A Joint PAHO/WHO-Ministry of Health Meeting on WHO Integrated Management for Emergency and Essential Surgical Care

16 August, 2007
Georgetown, Guyana
1. Executive summary

A joint meeting under the title “Reducing Deaths: Enhancing the Capacity of Regional and District Facilities for Emergency and Essential Surgical Care” took place on 16 August 2007 in Georgetown, Guyana. The meeting was organized by the Ministry of Health of Guyana and the Pan American Health Organization/World Health Organization.

The objective of the meeting was to introduce the Global Initiative for Emergency and Essential Surgical Care and the WHO Integrated Management of Emergency and Essential Surgical Care Toolkit to a core group of key managers, policy makers, key health providers and potential trainers.

Prior to the meeting joint field visits were made to Regional and District Hospitals and district health centres. The Guyana health care system is structured towards 5 levels of care. At the lowest level of care (level 1) are the health huts, level 2 consists of health centres, followed by district hospitals (level 3), regional hospitals (level 4) and tertiary referral hospital (level 5). Identified priority areas for capacity building include basic surgical skills for trauma (road accidents, falls, burns, injuries arising from violence) and pregnancy related complications.

2. Background\textsuperscript{1,2}

Guyana, the only English-speaking country in South America, located in the northeast of this continent, is a Heavily Indebted Poor Country (HIPC). Guyana is divided in 10 administrative regions. Approximately 30\% of the population live in urban areas. Among those living in rural areas, more than 60\% live in the coastal parts of the country with relatively high population density and access to the urban centres (UNDP, 1999), while the rural interior is very sparsely populated.

Due to political instability and conflicts, investment, development and economic growth have been deeply impaired in Guyana. Actually, with a Gross National Income (GNI) per capita of $990, and 35\% of the population living below the national poverty line, Guyana ranks 107 out of 177 on the Human Development Index. Inequity, poverty, and violence have continued to interfere with Guyana's health system. Although Guyana's constitution established access to health care as a right, yet 12.5\% of Guyana's population do not have access to health care due to inequalities and poor distribution of health services. Furthermore, healthcare coverage and

infrastructure development are prejudiced by Guyana's low population density and the geographical difficulties by some communities.

Maternal and paediatric diseases and conditions, such as acute respiratory infections, nutritional deficiencies, and malnutrition, correspond to 20.2% of loss of Disability Adjusted Life Years (DALYs). Guyana's maternal mortality rate (161 deaths per 100,000 live births) is higher than other countries in the region, while the infant mortality rate of 54 deaths per 100,000 live births, primarily due to perinatal conditions, contributes to an under-5 mortality rate of 64 per 1000. The burden of communicable diseases, such as HIV/AIDS, tuberculosis, and malaria, as well as noncommunicable diseases, such as diabetes, cardiovascular disease, and cancer, is high and increasing.

Public health care system of Guyana is highly decentralized. The Ministry of Health (MOH) has overall responsibility for policy formulation, strategic planning and management of health information systems, while the ten Regional Democratic Councils are responsible for healthcare delivery within their boundaries. The public health delivery system is based on a five-tiered structure and an upward-moving referral system consisting of 182 health posts, 112 health centres, 18 district hospitals, 4 regional hospitals and 5 national hospitals which include the Georgetown Public Hospital Corporation (GPHC), the largest health facility in the country that serves as tertiary referral hospital, and the National Psychiatric hospital in Region 6.

Improving the health care infrastructure in Guyana is a great challenge. The Ministry of Health has weak managerial capacity, weak quality assurance and inefficient allocation mechanisms. Regional hospitals in (semi) urban settings are over-utilized, while primary care and district facilities are neglected. Accurate health information about non communicable diseases and injuries is lacking due to poor disease surveillance systems. Moreover, insufficient public funding, poor management, and particular a constant outflow of qualified staff exacerbate the challenges to the health care system of Guyana.

The National Health Plan provides a framework for health sector development, whose implementation is led and supported by the Ministry of Health (MOH). This Plan is strictly linked to the National Development Plan and Poverty Reduction Strategy Papers, aimed to build up infrastructures and to promote economic growth and extensive investment in human resources. At present the current plan is in review and will be followed by a further National Health Plan (2008-2012).

3. Objectives

- Joint WHO-MOH meeting towards strengthening capacities of health personnel on IMEESC at regional health facilities in Guyana
- Introduction of the WHO IMEESC toolkit towards a standard training
4. Field visits to the health facilities

The field visits were carried out for a situation analysis about access to life saving emergency and essential surgical and anesthesia procedures to various levels (tertiary, secondary and primary health facilities). The field visit team included focal persons representing WHO/HQ, PAHO/WHO country office and MOH. The following health facilities were visited via little aircrafts and boats:

- Georgetown hospital,
- Bartica District Hospital,
- Demerara Regional Hospital
- Health Centers:
  - Leonora Diagnostic Centre
  - Diamond Diagnostic Centre
  - Agatash Health Hut

Not infrequently country hospitals are unable to perform even basic emergency surgical procedures, mainly due to lack of continuous oxygen supply and anaesthesia equipment. This further enhances the difficulty of patient's referral especially in urgent situations, with a consequent high rate of death and disability.

5. Joint WHO meeting for facilitators

A Joint WHO-MOH Facilitators Meeting was held for the launch of WHO EESC Project and needs assessment for EESC in Guyana. The meeting participants included key policy makers, key health providers, and directors of surgical, obstetrics, anesthesia and nursing departments and representatives of WHO country office. The WHO IMEESC toolkit was introduced to participants and its applicability was demonstrated in the day to day practice, training, and guidance on policy decisions at all levels of healthcare aiming to reduce death and disability in trauma, pregnancy related complications and infection (including HIV).

6. Discussions

The following issues were discussed:

- Research is required on the situation analysis of access to safe emergency and essential surgical interventions at the first referral health facilities in Guyana, particularly on the infrastructures available at remote Geographic area;
- Role of communication particularly related to referral problems of the patients;
- A MoH's project on telecommunication has been mentioned;
- The Health Care delivery network requires intensive training at all levels, especially of health personnel from the first level of 'health hut' and the second level of health centre, however, an extensive diffusion of the IMEESC guidelines to the whole health system needs to be emphasized;
- Lack of specialists and inadequately trained health
personnel at first referral level health facilities raises the urgent need to strengthen capacities for surgical and anaesthesia services;

- The need to share experiences of introduction and implementation of the *IMEESC* training project with the other twenty countries;
- The role of *GIEESC* to support capacity building;
- The adaptation of *IMEESC* to Guyana, as suggested by the MOH;
- The need for both training in procedures and functioning equipment particularly in surgical and anesthesia services, as well as regular supply of oxygen was emphasized;
- The creation of a committee formed by MOH and representatives of key training sites and hospitals;
- Suggestions for Training of Trainers (TOT): to identify pilot region hospitals and agree on a generic curriculum for assistant medical officers;
- The need to equip lab training centers for strengthening skills;
- Interest was generated about the possibility of organizing cascade TOT on *IMEESC* in 2007;
- Experiences from Medex2, emphasized the need for a referral book on emergencies;
- The limitations of anesthesia services should be addressed.

**Bartica Hospital:**

- This district hospital provides emergency services and has a 50 beds inpatient capacity. It is a major referral centre for Region 7, catering for the local community, isolated Indigenous villages, and mining communities;
- Professional staffing includes 2 staff doctors, 3 Medexes, 15 nurses and 4 technicians;
- There are no surgical or anaesthetic staffs. Hence the operating theatre, though fitted with most equipment for simple surgical procedures, has not been utilized for several years. In addition recent official upgrading of emergency or surgical skills of the staff have not been carried out;
- There is a treatment room dedicated to the management of emergencies, equipped with appropriate materials. However, there is no log or any maintenance records of these materials and equipment;
- Procurement and supply of materials as reported by the staff is sometimes erratic. For example, oxygen is supplied in cylinders from another region and occasionally these have been unavailable;
- Therefore the hospital has been relegated to one that usually transfers trauma patients to a higher level centres immediately after resuscitation and stabilization, even when patients require only basic surgical procedures.

**Agatash Health Hut3**

- As many health centres in region 7, is staffed by one community health worker. It offers little or no surgical care and refers cases requiring it to the Bartica Hospital.

### 7. Recommendations and Action Plan

The meeting resulted in the following recommendations and action plan:

- The *IMEESC* was seen as a way towards improving the first referral level health facility’s services. The WHO *IMEESC* package was unanimously accepted.

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2 A Medex is a mid-level health worker taking over some of the tasks normally performed by medical doctors. They are comparable with Nurse Practitioners or Medical Assistants. In Guyana the Medex are considered the backbone of the health care delivery system in the remote areas.

3 A Health Hut is the first level of care in Guyana. Health Huts are staffed by one Community Health Worker and provide preventive care with limited treatment services.
• Situation analysis needs to be done from all levels of health facilities in each region.
• Trainers for TOT will be selected on the selection of topics.
• Committee will be formed with members of MOH, PAHO-WHO/Guyana, universities and professional societies of surgery and anesthesia.
• TOT workshop for strengthening capacities in EESC at first referral level health facilities will be held in September 2007.
• A report for the Facilitators meeting will be prepared for dissemination including WHO website.
• WHO IMEESC toolkits will be sent to WHO country representative for the training workshops.
• WHO country office along with WHO HQ will assist in the adaptation of the WHO IMEESC toolkit for local needs.
• The Facilitators Workshop Report will be prepared for dissemination through website in September 2007.
• WHO will be assisted in the joint proposal on IMEESC for Guyana.
• A follow up on the video conference workshop in Barbados will be undertaken in October 2007.

8. Conclusions

The meeting concluded with a consensus by MOH and WHO country office and EESC was seen as a way towards improving the first referral level health facility’s services. The WHO Global Initiative package was hence forth unanimously accepted. A committee (Task force) on EESC was established
• to develop strategies for rolling out the IMEESC package in coordination with the GIEESC,
• to integrate the EESC to first referral level health facility
• to adapt the WHO IMEESC toolkit for strengthening capacities to local needs through a standardized training for the frontline health personnel performing life saving emergency and surgical (including anaesthesia) interventions in Guyana.

9. Acknowledgments and collaborations for support

- Directors and staff of health facilities visited,
- MOH Guyana,
- PAHO/WHO country office Guyana, and WHO/AMRO/PAHO,
- Departments of Essential Health Technologies, Evidence and Information for Policy (Patient Safety), Making Pregnancy Safer, Violence and Injury Prevention, Child and Adolescent Health,
- Surgical Association.

Annex 1. Program Agenda

- Visits to health facilities for a Situation analysis.
- Joint WHO-MOH Meetings with directors of teaching hospitals and rural health facilities, Ministry of Public Health
Annex 2: List of Meeting Participants

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Ms. Merlene Ferria 
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Agatash village Community Health worker 
Health Hut region 7

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