the LAC region. Additionally, only 54% of women initiated antenatal care during the first trimester of pregnancy, posing significant risks to mothers and newborns.

1.4 There are significant geographic inequities in access to health care, particularly in the rural interior where the majority of residents are indigenous. In Region 1 only 67% of women had four antenatal consultations, and in Region 9 institutional deliveries are estimated at 47%. Unmet need for contraception varies between 22% in Region 6 to 40% in Region 1.[4]

1.5 Evidences shows that the main barriers for accessing contraceptives, as reported by women of reproductive age, are health concerns and fear of side effects, which may be improved by health education and information through adequate family planning counselling and communication campaigns. Previous research shows that the main barriers for access and use of health care, on the supply side, are related to the insufficient availability of providers and drugs and other supplies. On the demand side, the main barriers include not wanting to go alone and having to take transport.

1.6 Demand-side barriers can influence important patient decisions regarding the use of health services, particularly in the rural interior. For example, delays in recognizing signs of complications and deciding to seek care for an obstetric emergency contribute to negative maternal and neonatal outcomes.

---

1 PAHO Basic Indicators.

2 The percentage of children under five who suffer from moderate to mild malnutrition reduced from 12% in 1997 to 6% in 2008. The under-five mortality rate declined from 102/1,000 LB in 1991 to 24 in 2014. HIV incidence decreased and access to antiretroviral drugs increased from 18.4% in 2004 to 83.5% in 2008. Sources: MDG Progress Report 2011, Chief Medical Officer Report 2014, and Health Vision 2020.

3 An estimated 94% of households have access to improved sources of drinking water and 95.4% to improved sanitation facilities. Guyana Multiple Indicator Cluster Survey 2014.

4 MICS 2014

1.7 The Inter-American Development Bank aims to address such challenges through the execution of the investment loan "*Support to Maternal and Child Health"* (GY-L1058). This loan will be executed in parallel to the technical cooperative (TC), *Support for Maternal and Child Health Improvement Program* (GY-T1121). The aim of both the loan and program are to reduce maternal, perinatal, and neonatal deaths in Guyana by 2020. The TC will finance institutional strengthening activities, focusing on the Maternal and Child Health Department (MCD) within the MoPH, by supporting improvements to the supply of human resources and financing technical studies. The Bank has previously funded projects in Guyana focused on health systems and nutrition.

II. PURPOSE OF THE CONSULTANCY

2.1 The objectives of the study are as follows: (1) assess readiness of the physical health facilities network to deliver the MCH program; (2) collect information on the barriers to access on the side of supply and demand of reproductive, maternal, and neonatal health services at the local level, using qualitative methods.

2.2 This study consists of a qualitative analysis and participatory diagnostic conducted at local level to determine supply and demand barriers to accessing reproductive, maternal, and neonatal health services.

2.3 Focus groups for women (15-18 years of age, 18-25, 25-45) and men (15-21, 22-29, and 30-45) from indigenous and non-indigenous populations should be conducted to determine their level of knowledge of family planning, prenatal checkups, labor and delivery; their decisions to use or not to use health care services; and identification of geographical, financial, cultural and other barriers to use of health care services. Once these barriers are identified, the consultant should discuss and propose within the groups, possible actions that could be taken to overcome these barriers.

2.4 In addition, the study will be complemented by means of interviews with healthcare providers and managers. On the supply side, difficulties of providing health care services in these areas should be taken into consideration, and should include community health care providers, midwives, technicians, and primary health care nurses and physicians. Some of the barriers may be related to lack of medicines, payment to providers and other medical supplies. In this case, the consultant must conduct an analysis of processes at local level to identify process barriers from the bottom up, meaning the consultant should identify if clinics set goals and quality improvement guidelines at the local level, measure their performance, what incentives these actors have, who supervises them, and who controls the budget, access to medications, and makes decisions about human resources. This should also include managers at the district level including poly-clinical administrator and directors. This study will include urban and rural centers for each district.

2.5 Use of qualitative methods (focus groups, interviews, or observations) is recommended in conducting this study, and the consultant is expected to make a methodological proposal preliminary to the study that should include data collection methods, as well as data analysis methods. The study should help the consultant define clearly stated, concrete recommendations and interventions, based on suggestions from providers and users, which may be implemented to reduce access barriers to the health care services identified during the qualitative studies.

III. CHARACTERISTICS OF THE CONSULTANCY

3.1 **Type of consultancy:** Individual consultant

3.2 **Start date and duration:** XX non-consecutive days, from MONTH X 20XX- MONTH X 20XX

3.3 **Location(s) where services are to be provided:** Guyana

3.4 **Qualifications:** The consultant must hold a Master's Degree in anthropology, sociology, public health or similar fields of knowledge, and have previous work experience with marginal and indigenous groups in Latin America and the Caribbean. Extensive experience in fieldwork and in conducting and facilitating qualitative studies in the maternal and child health and health systems fields. The consultant must have demonstrated in-depth knowledge of access barriers to and use of health care services from the perspective of supply and demand, as well as experience in participatory diagnoses and mapping processes. Publication of previous works with similar characteristics is desirable.

IV. ACTIVITIES OF THE CONSULTANCY

4.1 Submittal of a methodological proposal for the collection and analysis of data on access barriers to and use of reproductive, maternal, and neonatal health services at the local level in Guyana, as well as a work plan including trips to the communities and facilities where *Support for Maternal and Child Health Improvement Program* will be implemented, and a study schedule. The proposal must include the interview questionnaires and script, consent forms, and approval plan by an ethics committee in Guyana.

4.2 Conduct a literature review of similar previous studies in the country: a review of the literature on barriers to access and use of reproductive, maternal, and neonatal health services. Additionally review similar studies that have been conducted in countries with a similar health profile and level of development.

4.3 Conduct study to identify supply and demand side barriers to access reproductive, maternal, and neonatal health services at the local level health care services in country. Use the findings of the barriers study to establish clearly stated and concrete recommendations on possible interventions on the side of supply and demand that may be implemented to reduce access barriers to reproductive, maternal, and neonatal health services at the local level. The aforementioned recommendations should be justified by means of examples from similar contexts.

4.4 Analysis of supply side barriers:

4.5 Design and carry out a methodology for collecting and analyzing data on barriers to access health services in the poorest populations, and a work plan including travel to communities and areas where the *Support for Maternal and Child Health Improvement Program* will be implemented and schedule to stop the study. The proposal should include questionnaires, script, consent forms and plan for approval by an ethics committee in Guyana.

4.6 The methodology should include at least the following aspects

a. Relevance of the types of services offered to the public

b. Level of demand in clinics (congestion, waiting times)

c. Opening hours

d. Waiting times by beneficiaries

e. Supply of inputs

f. Basic equipment

g. Adequacy of staffing

h. Training human resources

i. Monitoring services

j. Institutional practices that facilitate or constrain the effectiveness of service delivery such as supervision, use of direct incentives

k. Asking staff what they would change to improve services

4.7 Activities include:

4.8 Visit X primary and secondary care-level units in the areas previously mentioned (Fixed Network and attention shifting, if applicable) and second level, as well. The specific activities would be:

a. Instrument design;

b. Training of field staff;

c. Survey and monitoring;

d. Transcription and triangulation, and

e. Analysis of results and preparation of a report with key findings and recommendations.

f. Review layout of the MoPH and interview staff responsible for maternal and child health components in the central level the MoPH.

4.9 Analysis of barriers to demand

4.10 Create a profile of users of the identified reproductive, maternal, and neonatal health services. Such characterization should include information on the profile of poverty and population health. The consultant can perform the analysis with sources of information considered relevant to the analysis (surveys, censuses, etc).

4.11 Explore barriers hypothesis directly from the perspective of users of health services through X focus groups, using a participatory approach to capture what are the perceived barriers and what would be necessary to create behavior change in these individuals.

4.12 Conduct focus groups with users of the health system in the areas and groups previously mentioned in conjunction with the MoPH staff

4.13 The activities include, inter alia, the following:

a. Design guidelines

b. Recruitment of participants

c. Moderation meetings

d. Transcription

e. Analysis of results

4.14 Analysis and Recommendations:

4.15 Conduct a study to identify bars access to health services for both supply and demand. Using the results from the study of barriers to establish clear and concrete recommendations on possible interventions by both the supply and demand sides that could be implemented to reduce barriers of access to health services in Guyana. These recommendations must be supported with examples made in similar contexts.

4.16 The study will develop a matrix analysis of alternative adjustments and innovations on the basis of the analysis, which will identify the complexity and feasibility of each recommendation.

V. OUTPUTS, REPORTS AND PAYMENTS

5.1 20% upon execution of the contract and delivery schedule for the completion of the study

5.2 25% upon submittal of report containing methodology, finalized schedule and work plan

5.3 25% upon submittal of the preliminary report with the results of the study focusing on the barriers to demand and supply of health services

5.4 30% upon submittal of final consultancy report and recommendations for interventions

VI. COORDINATION

6.1 The consultant's work will be coordinated and managed by IDB staff in XX.

TERMS OF REFERENCE

TECHNICAL OVERSIGHT OF PROGRAM AND CAPACITY BUILDING OF THE MCH UNIT IN GUYANA

Support for Maternal and Child Health Improvement Program

BACKGROUND

1.1 Over the last two decades significant progress has been made within the health sector of Guyana. Life expectancy increased from 62 years in 1991 to 67 years in 2015 and the burden of communicable diseases such as HIV/AIDs, malaria, and tuberculosis decreased.[1] Guyana met the Millennium Development Goals targets for nutrition, child health (under five years of age), and communicable diseases,[2] as well as the ones related to water and sanitation,[3] positively impacting on health outcomes.

1.2 Despite this progress, Guyana continues to experience maternal and infant mortality rates (less than one year of age) that are among the highest in the Latin America and the Caribbean (LAC) region. The maternal mortality ratio is estimated at 121 per 100,000 live births and the infant mortality rate is estimated at 23 per 1,000 live births. The majority of infant deaths occur in the neonatal period (up to 28 days after birth). The main causes of maternal mortality are post-partum hemorrhage and pregnancy induced hypertension, while the leading causes of neonatal deaths are prematurity and respiratory illness. Pregnancy in adolescence is high (about 20% of all live births), illustrating a gap in services for younger populations.

1.3 The national health system in Guyana is public, universal, and free for all. Most people depend directly on the public sector; however an estimated 5% of the population access private services through voluntary private health insurance. The Ministry of Public Health (MoPH) is the steward of the system, responsible for policy-setting, regulation and supervision, and health surveillance.

1.4 The public system is financed by general taxation; public health expenditures represented 3.1% of GDP in 2014. Regional Democratic Councils (RDCs) are responsible for service provision, under the guidance and oversight of the MoPH. The health care network includes health posts, health centers, district hospitals, regional hospitals, and national referral hospitals.

1.5 The Family Health Department (or "Primary Healthcare Department"/Program headed by the Deputy Chief Medical Officer (DCMO) is responsible for a number of core health programs delivered by the MoPH centrally and locally. In particular, Maternal and Child Health unit. The MCH unit is charged with the administration and execution of family health programs including immunization programs, women's health, child care and others. The Maternal and Child Health Unit (Sub-Program), headed by the Maternal and Child Health (MCH) Officer, and works in collaboration with the Regional Health Services Department and other programs/departments in the implementation of its activities.

1.6 The MCH Unit is comprised of the following positions: (a) 1 MCH Officer; (b) 2 medical experts, of whom 1 is responsible for assisting in vaccination and one to assisting in prevention of mother to child transmission of HIV; (c) 3 health nurses

---

1 PAHO Basic Indicators.

2 The percentage of children under five who suffer from moderate to mild malnutrition reduced from 12% in 1997 to 6% in 2008. The under-five mortality rate declined from 102/1,000 LB in 1991 to 24 in 2014. HIV incidence decreased and access to antiretroviral drugs increased from 18.4% in 2004 to 83.5% in 2008. Sources: MDG Progress Report 2011, Chief Medical Officer Report 2014, and Health Vision 2020.

3 An estimated 94% of households have access to improved sources of drinking water and 95.4% to improved sanitation facilities. Guyana Multiple Indicator Cluster Survey 2014.

(retired) who act as health visitors responsible for surveillance, health quality, and integrated management of childhood illness; (d) 1 national vaccination nurse and 3 nurses under her supervision; (e) 8 HIV counselors testers; (e) 1 Deputy Nursing Officer; and (e) 1 administrative manager, 1 clerk, 1 secretary and 2 drivers. However, it must be noted that only the counselor testers, the Deputy Nursing Officer and drivers have been officially formalized in the Department with fixed positions under the public service of Guyana, and the rest discharge their responsibilities under term contracts renewed on yearly basis.

1.7 The Inter-American Development Bank aims to address health challenges in Guyana through the execution of the investment loan "*Support to Maternal and Child Health"* (GY-L1058). This loan will be executed in parallel to the technical cooperative (TC), *Support for Maternal and Child Health Improvement Program* (GY-T1121). The aim of both the loan and program are to reduce maternal, perinatal, and neonatal deaths in Guyana by 2020. The TC will finance institutional strengthening activities, focusing on the Maternal and Child Health Department (MCD) within the MoPH, by supporting improvements to the supply of human resources and financing technical studies. The Bank has previously funded projects in Guyana focused on health systems and nutrition.

II. PURPOSE OF THE CONSULTANCY

2.1 The objectives of the consultancy are as follows: (1) provide technical oversight on the project; (2) support and facilitate capacity building of the MCH unit.

2.2 This consultancy consists of managing program implementation and supporting capacity building activities. It provides technical oversight to the design and implementation of activities under GY-l058 to improve the quality of reproductive, maternal and neo natal health services.

2.3 The consultant will utilize the assessment as well as feedback from the MCH to provide ongoing technical assistance and facilitate tailored capacity building. There will be a focus on institutional, functional and human resource requirements for MCH Unit. The consultant will provide technical assistance and monitoring of other consultants within the project and their corresponding work outlined in the project TORs.

2.4 The consultant will respond to the needs of the MCH unit, providing technical assistance as well as needed capacity building of program management. The consultant is responsible for the management and execution of the project work plan, as well as all deliverables.

III. CHARACTERISTICS OF THE CONSULTANCY

3.1 **Type of consultancy:** Individual consultant

3.2 **Start date and duration:** XX non-consecutive days, from MONTH X 20XX- MONTH X 20XX

3.3 **Location(s) where services are to be provided:** Guyana

3.4 **Qualifications:** The consultant must hold a Master's Degree in anthropology, sociology, public health or similar fields of knowledge, and have previous work experience with health systems and neonatal and maternal health service delivery.. The consultant must have demonstrated in-depth knowledge of health systems strengthening from the perspective of institutional capacity building, as well as experience in participatory diagnoses and mapping processes. The consultant should

have extensive prior experience in project management and providing technical assistance to government agencies.

IV. ACTIVITIES OF THE CONSULTANCY

4.1 Literature Review

4.2 Conduct a literature review looking at assessments of institutional capacity within the MoPH in Guyana as well as review similar studies that have been conducted in countries with a similar health profile and level of development. Review organizational documents related to the policies and procedures of the MCH unit and the broader MoPH context.

4.3 Plan for Technical Oversight:

4.4 Develop workplan in line with objectives of the program that incorporates the needs identified by the assessment and feedback from the MCH unit. Meet with the MCH unit to develop schedule and timeline of activities listed in the workplan. Identify areas for capacity building of program management skills. Meet with consultants to identify workplans specific to each of their TORs.

4.5 Provide technical assistance to consultants recruited under GY-L1058 as they execute their TORs and ensure that all project deliverables listed within those corresponding TORs are completed and achieved to the satisfaction of stakeholders.

4.6 Establish process of communication and feedback between the consultants as well as relevant staff at the MoPH and MCH unit. Set up regular check-ins with MoPH/MCH staff as well as IDB to monitor the progress of the program.

4.7 Make amendments to the workplan and activities based on discussions with appropriate parties. The consultant is responsible for any other output defined by the IDB that fulfills the needs of the project.

4.8 A final report will detail the technical oversight provided and deliverables achieved.

V. OUTPUTS, REPORTS AND PAYMENTS

5.1 20% upon execution of the contract and delivery schedule.

5.2 25% upon submittal of report containing finalized schedule and work plan

5.3 25% upon submittal of the midterm report with progress on capacity building activities for the MCH unit

5.4 30% upon submittal of final consultancy report including all capacity building activities and technical assistance completed within the MCH Unit.

VI. COORDINATION

6.1 The consultant’s work will be coordinated and managed by IDB staff in XX.

PROCUREMENT PLAN FOR NON-REIMBURSABLE TECHNICAL COOPERATIONS									
Country: Guyana				**Executing agency: SPH/CCB**					**Public sector**
Project number: GY-T1121				**Title of Project: Support for Maternal and Child Health Improvement Program**					
Period covered by the plan:									
Threshold for ex-post review of procurements:			**Goods and services (in US$):___**			**Consulting services(in US$):__275,000_____**			

Item Nº	Ref. AWP	Description (1)	Estimated contract cost (US$)	Procurement Method (2)	Review of procurement (3)	Source of financing and percentage		Estimated date of the procurement notice or start of the contract	Technical review by the PTL (4)	Comments
						IDB/MIF %	Local/other %			
1		**Component 1: Institutional Strengthening of the Ministry of Public Health**								
		Individual consultants								
		Consultancy to provide technical oversight to the design and implementstion of activities to improve the quality of reproductive, maternal and neo natal health services.	80,000.00	IICQ	*ex post*	100			yes	
		Consultancy to conduct assessment of the organization structure of the MCH Unit and the development of a new organigram	60,000.00	IICQ	*ex post*	100			yes	
		Consultancy to develop a recruitment and retention plan for nurses and midwives	20,000.00	IICQ	expost	100			yes	
		Consultancy is to develop nursing and midwifery curriculums with a stronger focus on maternal and child health and primary care	20,000.00	IICQ	ex post	100			yes	
2		**Component 2: Technical studies**								
		Individual consultants								
		Consultancy for a supply and demand assessment	95,000.00	IICQ	*ex post*	100			yes	
		Study Tour (exchange trip)	25,000.00	CQS	*ex post*	100			yes	
3		**Project Execution Unit**								
		Operating expenses	50,000.00							
		Total	0	Prepared by:			Date:			

(1) Grouping together of similar procurement is recommended, such as computer hardware, publications, travel, etc. If there are a number of similar individual contracts to be executed at different times, they can be grouped together under a single heading, with an explanation in the comments column indicating the average individual amount and the period during which the contract would be executed. For example: an export promotion project that includes travel to participate in fairs would have an item called "airfare for fairs", an estimated total value od US$5,000, and an explanation in the Comments column: "This is for approximately four different airfares to participate in fairs in the region in years X and X1".

(2) **Goods and works:** CB: Competitive bidding; PC: Price comparison; DC: Direct contracting.

(2) **Consulting firms:** CQS: Selection Based on the Consultants' Qualifications; QCBS: Quality and cost-based selection; LCS: Least Cost Selection; FBS: Selection nder a Fixed Budget; SSS: Single Source Selection; QBS: Quality Based selection.

(2) **Individual consultants:** IICQ: International Individual Consultant Selection Based on Qualifications; SSS: Single Source Selection.

(2) Country system: include selection Method

(3) **Ex-ante/ex-post review:** In general, depending on the institutional capacity and level of risk associated with the procurement, ex-post review is the standard modality. Ex-ante review can be specified for critical or complex process.

(4) **Technical review**: The PTL will use this column to define those procurement he/she considers "critical"or "complex"that require ex ante review of the terms of reference, technical specifications, reports, outputs, or other items.