Review POW 2004
Ministry of Health
GHANA

Report of the External Review Team

Accra, April 2005

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Acknowledgements

This report was prepared by a Review Team (RT) of international and Ghanaian consultants, at the request of the Annual Sector Review Steering Committee, chaired by the Ministry of Health, Ghana. It represents the final stage of an intensive bottom-up review process that started in the districts and then passed on from there to the regions and to the national levels of the various agencies. This annual review scrutinised the third year of the Ministry of Health's second Five Year Programme of Work 2002-2006, being the POW 2004.

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The team bears collective responsibility for the findings and opinions expressed in this report. They cannot be attributed to team members' organisations, their sponsors or to the Ministry of Health.

Abbreviations

ACT……..Artesimine-Amodiaquine Combination Therapy
ACSD ..... Accelerated Child Survival and Development Project
ADHA…….. Additional Duty Hours Allowance
AFP ..... Acute flaccid paralysis
AIDS..... Acquired immune deficiency syndrome
AMO ……Assistant Medical Officer
ANC..... Antenatal care
ART ..... Anti retroviral therapy
ASR ……Ashanti Region
AYA……..African Youth Alliance
BCC ……Behavioural Change & Communication
BOR ..... Bed Occupancy Rate
BPEMS..... Budget and Public Expenditure Management System
BMC ..... Budget management centre
CBD……Community Based Distribution
CBGP……..Community Based Growth Promotion
CBS……..Community Based Surveillance
CDC……Communicable Disease Control
CDR ..... Case detection rate
CFR..... Case fatality rate
CHAG..... Christian health association of Ghana
CHIM..... Centre for health information management
CHN……Community Health Nurse
CHO ..... Community Health Officer
CHPS ..... Community health planning and service
C-IMCI..... Community component of integrated management of childhood illness
CMA ..... Common Management Arrangements
CME ……Continuing Medical Education
CPR..... Contraceptive prevalence rate
CR ……Central Region
CVA..... Cerebral-vascular accident
DA ..... District Assembly
DHMT……District Health Management Team
DMHIS ……District Mutual Health Insurance Schemes
DOT..... Directly observed therapy
DP……Development Partners
DPT ..... Diphtheria Pertussis and tetanus
EBF……..Exclusive Breast Feeding
EMT ……Emergency Medical Technicians
EO……Expected Output
EmOC ..... Emergency obstetric care
EsOC ..... Essential obstetric care
EPI……Expanded Programme on Immunisation
FP……Family Planning
GAC ……Ghana AIDS Commission
GAR ……Greater Accra Region
GAS ……Ghana Ambulance Services
GDHS ……Ghana Demographic Health Survey
GHS ..... Ghana Health Service
GOG..... Government of Ghana
Govt ..... Government
GP..... General Practitioner
GPRS..... Ghana poverty reduction strategy
GW……Guinea Worm
GWEP ..... Guinea worm eradication programme
HBC……Home Based Care
HC..... Health Centre
HF……Health Facility
HIV..... Human immunodeficiency virus
ICT ……..Information Communication Technology
IDSR ……Integrated Disease Surveillance and Response
IEC..... Information education and communication
IGF..... Internally Generated Funds
ILO ..... International Labour Organisation
IMCI ..... Integrated management of childhood illness
IME..... Information monitoring evaluation
IMR ..... Infant mortality rate
IPD..... Inpatient department
IPT ..... Intermittent preventive treatment
ITN ..... Insecticide treated net
KNCV..... Royal Netherlands TB Association
LSS……..Life Saving Skills
MA……Medical Assistant
MDA..... Ministries, departments and agencies
MDBS……..Multi Donor Budget Support
M&E……Monitoring and Evaluation
MDG..... Millennium development goals
MDR..... Multi Drug resistance
MMR ..... Maternal mortality rate
MOH..... Ministry of health
MOLG ……Ministry of Local Government
MOU..... Memorandum of Understanding
NACP..... National AIDS control programme
NCD ..... Non communicable disease (control)

NDPC ..... National Development Planning Commission
NHIS / C……..National Health Insurance Scheme / Council
NID ..... National Immunisation Day
NMCP..... National Malaria control programme
NNMR……..Neo-Natal Mortality Rate
NR……Northern Region
NTP ..... National Tuberculosis control programme
OPD ..... Outpatient department
PAC ……Post Abortion Care
PE ..... Personal Emoluments
PH ..... Public health
PLWHA ..... People Living with HIV/AIDS
PMM……Prevention of Malaria Mortality
PMTCT..... Prevention of mother to child transmission
PNC..... Postnatal care
POW..... Programme of work
PPM ……Procurement Procedures Manual
PPME ..... Policy planning and monitoring
PRSC ..... Poverty Reduction Support Credit
QC / A ..... Quality control / Assurance
QAU ……Quality Assurance Unit
RBM ..... Roll back malaria
RCH ..... Reproductive and child health
RDU ..... Rational drug use
RHMT..... Regional health management team
RT……Review Team (POW 2004)
SAFE …… Strategy for Trachoma Control
SD..... Supervised delivery
STG..... Standard treatment guidelines
STI ..... Sexually transmitted infections
SWAp..... Sector wide approach
T&AMC ..... Traditional and Alternative Medicine Council
TAP ……Treatment acceleration programme
TB ..... Tuberculosis
TBA..... Traditional birth attendant
TT ……Trachoma Surgery
TTBA……Trained TBA
TH ..... Teaching hospital
U5MR..... Under five mortality rate
UER……Upper East Region
UWR……Upper West Region
VCT……Voluntary Counselling & Testing
VR ……Volta Region
WB……World Bank
WHO ..... World health organization
Wt/A ..... Weight for age

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Introduction

This report was prepared by a Review Team (RT) of international and Ghanaian consultants, at the request of the Annual Sector Review Steering Committee, chaired by the Ministry of Health, Ghana. It represents the final stage of an intensive bottom-up review process that started in the districts and then passed on from there to the regions and to the national levels of the various agencies. The annual review scrutinised the third year (POW 2004) of the Ministry of Health's second Five Year Programme of Work 2002-2006.

The RT worked on the basis of a Terms of Reference that covered various objectives summarised in the table below. In addition the RT was asked to:

- Undertake a strategic review of the sector, critically analysing available evidence on why the overall sector performance over 2004 is decreasing / slowing down; and
- Provide detailed suggestions on the way forward not only for the next POW 2005/06, but also for drafting of the third Five Year POW (POW III, 2007-2011), taking Ghana's commitment to the new GPRS and the MDGs into account.

Table 01. Coverage of the Terms of Reference (TOR)

Objectives of the Review POW 2004	Extent covered in this report
1. Assess progress and challenges towards bridging inequalities in health.	1. There are different types of inequalities. They are discussed extensively in chapter 3.
2. Assess the performance of the sector and its sub-components with respect to the over-arching objectives based on the Ghanaian sector-wide indicators.	2. Covered in detail in section 2, where health status indicators are presented over a 15 year period (1988-2003), followed by performance outputs between 2002-2004 in clinical care and disease control.
3. Assess progress and constraints in the implementation of the health component of the MDBS matrix	3. Implementation of the health component in the MDBS matrix is presented in chapter 7.3 together with GPRS indicators.
4. Assess progress and constraints to the implementation of previous summit recommendations	4. A one by one account of what happened with the various recommendations of the Review of POW 2003 is given in Annex 3.
5. Assess progress and challenges towards the 7 strategic objectives of the sector	5. A 'Summary Judgement' is given in the box below. All seven strategic objectives are discussed in chapters 2-7.
6. Identify policy and programmatic measures for scaling up activities towards achieving the MDGs	6. Measures to achieve MDG are discussed in the executive summary and in chapter 3.7.
7. Recommend critical success factors for improving performance of the health sector.	7. Critical success factors to improve performance are synergy and better coordination between all actors. Details are found in the executive summary and throughout in the chapters 2-8.

Performance during POW 2004

Our detailed review of the Sector Wide Performance indicators (Table 02 below) shows that 2004 was another year in which limited progress was achieved towards the attainment of the annual targets. While some interventions showed improvement and others showed decline, the overall picture is that output indicators remained constant over the last three years.
A similar picture appears in the financial indicators: In 2004, the actual share of the GOG budget spent on health fell to 8.2% - below the 2001 level. The percentage of government recurrent budget for health was lower in 2004 than in 2003, but the actual share of GOG recurrent spending has remained stable around 11-12% over the past three years. The total health sector spending has increased from USD 6.3 per capita in 2001 to USD 13.5 in 2004. Direct GOG funding increased from USD 3.1 in 2001 to USD 5.7 in 2004. Fortunately, resources came earlier and more regular to the BMC allowing for higher spending, but the money seems not yet to reach the lowest (sub-district) levels.
More efforts and commitment are needed from MOH, MOF and the DP, if Ghana seriously wants "to go for the MDG". In particular, difficult decisions appear necessary to address the poor synergy in planning and targeting between MOH, its Agencies and the District Assemblies. Without concerted efforts by all and agreement over what needs to be done and how, synergy is lost, as priorities move in various directions.

Box: Summary judgement of progress in POW 2004 on 5 Year POW II targets

1. Improve **geographical & financial access**: While geographical access seems to have expanded at the same pace as the population increase, financial access seems to have improved for women, due to the policy of free deliveries. However deprived areas are not catching up.
2. Improve **quality of care**: Important QA and supervision work is undertaken, but not fully captured in SWAp indicators. Malaria Case Fatality Rate is far away from its target and Maternal Audits are performed less (70%). It is unclear to what extent the findings from these audits improve maternal services
3. Improve **efficiency:** Efficiency in service delivery seems still low, as financial resources reach the sub-district and the district only to a limited extent, creating poor working conditions in many facilities. Efficiency gains seem possible, if synergy ca be found
4. Foster collaboration & **partnership**: The organisational changes initiated with the creation of the GHS and other Agencies have not yet created the expected gains. Responsibilities between MOH and the Agencies still await clarification. There appears little synergy for joint planning and target setting.
5. **Increase resources** & manage them equitably & efficiently: Financial resources to the sector have increased slightly, but the Abuja target is not yet in reach. The proportion of donor funds that are earmarked have decreased from 62% in 2001 to 26% in 2004. Figures on the distribution of these resources to the regions were not available during the mission.
6. Bridge the **inequality gap** in access to quality services: It is not easy to say whether Ghana moves towards closing the gap; Such a process takes a much longer time period to become visible and would need special investigations to make firm statements.
7. Ensure **sustainable financing** that protects the deprived & vulnerable: This is a long term goal that cannot be reached within the POW 2004. MDBS and GPRS will hopefully be capable to provide the resources needed to move further towards the MDG targets, but only if the MOH share of the GOG budget will increase substantially.

Table 02. Trend of sector-wide performance indicators POW II 2001-2004

Indicators	BASELINE 2001	PERF 2002	PERF 2003	PERF 2004	2004 Targets	TARGETS 2006
Objective: Improved Health Status						
Infant mortality rate	57	55	64	NA	NA	50
Under five mortality rate	108	100	111	NA	NA	95
Maternal Mortality ratio	214 ('93)	204	187	NA	NA	150
% Under five years who are malnourished (Wt/A)	25	NA	22.1	29.9	22	20
HIV sero prevalence among pregnant women	2.9	3.4	3.6	NA	3.6	2.6
Objective: Improved Service Outputs and Health Service Performance						
Performance of Clinical Care (Coverage and Quality)						
Outpatient visit per capita	0.49	0.49	0.50	0.52	0.55	0.6
Hospital admission rate/1000pop	34.9	34.1	35.9	34.5	38	40
Bed occupancy rate	64.7	65.5	64.1	63.0	65	80
# specialized outreach services				162	158	
Tuberculosis Cure Rate	47.9	55.1	61.0	--	65	80
TB Case Detection Rate	61	59	58	56	55	65
Under-Five Malaria case fatality rate	1.7	1.9	3.7	2.8	1.2	1.0
% Tracer drug availability	70	80	93	87.5	90	95
Performance of Reproductive Health Services (Coverage and Quality)						
% FP acceptors (CPR)	20.3	21	22.6	24.3	28	40
% ANC coverage	93.5	93.7	91.2	89.2	94	99
% PNC coverage	52.9	53.6	55.8	53.3	57	60
% Supervised deliveries	49.2		51.9	53.4	60	60
% Maternal audits to maternal deaths	<10	67	85	70.5	85	50
Performance of Preventive Services and Surveillance						
EPI coverage - DPT3	76.3	77.9	76	75	80	85
EPI coverage - measles	82.4	83.7	79	78	80	90
# Guinea Worm cases	4,739	5,611	8,290	7,275	5000	0
AFP non polio rate	2.8	2.3	1.4	1.5	3.5	4
Objective: Improved Level and Distribution Health Resources						
Human Resources						
Population to Dr ratio	22,811	22,193	17,489	17,615	20,500	16,500
Population to Nurse ratio	2,043	2,080	2,598	1,513	1,800	1,500
Health Infrastructure						
CHPS zones completed (functional CHPS zones)	19	39	55	84	85	400
Finance						
% GOG budget on health budget / actual	NA / 8.7	7.6 / 9.3	9.5 / 9.1	8.2 / 8..2	9.4 / NA	10
% GOG Recurrent on health budget / actual	NA / 10.2	10.5 / 11.5	12 / 11.2	10.7 / 11.9	13.3 / NA	15
% GOG Recurrent on health, items 2+3 Budget / actual	NA / 8.1	12.1 / 5.9	7.5 / 6.9	6 / 5.4	6.6 / NA	NA
% Items 2+3 / 1+2+3 Budget / actual	NA / 16.2	30 / 13.1	16.1 / 13.2	16.4 / 11.4	11.3 / NA	NA
% spending on Districts and below, items 2+3 Budget / actual	48.5 / XX	XX / 40.9	47.8 / 35.4	45 / 37.9	NA	43
% Earmarked / total DP budget / actual	NA / 62.3	44.7 / 32.8	40.8 / 39.5	41.3 / 26.3	NA	40.9 / 40.9
% IGF from Pre-payment	3	NA	NA	NA	NA	20
% Rec. from GOG+HF allocated to Private Sector	1.2	NA	NA	NA	NA	2
% Rec. on exemptions	3.6	NA	NA	NA	NA	8

Why progress slowed down?

The overall picture of achievements under POW I and II has been summarised in Table 02 on the previous page and in the MDG table in chapter 3.7. Looking back over the last three years, it appears that performance in 2004 is generally similar or down compared to those of 2003 and 2002, particularly in service outputs, access and service quality. Though marked variations exists in the regional service outputs, 2004 performances in most regions did not improve over that of 2002-03, and if at all, not consistently (Annex 7).

Looking over a much longer period of almost 15 years (between the baseline of the MDG in 1990, the start of POW I in 1997 and the middle of POW II, being 2004), the picture is more positive: health status has improved compared to 1990 and most outputs are improving (with exception of HIV/AIDS prevalence). However, it should be noted that the type and definitions of some of the indicators have changed or have not been recorded over such a long period.

Finally, looking at the impact indicators over the last five years (Table 1.1), the 2003 GDHS shows stagnation and generally worsened U5MR and IMR levels with only Upper East Region demonstrating consistent reduction. More detailed analysis has revealed worsened mortality during the perinatal and neonatal periods, particularly in UWR, ASR and ER. Expansion of cost effective interventions are known to contribute to important mortality reduction and this might be the case in UER. However such findings may need in-depth analysis to establish the real underlying factors, which for now, appear to relate to a combination of child health and reproductive health interventions, quality of service delivery together with planning and ownership by communities and DA.

However, these aggregate data do not analyse and reflect on WHY the targets have not been met and therefore why – despite all the hard work and the good money put at the table - the results have remained by and large at the same level and have not gone up during these last 3-4 years. Answers to such questions need to be formulated before suggestions can be made on what needs to be improved and in which direction POW III should move.

The central thesis of the RT is that **there is no simple or single answer for the observed low performance**. Rather there are a multitude of factors - each playing its role - that **together** may explain the stagnation in the sector. These include (i) technical flaws in the implementation of health programmes, (ii) imperfections in the support and management systems; (iii) institutional weaknesses in partnerships that have not been explicitly addressed and thus have continued to hinder the sector performance; and (iv) minimal contribution of health to collaborate with other sectors and departments.

Here we summarise the **most important imperfections and weaknesses** for each of the major ‘elements of the sector’ shortly. It is important to remember that it is the combination of these elements that in our opinion explains the current stalemate in the sector performance. Subsequently, suggestions for improvement in POW 2005 and in the Third Five Year Programme of Work (POW III) will be presented.

Priority interventions (chapter 2)

In general, little systematic attempt is made to package priority health interventions (and messages that are linked to the sector priorities) with the aim to achieving service outputs and certain behavioural changes for selected target audiences over time. This applies to the following areas:

Child Health:
Apart from UER, most child health related activities are not presented as a package composed of (i) Routine EPI+ (incl Vitamin A distribution and twice yearly de-worming) with (ii) Community IMCI (broad health promotion together with subsidized ITN distribution, weighing of children, counselling, Exclusive Breast Feeding (EBF) under 6 months and complementary feeding thereafter as part of CBGP), (iii) Clinical IMCI (at service delivery level); and finally (iv) early neo-natal care. At the moment, few linkages exist among the various sectors that help to implement these interventions. Even when the activities are packaged, their implementation is piloted only in a limited number of districts or regions,

Maternal and Reproductive Health:
Similarly, Reproductive Health and Safe Motherhood activities are undertaken at all levels, but are not mutually reinforcing, as they are not combined in a package consisting of (i) ANC (>4 visits/client, including subsidized ITN for pregnant women, Iron/Folic Acid, IPT and TT2+ injection); (ii) skilled attendance during deliveries and use of the Partograph; (iii) Post Natal Care (iv) Family Planning (incl CBD) and post-abortion care (PAC) and (v) Adolescent care and support. Safe Motherhood interventions do not address (vi) the referral system, and basic and comprehensive Emergency Obstetric Care (EmOC) that addresses the three delays (decision to seek care, reaching the facility and received care from skilled providers).

Communicable Disease Control (CDC):
The various elements of disease control are well-known, but synergy and coordination between Integrated Disease Surveillance & Response and the other disease control programmes, particularly Malaria control; TB control; HIV/AIDS and Guinea Worm control, is weak and difficult to organise, due to an ingrained vertical way of organisation of some of these respective programmes.

Health Promotion
Health promotion as a cross-cutting element is present in all the programmes. However, no systematic data-set related to Health Promotion outputs and behavioural change has been developed to guide the programmes in this field.

Delivery systems (chapter 4)

Community Health Planning and Services (CHPS)
Expansion of first line delivery systems towards the community is essential where distances of 5-10 km become an impediment for access. Unfortunately, this is still the situation in many districts. In such areas additional clinics need to be established and staffed with competent cadres. However, first, the concept of CHPS needs to be clarified. According to the RT, CHPS can best be characterised as an extension of the existing service delivery system towards Zones in areas with low geographic accessibility and with strong emphasis on the interface with the community. Once agreement is reached on the CHPS concept, the implementation should be left to regions, allowing them the flexibility to scale up on the basis of their needs.

Health Centres and District Hospitals
Many Health Centres lack full staff complement and logistics for the required interventions at that level. At the second line of service delivery, the District Hospitals only exist in part of the country. With the growth of the population and the creation of new districts as administrative entities of the central government (from 110 to 138 over the last two years), the network of district hospitals has not been expanded, thus seriously jeopardising the referral system and access to emergency (child and obstetric) services.

Quality Assurance and Regulation
Quality Assurance and regulation mechanisms have been introduced in the health system, but their use and adherence are not widespread. This applies not only for clinical care and public health interventions, but also for the overall management of health services.

Management of the sector (chapter 5 and 7)

Human resource management:
Staff requirements seem not linked with production and placement. There is generalised and sustained lack of staff in many health facilities, next to deficiencies in distribution at national, regional and district levels. Staff allocation is not linked to workload requirements.

Planning, budgeting and reporting:
Planning and expected outputs are already linked to budget and expenditure. The second part of the loop has not yet been addressed, linking expenditure back to outputs.

Performance agreement
Performance assessments do exist in theory but in reality have little real basis, as the targets have been decided by the central levels with little input and discussion from implementers. Currently, the performance agreements are based on an understanding by the signatories that as long as the resources are not provided, the targets cannot be reached and thus the agreement is not binding to any of them. The Expected Outputs that provide the basis for the Performance Agreement, show little consistency over the last three years (Annex 9).

Financial management
Although disbursement of funds has much improved, there are still delays that affect service delivery. This together with effective application of the exemption policy needs improvement. In many areas, health facilities under the district level do not receive the resources that are meant for them. Often, the responsible in-charge there is not even informed about their financial allocations.

Procurement
Procurement systems are well established in the sector. However, there is a general absence of basic equipment to allow for daily quality service delivery in health centres and hospitals (weighing scales, delivery kits, resuscitation equipment, thermometers, BP apparatus etc).

Monitoring and evaluation
M&E is well developed at national and programme level. However, the RT observed a lack of consistency in the data collection tools and the presentation of the expected outputs (EO) at all levels (in the various POW, in the Regional and in the District Health Plans). Each year new EO are being included in the plans, without sufficient feed-back and control (accountability) as to whether the earlier EO have been achieved.

Partnerships (chapter 4 and 7)

1. MOH and GHS – TH – Regulatory Bodies
There exists a longstanding and important issue related to the responsibilities of the MOH versus the various Agencies in areas related to (i) human resource planning and distribution, (ii) capital planning and implementation of capital programmes, (iii) procurement of health logistics and (iv) the acquisition and maintenance of equipment. These issues have remained unresolved for some time, thus contributing to flaws in communication and common understanding on the way forward.

2. GHS – CHAG
While a Memorandum of Understanding (MOU) exists that defines the relations between MOH and CHAG, CHAG has no such document to clarify its working relation with the GHS. Operationally, CHAG seems quite 'integrated' in the administrative and communication structures of GHS. The RT took note of CHAG's interest to initiate negotiations with GHS to develop an agreement that formalises such arrangements.

3. MOH – Development Partners (DP)
Some of the DP increasingly support Ghana either directly to the health sector (through the Health Fund) or directly to the Treasury (through General Budget Support and MDBS mechanisms). There remains substantial funding going through earmarked support that provide the sector with flexible and targeted resources, but that in the long run does not allow for sustainable interventions (details in chapter 6).

5. Public – Private Sector Partnership
The relations between the public and private (for profit) sector are generally good. The private sector participates in Regional performance meetings and in various service delivery activities, like TB control, outsourcing of laboratory facilities and HIV/AIDS. Licensing of the private sector is being done, but needs to be further developed.

6. Intersectoral Collaboration: DA - DHMT
The link between the District Assemblies and the decentralized departments such as Health and Education is weak, particularly in the areas of composite planning and budgeting, water and sanitary facility provision, health infrastructure expansion and PPM. There appears little transparency in the sharing of financial resources. This could be one of the reasons that Intersectoral collaboration has been effective in only few places.

Policies towards inequalities (chapter 3 and 6)

Financing and Budgeting
The sector succeeded in mobilising an increasing amount of resources to finance the plans and budgets of the sector. While the planning and budgeting process improved with the implementation of the Medium Term Expenditure Framework (MTEF), the system was ineffective in ensuring that actual expenditures were related to the stated outputs and objectives at the time of planning.
The resources, however, do not always flow to the sub-districts that are "BMCs of record". As the rural poor tend to access the health system at the lower levels, the absence of funds affects services for the poor.

Resource allocation / pro-poor support
Reimbursements for exemptions have consistently fallen short of the actual exemptions provided by BMCs. These have responded to this situation by either stopping or being selective in the granting of the exemptions. This deprives the poor of service and erodes confidence in the exemption scheme.

Improved procurement capacity at the centre has brought into focus a weakness in the accounting system of Central and Regional Medical Stores (CMS). The CMS accounting system is unable to track centrally procured items on behalf of BMCs and to charge these items to the respective beneficiary institutions through the Regional Medical Stores. It is therefore difficult to confirm that the planned resources are reaching the district level BMCs.

Additional resources have been targeted for the four deprived regions. Later this was refined into a selection of 55 deprived districts, which is a very broad target group (half of the country). As a result, efforts and resources may be spread too thinly to have significant impact. The unit for targeting is not sufficiently refined. As the NDPC poverty maps show, pockets of deprived communities exist within non-deprived districts. These have not been targeted for additional resources. Sometimes these pockets can be quite significant in size, e.g. urban slums.

Investment planning
At attempt has been made by the Ministry to clarify the roles of its agencies with respect to capital investment planning and execution. A Projects Steering Committee (PSC) is also functional. Communication between the MOH, the PSC and beneficiary agencies has however not been effective resulting in delays in project implementation. Planned expansion of training schools to allow increased intake is behind schedule because of these delays.

National Health Insurance Scheme (chapter 3 and 6)
The NHIS has not yet been scaled up to have had an effect on the access to health services. The NHIS appears to be on course in terms of the establishment of the NHIC and passage of the Legislative Instruments. However, the RT is of the opinion that there is still a long way to go. While the Insurance Schemes are at various stages of readiness, it is difficult to demonstrate the readiness of providers for accreditation. At the time of this review the MOH was also undertaking a review with the objective of removing all bottlenecks and to prepare for full implementation by the end of 2005.

Efficiency and effectiveness
MOH needs to explore opportunities to improve efficiency and effectiveness in budget execution and program implementation. Though not quantified, delays at various stages of the implementation process result in inefficiencies that challenge the effectiveness of planned interventions. Also, wide variations in productivity indicators suggest that there are inefficiencies in the health system. The RT believes that significant improvements in outputs can be achieved if operational efficiency and effectiveness is improved.

Summing up.
While in the past these five elements – priority interventions, delivery systems, management, partnerships and policies - have been addressed individually, the RT feels that it is the lack of synergy between these factors that now needs to be addressed. Management of the various Agencies need to agree on the principles that are to guide the way forward. Consensus should be achieved before new ideas are brought out. As the health sector is structured and organised at this moment, no real breakthrough can be expected. Indeed indicators show stagnation while financial resources have been increased. This could point towards flaws in leadership and management of the sector, as it is a sign of inefficiencies and decreasing cost-effectiveness of sector performance. Therefore, it is not only the

technical areas of service delivery that need to be addressed. More importantly, issues of responsibility, decision-taking, accountability and transparency seem to be at the core of the problem. 'Business as usual' will not bring improvements. The sector, as it is performing at this moment has arrived at its limits and cannot substantially improve further …., unless some of these major stumbling blocks are addressed and tough decisions are taken.

The way forward for POW III

In order to address the major bottlenecks that are blocking the health sector to move ahead and improve its performance, the RT suggests the MOH and the Agencies to address ALL the five elements presented below in their combination. As mentioned earlier, it is their lack of synergy that keeps the health sector away from moving ahead. These suggestions should be studied, clarified, eventually costed and given a timeframe, so that they can be adopted (or rejected) for inclusion in the next POW. The overall recommendations have been brought together in the summary table at the end of the document.

Priority interventions

Expand and enhance synergy between Child Health programmes:
Clinical IMCI case management must be expanded to cover all practicing prescribers in a time frame. Training must be decentralized to District Hospitals to reduce cost and facilitate follow-up after training. Guidelines for neonatal care and "neonatal care kit" must be introduced as part of IMCI case management. Full immunization could become a prerequisite for obtaining a birth certificate, which in turn must be a requirement for school enrolment. Similarly, fee-free Class-1 entry for children delivered by a health professional or Trained TBA and uniforms for fully vaccinated children could be introduced as an appropriate incentive. School health activities must continue and once/day feeding in school must be advocated together with the relevant district authorities. The implementation of these suggestions should be guided by the availability of professional staff, level of deprivation and extent to which Under Five Mortality has worsened.

Refocus implementation of a Reproductive and Maternal Health package:
Specific proposals need to be elaborated on a region by region basis, starting with those regions that have the worst coverage of maternity services. Focused antenatal care must be expanded and delivery targets must be allocated to skilled midwives. The concepts in Regional Prevention of Maternal Mortality Network (RPMMN) must be scaled up everywhere (schools, churches etc). Similarly, the referral system needs to be defined and re-established, in particular in poor areas with low EmOC coverage

Synergy internally between Disease Control Programmes and with other programmes:
Stimulate collaboration and synergy between:

- Malaria control (IPT & ITN distribution, home management of fevers, ACT therapy);
- TB control (Community DOTS and facility DOTS, including laboratory facilities for Smear + analysis and blood film for Malaria);
- HIV/AIDS, including VCT, Home Base Care (HBC), PMTCT and ARV treatment) and
- Guinea Worm control (set realistic targets in plans linked to potable water provision).

Package these interventions and revisit their targeting (national, regional and district, using the NDPC poverty maps (mainstream pro-poor interventions). Elaborate for both a phased and realistic, comprehensive implementation plan over medium to long-term periods that brings synergy between these programmes.

Health Promotion:
Critical health promotion messages must be developed to address essential child health and safe motherhood issues. These could be delivered through educational and social marketing structures. Context specific health promotion messages could be developed on a region by region basis, exploiting the peer groups and interpersonal approaches in addition to other media/ channels (multiple channels approach). Focus should be on child health messages (danger signs in sick children, diarrhoea, Malaria), Maternal and RH messages (IPF and ITN related) and nutrition-related advice (Expanded Breast Feeding and feeding frequency).

Delivery systems

Community Health Planning and Service (CHPS)
Agree on the essential elements of the concept and allow adaptation of CHPS to the regional reality. Elaborate a phased introduction of CHPS in the Regional Five Year Plans. The role and contribution of the DA in the construction and maintenance of the CHPS clinic and the training of CHPS staff (bonding arrangements) is essential and must be expanded. Secure the necessary political support at all levels.
In CHPS clinics but also in other settings, outreach services need to be initiated in close cooperation with the various voluntary workers that are already available[1] or that need to be trained for that purpose. Priority health promotion messages must be developed for use on a region by region basis. The focus must be on child health (EBF, danger signs in sick children, diarrhoea, Malaria), and Maternal and Reproductive health (EBF, regular ANC visits, delivery danger signs, the three delays) and nutrition.

Clinical Care and Quality Assurance:
Reinforce the work already started on quality assurance building on peer learning experience, promoting use of clinical and treatment protocols, intensifying RDU work, clients focus activities and reducing waiting times. Detailed suggestions are provided in the Clinical Review report of 2003[2].

Strengthen the referral system:
Region by Region, make an inventory of the current situation and develop realistic cost estimates to re-establish the district referral system together with the required staffing and equipment. Set regional priorities where to initiate this effort to expand the coverage and performance of the referral system. In urban settings, initiate Primary Facilities in secondary and tertiary hospitals to improve quality and decongest large hospitals.

Regulation:
Regulatory bodies have an important role in enhancing sector performance. However, there capacity is generally limited to effectively play that role, due to financial, managerial and institutional constraints. MOH is advised to review and strengthen the regulatory role of these institutions to allow them to fully play their part in the strengthening of the sector performance.

[1] Different types of volunteers operate in Ghana. They work in (i) Community Based Surveillance, (ii) Guinea Worm Eradication, (iii) CB Growth Monitoring; (iv) CB Distribution of FP commodities and other areas.
[2] Ghana Clinical Care Services Review, March 2004. Volume I and II (main report and annexes).

Management of the sector

Human Resource Management:
Every effort must be made to fill existing vacancies at all levels for: Medical Assistants, Enrolled Nurses, Straight Midwives, CHNs, Dispensary Technicians, Laboratory Technicians, nurse anaesthetists, and doctors. This will require an extensive planning effort to calculate needs, the financial consequences and deciding on the establishment of additional training schools or expand existing facilities. There should be a definition and clarification of responsibilities for human resource management between MOH, GHS and TH Collaboration with the private sector and political leadership is needed to find adequate solutions. District Assemblies should be encouraged to sponsor candidates for training and bond them to work in their regions for a specified period of time.

Planning, budgeting and reporting:
Continue the link between plans, budgets and expenditure. Stop needs based planning at the district BMC level. Plan directly with ceilings and work towards result-based planning. Include pro-poor priorities and indicators more explicitly in the planning format of the regional and district plans. Initiate linking financial inputs with real outputs. Bring them together in a short and standardised district reporting format.

Performance Agreements:
In order to create ownership and a sense of responsibility, the various performance agreements need to start from what the lowest level thinks it can achieve annually with the available budget. Only in this way can (s)he be held accountable for the result. Higher levels will have to adapt to that reality and come – through negotiations - to annual target setting for the various output indicators at regional and national levels. When reviewing performance agreements, ensure accountability when looking at plans versus achievements at all levels. Compare the same Expected Outputs and indicators over time to ensure continuity / consistency in monitoring.

Financial Management:
Clear and realistic guidelines should be established to allow all "BMC-of-record[3]" (Regional BMCs, sub-districts and Zonal CHPS Clinics) access to financial resources to implement the various plans and interventions they make each year. Timeliness of disbursement should also be improved by the implementation of agreed cash flow planning, standardised procedures etc.

Monitoring and Evaluation (M&E):
Review SWAp indicators, linking new monitoring framework with MDG and existing institutional structures (MOH, GHS, TH, separate from PPME). Define authoritative source for each data (see IME report[4]). Include poverty, equity, gender and cost effectiveness indicators (see Review POW 2003) for each of the agencies. Harmonise MDBS, PRSC and POW indicators. Harmonise targets between MOH and GHS. Justify the request for financial resources through reporting on agreed outputs in the agreement.

Partnerships

1. MOH – GHS - TH
Review the Act 525 in the light of the experience with its implementation. Redefine and clarify the responsibilities of MOH, GHS and the TH in the areas of human resource planning

[3] BMC-of-record is a Budget Management Centre allocated with financial resources, but with no authority to spend money without the approval from a spending officer.
[4] Appraisal of the Ghana Information, Monitoring and Evaluation (IME) system for the health sector, May 2004.

and distribution; capital investment planning and implementation of capital programmes; procurement of health logistics; and the acquisition and maintenance of equipment; Lines of communication and accountability also need to be reviewed and clarified.

2. GHS – CHAG
The relations between GHS and CHAG needs to be operationalised in a formal 'working agreement', clarifying the administrative and communication working relations and the financial contributions from both sides. Only then a Performance Agreement can be drafted.

3. GHS - TH
In order to establish clear lines of responsibility and communication, GHS and TH need to elaborate together a "Cooperation Agreement" that defines the areas of collaboration and the other areas of mutual interest (like human resource development, referral systems and use of equipment and other high cost investments).

4. Public – Private Sector Partnership
Collaboration with the private sector is quite good. These positive experiences now need to be expanded and brought to regional and district levels. A private sector investment policy should be drafted that support such initiatives and enhances opportunities for expansion of such collaboration.

5. MOH – Development Partners
Review the recent 2002 Management Arrangements (CMA II) between the MOH and the DP, updating ownership, alignment, harmonisation, results and mutual accountability, as defined in the recently adopted Paris Declaration on Aid Effectiveness (March 2005). Actively lobby to increase other partners to join the health fund, by inviting them to participate in reviews and meetings.

6. Intersectoral Collaboration: DA – DHMT
MOH should instruct Regions and Districts to build partnerships with DA at all levels and jointly define practical intersectoral activities (Guinea Worm, water & sanitation, nutrition, pro-poor activities); Initiate an Intersectoral desk within MOH and the Regions to coordinate intersectoral work. Regular and open communication will be the important first step towards improving the existing relations. Structured sessions should be introduced to commit DHMT to collaboration with the district authorities.

Policies towards inequalities

Financing and budgeting
Substantial financing needs to be infused into the sector, if the MDGs are to be attained. While part of the increase may come from economic growth, increasing taxes etc., there is still a need to press for increasing the health share of the GOG budget to reach the Abuja declaration, with a focus on increasing the budget for non-wage recurrent expenditure. Sub-district health management teams should be empowered to plan within their budget ceiling, to know their approved budget and to be able to implement against the plan and budget. The financial management system should be developed to allow for linkage of financial information to outputs and objectives.

Resource allocation / pro-poor support
The accounting systems and data extraction for analysis should be further developed, e.g. at CMS to allow tracking of procured items to beneficiary BMCs and in the MOH/GHS to allow easy analysis of expenditure for BMCs at all levels, including sub-districts.

Exemptions for direct user fees will gradually be phased out as NHIS is scaled up. The identification of the indigent, the positioning of each member in the six different levels of wealth that determines the premium level in the informal sector, remains a challenge. During the transitional phase of scaling up NHIS, funding for reimbursement of exemptions should be ensured to continue smoothly. Special attention should be given that the poorest and deprived are to enrol earliest in the scheme.

The recently developed poverty map that identify deprivation down to sub-district level provides an opportunity to plan a more targeted approach to improving services where they are most needed. This would include working with the urban poor that may well in numbers be comparable to the group of rural poor. The focus should be on targeting some very deprived areas step by step with a comprehensive plan that brings all interventions together.

National Health Insurance Scheme
The NHIS is planned to be fully implemented within the next year. It is important to recognise that it is a long process and that there will be a transitional and learning phase during which not all Ghanaians will be covered by insurance and doubts on rules and packages, premiums and tariffs will arise. The NHIS has the potential to make a difference for many Ghanaians in terms of access, not least the poor, but it will be essential that there is sufficient funding for exemptions, premium subsidies and for meeting the increased demands, both in the NHIS and in the MOH budget. This should be monitored closely so that adjustments can be made in time, if necessary.

Investment planning
Clear clarification of the roles of MOH and the agencies in investment planning and implementation has to be in place. An infrastructure development plan should be part of POW III based on a review of the infrastructure development criteria, taking into account the future resources available for maintenance. The system for planned preventive maintenance should continue to be strengthened at all levels in order to reduce the future need for rehabilitations and refurbishments.

Efficiency and effectiveness
Efforts to increase efficiency should continue. The emphasis on service delivery at the lowest level of the system should continue. There should be an appropriate balance between the inputs in service delivery - i.e. between human resources, drugs and supplies and other costs - and their results. Taking into account the total resource envelope, this balance in monetary terms has not shifted much over the past four years. However, we do not know whether this is the optimal balance. Such an assessment will be an important input for the next POW. There are indications that efficiency gains can be made at all levels and in most of the elements that have been presented in this document. Continuous efforts to monitor and take appropriate actions are needed.

1.1. Background

In 2001, the Ministry of Health (MOH) and Development Partners (DP) agreed a second five-year Programme of Work (POW II) 2002-2006 that provided the framework for investments and actions within the health sector. The POW II represents the health sector response to the Ghana Poverty Reduction Strategy (GPRS) and aims to bridge the inequalities in health in the country. The 2004 Programme of Work (POW 2004) defines the strategies to be implemented and the outputs and outcomes to be achieved against a resource envelope of 2.4 Trillion Cedis (274.9 million USD).

The review of the POW 2004 comes at a special moment in time. The recent findings of the Ghana Demographic Health Study (GDHS-2003) showed decline in the main impact indicators: Under Five Mortality (UFMR), Infant Mortality (IMR), Neo-Natal Mortality (NNMR).

Table 1.1. Impact Indicators 1988-2003 (GDHS).

Impact Indicators	GDHS 1988	GDHS 1993	GDHS 1998	GDHS 2003
National IMR /1000	77	66	57	64
National UFMR /1000	155	119	108	111
National NNMR /1000	44	46.1	30	43
< 5yrs Underweight (Wt/A)	--	27.4	24.9	22.1

When these findings were reported, both MOH and DP became concerned, as despite increased financial support to regions and districts and improved budget utilisation, no real improvements in a number of impact and output indicators have been registered.
The previous review of POW 2003 had pointed to similar findings, when stating:
"The review team therefore concludes that 2003 was a second year in which little progress was achieved towards the strategic objectives of the POW II. This lack of progress came in spite of an overall increase of nearly 30% in health sector expenditure since 2001. Better paid staff in more and better facilities has lacked the financial means to be more productive".

1.2. Terms of Reference

Against this background, the essential questions posed for the review of POW 2004 are:

- Undertake a strategic review of the sector, critically analysing available evidence on why the overall sector performance over 2004 is decreasing / slowing down; and
- Provide detailed suggestions on the way forward not only for the next POW 2005/06, but also for the drafting of the third Five Year POW (POW III, 2007-2011), taking Ghana's commitment to the new GPRS and the MDG into account.

The Terms of Reference further specify that the performance of the health sector in 2004 will be placed in the context of the progress made in the sector indicators since 2002 i.e. trends as well as cumulative performance. Performance will be judged against 2006 targets and the MDG. The review will be sector-wide in scope and include all recipients of funds from Government of Ghana (GOG) and DP. The analysis of sector-wide performance will aim to demonstrate the performance of components of the whole sector as well progress in bridging inequalities in the health sector.

1.3. Methodology and limitations

This report has been compiled by an independent review team (RT), composed of national and international consultants. The RT was asked to review the POW 2004, using inputs from all Budget Management Centres (BMC), Regional reports, power-point presentations from the national performance hearings, Agency reports, minutes of the two Summit meetings in 2004 and a half-yearly progress report by MOH, self assessments from DP, Progress reports from GPRS and Multi-Donor Budgetary Support (MDBS), reports from the UN Millennium Project, the GDHS 2003 and subsequent secondary analysis, the Ghana MDG progress report, and – finally - various technical reviews that have taken place in the course of 2004. This report also builds on the wealth of information provided in the earlier reviews of POW 2003 and POW 2002, together with the detailed studies that were part of these review processes[5] (Annex 8: References). For various reasons, the four in-depth studies that were intended to be submitted to the RT as part of the POW 2004 have not been undertaken[6].

In addition to reviewing the wealth of written material, the RT has based its views on interviews with a large number of informants, coming from the MOH, the Ghana Health Services (GHS), the Church Health Association of Ghana (CHAG), Korle-Bu Teaching Hospital (TH) and health staff working at regional and district levels in Northern Region, Ashanti Region and Greater Accra (Annex 1 / 2: People met and work programme). The choice of these regions was partly based on findings from a recent review of the DHS 2003, pointing to worsening performance in Ashanti, Volta and Upper West Regions, while the RT felt that at least one of the four deprived regions in the north of the country should be visited.

In comparison with the review of POW 2003, the preparation process has much improved: many of the documents needed and the overview of the SWAp indicators were available during the first days of the assignment. This allowed the RT to analyse findings and look for trends early in time. Most informants knew about the presence of the RT and flexibly allowed interviews at very short notice. Nevertheless, partly due to Easter with four holidays, it was not always possible to interview some of the informants at national level.

A limitation of the effectiveness of the review process is the 'disconnect in time' that exists between the presentation of results and recommendations of the previous POW at the Summit meeting in June each year and its non-inclusion in the next POW, that has already been drafted and presented at the Summit meeting at the end of the previous year. For that reason, the RT could find none of the suggestions made in POW 2003 back in the POW 2004 and only few transpired in the POW 2005. For example, the suggestions (Review POW 2003) relating to selective targeting of anti-poverty related activities and inclusion of poverty indicators in national, regional and district health plans, has seen little follow-up in the presentation of POW 2005 (Annex 3). Another limitation of the review process is the lack of consistency and follow-up in the presentation of the expected outputs (EO) in the three consecutive POW (see Annex 9).

[5] These studies were in 2003: Ghana's pro-poor agenda, the clinical services review; the appraisal of Information, Monitoring and Evaluation (IME) system; and the maternal mortality study. In 2002 studies reported on: aligning exemption policies with poverty reduction goals; the proposed National Health Insurance Programme; and the Private-Public Partnership in Health.

[6] These were (i) an evaluation of the deprived areas staff incentive, (ii) an analysis of child health policy and programmes, (iii) an evaluation of the planning and budgeting process at district levels and (iv) a review of the National TB Control Programme (NTCP).

2.1. Introduction

The 2004 POW is implemented by the Ministry of Health and its Agencies established by law. Achievements in the sector are therefore considered a joint responsibility of MOH, GHS, Teaching Hospitals and Statutory & Regulatory Bodies:

- Ministry of Health (MOH) provides stewardship, coordination and mobilization of resources. It also has the responsibility of harnessing support from the other sectors such as Education, Water, Agriculture, Gender, Transport and Communication.
- Ghana Health Service (GHS) provides public health and clinical services at regional, district and sub-district levels, including management of all public health facilities at these levels. GHS also provides tertiary services in some selected disciplines (e.g. mental health). All these functions are realised through contractual agreements with the RHMT, DHMT, CHAG and self financing private providers, while GHS remains responsible for their performance. CHAG is a particularly significant player, providing up to 48% of clinical services at district level and below.
- Teaching Hospitals (TH) are responsible for tertiary care, focusing on referred cases that need specialist attention. In addition, TH train doctors and ensure appropriate balance between, service delivery and training.
- Statutory Bodies are responsible for monitoring and enforcing ethical standards and practice of various professional and technical groups. They are, in addition, expected to educate the public on their rights to seek quality care.
- Development Partners support the GOG in implementing agreed policies, facilitation of SWAp, provision of technical and financial support and sharing information on international best practices.

Overall, GHS remains the lead provider of outpatient and inpatient services in 2004. However, the percentage distribution appears to indicate a shift towards more private sector OPD and IPD admissions as compared with the public sector (GHS and TH).

Table 2.1. OPD and hospital admissions by Agency 2003-2004

	2003		2004		
AGENCY	OPD %	Admission %	OPD%	Admission %	COMMENTS
GHS	68	53.7	63	51.8	Down
CHAG	14	27.1	19	30.6	Up
TH	9	13.5	7	12.1	Down
Quasi	6	4.1	5	4.1	Stable
Private	3	1.8	6	1.4	Up / down

Note: Military and Trust Hospitals in Accra not included. Private sector data not complete.

2.2. Overview of sector performance

2.2.1. Data reliability and utilization

The MOH clearly is improving on data management as indicated by the publication of the Health Information Bulletin and the recent appointment of a Director for Information and Research. This should help to harmonize data collection, speed up analysis and provide user friendly feedback. MOH/GHS publishes its own analysis and will in future provide a full statistical digest to enable others to perform different types of analysis, or check the assumptions underlying the analysis. In this review, the RT had access to aggregated data for most performance indicators. As with previous reviews, the RT made every effort to check consistency, completeness and reliability of the data. CHPS are not consistently included in all districts reports. There were inconsistencies in the data submitted by some regions. Quality control of the data is still inadequate and is not uniformly applied.

The quarterly district and regional reviews were observed to be taken place and provided an opportunity for feedback and use of data for planning. However, this is constrained by delays in collation and weak culture of data utilization by management. The multiplicity of data sources and the inconsistencies in the numbers from different sources is another impediment to utilization.

Output indicators at national level continue to correspond quite well - using the population proportions from the 1984 census - with the population based information recently collected by GDHS. This indicates that at least for these indicators, figures collected by MOH do provide a reasonable perspective of the situation in the country.

Table 2.2 shows performance against targets in 2003 and 2004. Overall sector performance in 2004 is summarized in table 2.3.

Table 2.2. Selected performance indicators against Targets 2003-2004

Indicators	MOH Targets 2003[7]	Achievement* 2003 (actual)	Target Achieved	MOH Targets 2004[8]	Achievement* 2004 (actual)	Target Achieved
OPD Visits/capita	0.55	0.50	No	0.60	0.52	No
Hosp Admis/1000	36	35.9	Yes	38	34.5	No
U5 Malaria CFR %	1.5	3.67	No	1.2	2.8	No
TB Cure Rate	50	61.0 #	Yes	65	NA	No
CPR %	25	22.6	No	28	24.3	No
ANC Coverage %	99	91.2	No	94	89.2	No
PNC Coverage %	--	55.8	Yes	55	53.3	No
Supervised Deliv %	55	51.9	No	80	53.4	No
DPT3 Coverage %	80	76	No	100	75	No

* = The figures presented here include Teaching and Psychiatric Hospitals. # = From 2002 Cohort Analysis

For most sector-wide indicators, performance in 2004 did improve compared to set targets. Of 20 indicators (70%) for which performance targets have been set and data are available, 7 achieved their target, while 13 did not (Table 2.3). There were also marked variations in regional performance. In addition to this there are equally significant intra-regional variations within the same program.

[7] MOH,The Ghana Health Sector Annual Programme of work 2003, January 2003
[8] MOH, The Ghana Health Sector Annual Programme of work 2004, January 2004

Table 2.3. Overall performance in Sector Wide indicators and Targets 2004

Indicator	2004 Targets	2004 Achievements	Comments
Objective: Improved Health Status			
Infant Mortality Rate / 1000 live births	64	64	Same as 2003 GDHS
Under five mortality Rate/ 1000 live births	111	111	Same as 2003 GDHS
Under five who are malnourished	22.1	29.9	Below target
Maternal Mortality Ratio/ 100, 000 live births	214	N/A	Maternal mortality survey planned
HIV Sero Prevalence	3.0%	3.6%	Below target
Objective: Improved Service Outputs and Health Service Performance			
Performance of Clinical Care (Coverage and Quality)			
Outpatient per capita	0.55	0.52	Below target
Hospital admission rates per 1000 popul.	38	34.48	Below target
Bed occupancy rates	65%	63%	Below target
# specialized outreach services	158	162	Target met
Tuberculosis Cure Rates (%)	58%	61%	Target met
Under five malaria case fatality rate	3.50%	2.8%	Target met
% Tracer drug availability	90%	87%	Below target
Performance of Reproductive Health Services (Coverage and Quality)			
% FP acceptors	24%	24.3%	Target met
% ANC coverage	94%	89.2%	Below target
% PNC coverage	57	53.3%	Below target
% Supervised deliveries	60	53.4%	Below target
% Maternal deaths audited	85%	70.5%	Below target
Performance of Preventive Services and Surveillance			
EPI coverage (Penta)	80%	75%	Below target
EPI coverage (measles)	85%	78%	Below target
Guinea worm cases	5000	7275	Worsened, target not realistic
AFP non polio rate	>1	1.5	Target met
Objective: Improved Level and Distribution Health Resources			
Human Resources			
Doctor to Population ratio	1:16,500	1: 17,615	Below target
Nurse to Population ratio	1:2,000	1:1,513	Target met
Health Infrastructure			
No. completed CHPS zones	85	84	Target met

2.2.2. Health status

Although health status indicators cannot be calculated on an annual basis, important reference is made to the findings of the various Demographic Health and Surveys carried out over the last 15 years. The substantial improvements in outcomes made since 1984 worsened over the last five years:

- Infant Mortality: The GDHS (2003) gave an IMR of 64/1000. IMR accounted for 75.6% of U5MR in 2003. The same pattern of worsening mortality rates was seen in rural-urban trends although the gap narrowed due to greater increase in urban areas.

- Neonatal Mortality: NNM Rates, particularly Early Neo Natal accounted for a significant proportion of the Infant Mortality. Coupled with high Peri-Natal Mortality, these findings suggest insufficiencies in Safe Motherhood interventions (birth spacing and breastfeeding practises).

Figure 2.1. Trends in Childhood and Neo-Natal Mortality 1988 – 2003

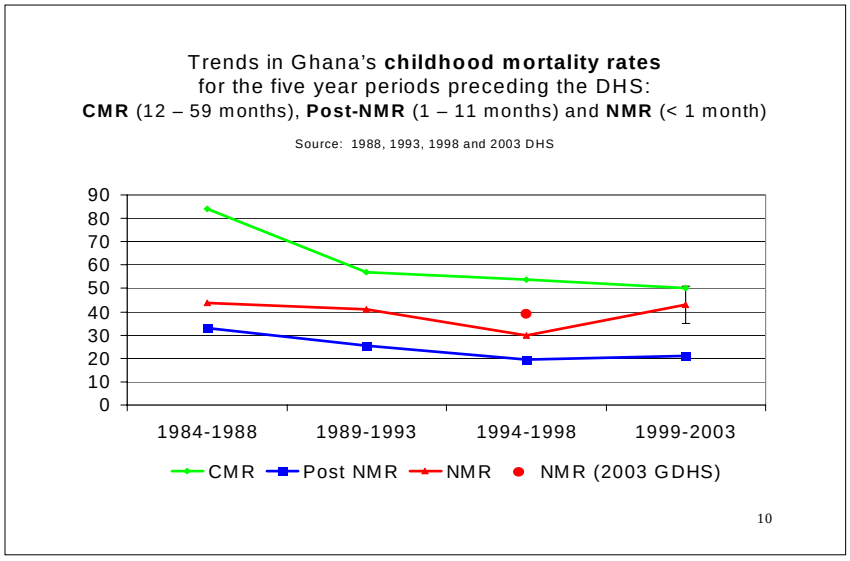
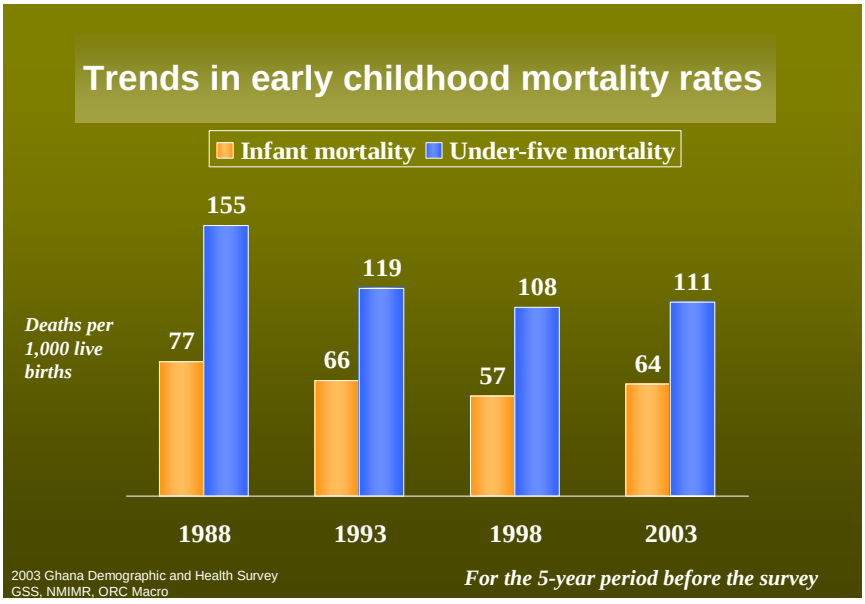


Figure 2.2. Trends in IMR and UFMR 1988 – 2003



- Malnutrition is very prevalent in Ghana: According to GDHS (2003), 30% of U5 had chronic malnutrition (stunting), 7% were wasted and 22% were underweight.

- Maternal mortality: The real levels of MMR in Ghana are still unknown. Community based data from IDSR continue to register much lower levels than the regional average, with significant regional variation.

- HIV sero-prevalence: After the initial increase from 2.9% in 2001 to 3.6 in 2003, HIV sero-prevalence in pregnancy seems to have stagnated at that level in 2004, although results of the sentinel survey are awaited. Barring dramatic changes in 2005, it is unlikely that the 2006 target of 2.6 will be realized.

2.2.3. Priority health interventions

- Clinical care: The Ghana Clinical Care Service Review of March 2004 has important recommendations that should be studied and put into effect. Clinical Care outputs had mixed results in 2004. OPD attendance per capita increased from 0.5 to 0.52, while the admission rate per 1000 pop decreased from 35.9 to 34.5. Targets were not met for facility based activities but were met or exceeded for activities that had a significant share of community-based and outreach work (like ANC, EPI). This is an important observation with implication for health indicators that rely on the quality and performance of clinical care.

- Disease control services: Targets were not met for EPI while the situation even worsened for Guinea Worm Eradication. The TB indicator was met, due to the improved performance of the TB program in 2004 (under the Global Fund supported activities in Accra and Kumasi).

As Table 2.4 shows, the performance of most of the indicators over the last three years (since the start of POW II) has been mixed.

Table 2.4. Priority intervention indicators 2001-2004

Indicators*	2001	2002	2003	2004	Observations 2003	Observations 2004
OPD Visits per capita	0.49	0.49	0.50	0.52	Stable	Up
Hosp Admission Rate	34.9	34.1	35.9	34.4	Better	Down
Bed Occupancy Rate (BOR)	64.7	60	66	63.0	Stable	Stable
Bed Turnover Rate	40.6	39.6	39.7	43.0	Stable	Up
Average Length of Stay (days)	5.8	6.0	5.9	4.3	Stable	Down
Specialist Outreach (days)	135	160	175	162	Better	Stable
Under Five Malaria CFR	NA	3.74	3.67	2.8	Stable	Better
% Tracer Drug availability	70	85	93	87.5	Better	Stable
TB Cure Rate #	58.9	53.8	61	NA	No trend	Up
CPR	20.3	21	22.6	24.3	Better	Up
ANC Coverage	93.5	93.7	91.2	89.2	Worse	Down
PNC Coverage	52.9	53.6	55.8	53.3	Better	Down
Supervised Delivery*	49.2	52.6	51.9	53.4	Stable	Up
DPT3 Coverage	76.3	77.9	76	75	Stable	Down
HIV Sero-Prevalence	2.9	3.4	3.6	NA	Worse	Up
Guinea Worm Case	4738	5611	8290	7275	Worse	Stable

Source: CHIM Report 2003. # From 2002 Cohort Analysis; DHS = deliveries by health professionals.
* = “Supervised Delivery” = deliveries by health professionals & Trained TBA;

2.3. Detailed performance assessment

The list of priority health interventions to address the health problems in POW II are shown below. They are divided into Services, Disease Control, Surveillance and Intersectoral collaboration. The various programmes that operate under these headings will be briefly presented below.

Priority Health Interventions

- 1. Services
  - Maternal and Reproductive Health Services
  - Child and Adolescent Health Services
  - Accident and Emergency Services
- 2. Disease Control
  - HIV/AIDS and STI Prevention and Control
  - Tuberculosis and Buruli Ulcer Control
  - Malaria Control
  - Guinea worm Eradication
  - EPI - Polio eradication and Measles Elimination
  - Prevention of Blindness
  - Non Communicable Disease Prevention and Control
- 3. Integrated Disease Surveillance and Response
- 4. Intersectoral collaboration

2.3.1. Health services

Maternal and Reproductive Health services

Expected output:

- *80% supervised delivery*
- *50% of Public Health facilities meet standards for EOM*
- *10/100000 maternal mortality ratio*
- *28% family planning acceptor rates*
- *1,200,000 couple year protection*

Reproductive health outcomes have not improved in recent years and are therefore of great concern to the sector. Uncertainty of the actual MMR estimates is another concern since the current estimate of 214/100,000 is not supported by recent studies. The 2004 POW focused on strategies to improve access to essential and emergency obstetric care, family planning to reduce unwanted pregnancies and harness synergy with HIV/AIDS and STI interventions. Selected priority activities for this period were: Dissemination of the revised RH policy, development of standards and protocols; strengthen institutional capacity to provide EmOC; training in Life Saving Skills (LSS) and FP; intensifying health promotion activities in Safe Motherhood and FP; improving the referral system from community to health facility; institutionalizing maternal audits and making maternal death a notifiable event; scaling up PMTCT; strengthening Post Abortion Care (PAC); scaling up cervical cancer screening, and implementing exemptions for supervised deliveries.

Most output indicators improved over 2003. However, the 2004 targets were generally not met and wide regional variations persisted. The exemption policy was implemented but it may be too early to assess the impact. Family planning improved slightly by two percentage points over 2003 but missed the target by 5%. This unfortunately has been the trend over the years. The RT observed that FP services in Ghana were still largely facility based. The crunch on human resources, including a high turnover of staff is likely to affect FP service provision. The RT therefore recommends intensification of community based approaches within the CHPS concept. ANC coverage decreased in 2004 to 89.2, which was worse than the 2001 baseline of 93.6. The average number of ANC visits increased slightly to 3.3. Supervised deliveries also increased marginally from 51.9 in 2003 to 53.4 in 2004. This was however well below the POW target of 60%. It should be noted that Ghana includes trained TBAs in this group which is not captured in DHS. Given that the DHS reported supervised delivery rate of 47% in 2003, it would be of interest to analyse what proportion of deliveries are actually supervised by trained TBAs, including the trends. CHPS provides an excellent opportunity to begin addressing this situation, but will require that the CHOs be provided with requisite basic skills, supplies and support.

Institutional MMR decreased from 2.2/1000 to 1.8/ 1000 between 2003 and 2004. Maternal audits, on the other hand dropped drastically in this period, from 85% to 55.9%. This was even lower that the 2001 baseline figure of 60%. Maternal Mortality is a central concern in Ghana and the RT recommends that the planned MM survey be done immediately in order to clarify the situation and provide an agreed baseline against which future progress will be assessed. Making MM notifiable will also help improve the reporting. It is reported that 67.3% of district and regional level facilities offered emergency obstetric care (basic and comprehensive) but the quality of the service needs to be looked at, given the human resource situation. Post natal coverage seems to have stagnated at below 55%.
Unsafe abortion remains a significant cause of maternal mortality in Ghana. Although an internationally acknowledged Post Abortion Care program that allows nurses to perform MVA has been in place for over a decade, its expansion to the districts has been rather slow.

The RT noted with appreciation the concern and effort put in addressing maternal and newborn mortality in Ghana. In general, Ghana has adopted the right approach and is trying to put in place recognized cost effective strategies. The 2003 Maternal Health review brought out many issues that need to be addressed both in the short and long term. They are endorsed by the RT. The major issues stalling improvement can be summarised as:

- inadequate coverage and slow pace of expansion;
- inadequate attention to quality of services;
- inadequate integration with other priority programs (especially HIV/AIDS, Malaria),
- inadequate supportive supervision;
- Weak referral system, and
- inadequate community participation.

As will be seen in the next chapters most of these have strong systems and inter-sectoral components that can only be addressed with commitment from higher echelons of administration. RCH units need to identify champions at those levels to sustain advocacy.

The RT emphasizes that that there are no quick fixes to reduce maternal mortality. Family planning must be intensified to reduce the number of high risk pregnancies. No country has managed to impact on maternal mortality without marked improvement in this area. In addition, there is no alternative to increased and sustained investment to increase access to quality ANC and supervised delivery. The RT observed the adverse effect the HR crisis is having on emergency obstetric care, because some district hospitals have neither a doctor nor anaesthetist. This is discussed in detail by the Maternal Mortality report and can not improve unless appropriate action is urgently taken.

Table 2.5. Reproductive health indicators 2001-2004

RCH Indicators	MOH 2001	MOH 2002	MOH 2003	MOH 2004	DHS 2003	Observations 2003	Observations 2004
ANC Coverage	93.6	93.7	91.2	89.2	91.9	Worse (target 99)	Same
ANC Average No Visits	2.8	2.9	3.1	3.3	NA	Better	Better
PNC Coverage	52.9	53.7	55.8	53.3	NA	Better	Stable
Supervised Delivery* N	49.3	52.6	51.9	53.4	47**	Stable (target 55)	Marginal increase
Contraceptive Prev Rate (CPR)	20.3	21	22	24.3	18.7	Better	Better
% Malnourished Children	25%		NA	29.9	22	--	
Institutional M. Mortality1000	2.6	2.0	2.2	1.8	NA	Unclear GPRS: 1.6/1000 (05)[9]	
% Maternal Audits	60	75	85	55.9	--	Better (73-100%)	Low
Caesarean Section Rate	4.7	5.3	6.0	5.7	--	Better (WHO: 5-15%)	Stable
EOC Facilities % Basic + Compr/EmOC				67.3	--		

* = "Supervised Delivery" = deliveries by health professionals & Trained TBA;
** = DHS uses the definition of 'Deliveries by Health Professionals'.

Child and adolescent health services

Expected output:
- *20% malnutrition rate among children attending CWC*
- *80% of districts implementing complete IMCI*
- *20% of Public-private facilities providing babe friendly maternity service*
- *Functional ICC for school health in place*
- *50% pre-service institutions teaching IMCI*

Priority activities selected for child and adolescent health were the incorporation of IMCI and pre-service training, scaling up of IMCI in all districts, making more institutions baby and adolescent friendly, improving growth monitoring and education of mothers on nutrition, establishing child health week and developing a joint MOH/MOE strategic plan for school health. The GDHS 2003 showed increasing U5 and IMR, particularly in Upper West, Ashanti, and Volta region. The high Neo-Natal Mortality rates have already been presented in Fig 2.1.

IMCI: The year 2004 saw the first district level IMCI training and increased collaboration with the private sector. The number of districts and regions actively implementing IMCI increased as 575 health workers were trained in 62 districts. In total 56.% of districts were implementing IMCI in 2004. IMCI was also incorporated into training curricula of MAs and Nurses. Nutrition did not fare that well as indicated by the proportion of malnourished children which increased above the 2001 baseline. Breast feeding showed remarkable improvement, as indicated by the 135 facilities currently accorded baby-friendly status

[9] The Maternal Mortality Review conducted in March 2004 (as part of the review of the 2003 POW) mentions the target of the GPRS being 1.6/1000 live births in 2005 and the target of MDG being 0.54/1000 live births in 2015. However, it is not clear whether these figures refer to institution based (as presented in this table) or population based data. As no population based figures are available, the real situation concerning Maternal Mortality in the country remains unclear.

(compared to only 83 in 2003). Exclusive breastfeeding at 6 months stood at 53%. The major bottleneck in nutrition is the weak community level interventions and inability to overcome dangerous traditional feeding practices. Both growth monitoring and education of mothers have not been adequately scaled up.

School health: There are several activities in school health, including production of a draft policy, draft guidelines for service provision for GHS, 69,313 children physically examined (up by 2.5% on 2003), 16.6% of schools given health talks (only 1% increase over 2003).

Adolescent health: Interventions continued to receive support from the African Youth Alliance (AYA) project, with focus on establishing youth-friendly services. Thus, 9 of 10 regions trained resource teams and more than 500 health workers were trained. This was accompanied by establishment of Youth friendly corners in some facilities in GAR, VR, CR, ASR and UWR. There was also an attempt to disaggregate data to highlight adolescent health issues. Staff shortage, attrition and infrastructure continue to hamper scaling-up of youth friendly services across the country. More needs to be done in this area. It needs to be integrated in pre-service curricula to ensure sustainability. Production of relevant IEC materials should also be stepped up, under the coordination of the Ghana Population Commission and involving NGO's.

Table 2.6. Child health indicators 2001-2004

RCH Indicators	MOH 2001	MOH 2002	MOH 2003	MOH 2004	Observations 2004
% Malnourished Children	25%		NA	29.9	
% District implementing IMCI				56.4	
Babe friendly facilities	40	62	83	135	Better
Pre-service schools teaching IMCI				All Started	
Functional school ICC*				Done	

* ICC: Interagency coordinating committee

Scaling-up remains an important step in improving both child and adolescent health outcomes. Activities have been intensified in only a few districts and institutions, mainly where designated funds are available or there is a special program supported by an external agency (e.g. AYA and UNICEF). In Northern Region, it is unlikely that the same level of intensity in IMCI can be sustained, leave alone scaling it up, when the financial inputs from UNICEF cease. MOH does not have the resources to sustain such successful pilots. The challenge to improving child and adolescent health is scaling up from successful pilots and increase real coverage while maintaining intensive support-supervision and quality of services.

Accident and emergency services

Expected output:
- *5 Regions linked to the ambulance service*
- *20% Facilities meet functional criteria*
- *Policy to include Ambulance in NHIS*

Most health facilities in Ghana, especially public ones, provide 24 hour services. A National Ambulance Policy was developed in 2003 and received cabinet approval in 2004. The 2004 priority was therefore to implement this service and improve management of emergencies. Selected activities included – operationalising the national ambulance service; development of standards and protocols for emergency care; equipping accident and emergency centres; training of hospital teams; review of hospital fee exemption scheme to include emergencies and including payment of ambulance service in the NHIS and vehicle insurance schemes.

The Ghana Ambulance Service (GAS) began as a pilot in 7 locations (high accident incidence areas) in 3 regions during 2004. A draft policy has been passed by cabinet forming the basis for ongoing drafting of legislation for a bill to be presented to Parliament in July 2005. The implementation plan is slightly delayed but most targets are on track. There is a provision within the draft policy for hospital preparedness to meet criteria for accreditation for NHIS to receive ambulance patients.

Free emergency treatment for the first 48 hours has been implemented but procedures for re-imbursement of hospitals have yet to be worked out. The rate of expansion of the GAS is dependent on training of Emergency Medical Technicians (EMTs). The target set was 400 trained by 2005. With 150 trained in 2004 and an additional 100 in 2005 it is anticipated to meet the planned target in 2006. The EMT is a new cadre that needs to be captured in the sector HRH policies and strategies when the latter is reviewed. Attention should be paid to the findings and recommendations of the Ghana Clinical Care Service Review, March, 2004.

2.3.2. Disease control

HIV/AIDS and STI prevention and control

Expected output:

- *6 facilities providing ARV therapy*
- *2000 patients on ART*
- *6000 mothers on PMTCT*
- *40% Health workers trained in STI and opportunistic infections management*

The programme continued to focus on delivering the health component of the HIV/AIDS and STI prevention control, working closely with the Ghana AIDS Commission. In 2004, it paid particular attention to scaling up of ART and traditional prevention strategies.
This was implemented through the following activities: scaling-up ART based on the 3X5 strategy; increasing access to VCT services; strengthening sentinel surveillance and scaling up PMTCT; Strengthening capacity of both public and private providers in managing STI and opportunistic infections; implementing Behavioural Change and Communication (BCC) strategy, including improved perception of risk, increased demand for condoms/VCT and reducing victimization of PLWHA.
The HIV/AIDS program is well resourced, with additional funding expected from the World Bank's Treatment Acceleration Programme (TAP) for accelerating ART. Progress is attributed to increased funding, more focused management, pre- and in-service training in VCT and PMTCT, linkage of VCT/PMTCT and integration with FP/RH activities.

Sentinel surveillance: A sentinel survey system has been in operation in Ghana since 1990. It is based on annual sero-prevalence survey of selected sentinel sites using unlinked anonymous method and antenatal clients. The sites increased from 30 in 2003 to 35 in 2004, with improved testing kits and better dissemination of reports. Each region now has at least one rural site.

VCT and PMTCT: These have been more closely linked, leading to rapid increase in sites from 2 in 2002, 19 in 2003 to 52 in 2004. PMTCT has been expended to all the ten Regional and Teaching hospitals. They have also been integrated in pre-service training.

Table 2.7. HIV/AIDS indicators 2001-2004

HIV/AIDS Indicators	MOH 2001	MOH 2002	MOH 2003	MOH 2004	Observations
HIV Sero-prevalence (median)	2.9	3.4	3.6	NA	Up
VCT Centres	0	4	26	52	Up
Clients receiving VCT			6,698	15,490	Up
PMTCT sites	0	2	19	52	Up
Women put on Neverapine		249	--	190	Down
ART sites	0	2	3	4	Up
Facilities providing ARV			3	4	Target not met
Patients on ART			197	2,028	Target met
Mothers on PMTCT (accessing)				8,490	Target met
Health Workers trained in STI case mgmt		NA	NA	NA	No data available

ART: Although improvements were recorded, targets were missed for all ART related indicators. There are now four sites offering ART, two less than planned for 2004. Only the Korle-Bu Teaching Hospital offers a comprehensive care package. The number of patients in ARV therapy increased from 197 in 2003 to 2028 in 2004. Plans are in place to establish ART sites in all regional capitals, 4 private facilities and 15 district hospitals by the end of 2005. National Accreditation Criteria will be used to assess site readiness, focusing on districts with prevalence above 5% or where there is a concentration of PLWHA.

Despite all these achievements, HIV sero-prevalence seems to increase. This may be due to: targets have not been set realistically; there is inadequate focus on prevention and BCC and IEC and too much attention to ART/PMTCT and PLWA; or annual assessments take place too frequently. Obviously more work is needed to address these bottlenecks.

Tuberculosis and Buruli Ulcer

Expected output:

- *80% districts with functional diagnostic centres*
- *65% TB Cure rate*
- *Establish BU prevalence rate*

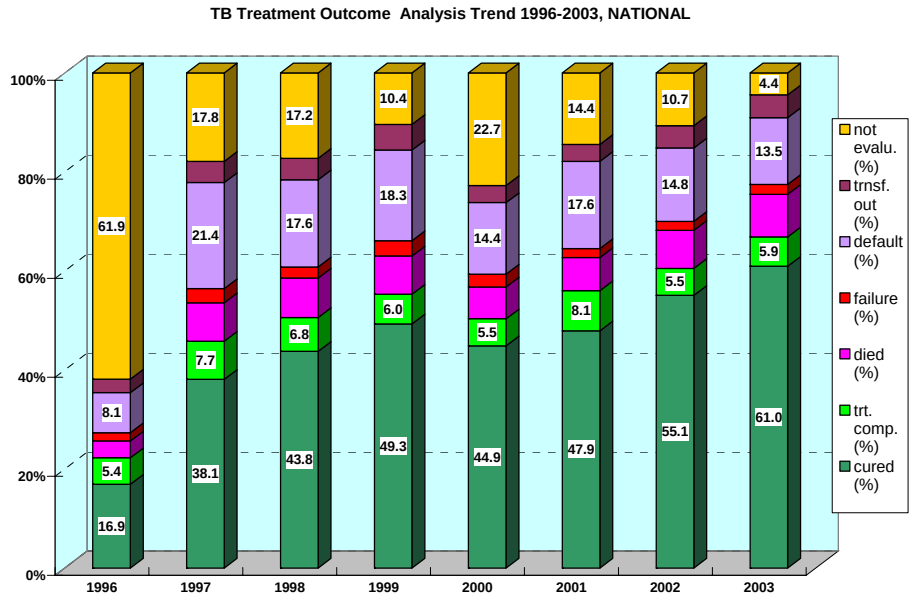
TB has increased steadily due to the HIV/AIDS epidemic. Priority activities selected for 2004 were: Training public and private providers in DOTS; establishing TB diagnostic centres in every district; strengthening defaulter tracing; and intensifying community education on prevention and care.
Performance of TB program has improved in the last year, fortified by increased funding from the Global Fund. Success was also attributed to innovation (private sector participation in Greater Accra/Ashanti regions and treatment supporters) and stronger regional ownership of activities. However, case detection rate fell from 58% to 52%, lower than the 2004 target of 55%, but Cure rate is increasing to 61% (2003 target of 60%).

Table 2.8. TB Indicators 2001-2004

TB related Indicators	MOH 2001	MOH 2002	MOH 2003	MOH 2004	Observations
Case Detection Rate/100.000	62	59	58	56	Stable; (NTP data)
TB Cure Rate	47.9	55.1	61	NA	Better
TB Defaulter Rate	17.6	14.8	13.5	NA	Stable

Although only two regions failed to meet their targets, formidable challenges still persist. Scaling-up of the innovation will require additional intensity. Both CHPS and private sector offer opportunities, but it will require additional sustained investment. Health systems issues such as human resources, drugs logistics and laboratory facilities should also be addressed. The program recognizes weakness in its IEC component. An extensive review of the NTP is recommended in order to maximise the use of the expected funds from GFATM.

Figure 2.2. TB Treatment outcome analysis trend 1996-2003



Buruli Ulcer.

The main activities planned in 2004 for control of Buruli ulcer included: Training of providers and equipping of health facilities to improve diagnosis and management; Review of the exemption policy to include treatment of Buruli ulcer; integration of Buruli ulcer surveillance into the surveillance system.

Cases of Buruli ulcer increased in 2004, probably a factor of intensified case detection in some districts and better reporting. This was particularly evident in certain districts in Ashanti region. Planned activities were largely realized. The exemption policy was effected and BU is now included in the disease surveillance system. Training was however limited, mainly due to limited resources.

Malaria control

Expected output:

- *Reviewed malaria policy*
- *43% targeted population sleeping under ITNs*
- *25% <5 malaria case fatality rate*

Malaria remained the leading cause of OPD attendance in 2004. The focus in 2004 was to scale up both prevention and case management. Priority activities were: revision of malaria control strategy to scale up ITN and IPT (children U5 and pregnant women); updating the anti-malaria drug policy; consolidating use of pre-packed anti-malaria drugs in home and institutional treatment and; pilot voucher system in the Volta Region.
The new drug policy was implemented 2004, but more work needs to be done to ensure application at clinical level. Backed by additional funding from Roll-Back Malaria (RBM) Initiative and the Global Fund, intensified malaria activities in 2004 led to positive outputs in all areas, especially in the 20 pilot districts:

- Overall morbidity in health facilities fell (from 45% in 2003 to 43% in 2004) but increased in 4 out of 10 regions. Case Fatality Rate fell to 2.8%, compared to 3.5% in 2001 (regional variation was from 2-5%).
- IPT coverage rose to 33% in the 20 pilot districts. Plans are underway to scale this up nation-wide in 2005.
- Knowledge on fever management in homes increased from 22% to over 70%.
- Innovative approaches, including vouchers, community and facility based subsidy of ITN and social marketing, are credited for the sharp increase in ITN coverage from 3.5% in 2003 to 15% in 2004. NR has the highest ITN coverage of over 40% and was not include in the internal assessment made by the Malaria unit.

Table 2.9. Malaria Indicators 2001-2004

Malaria Indicators	MOH2001	MOH2002	MOH2003	MOH2004	Observations
Under Five Malaria Case Fatality Rate	3.5	3.74	3.67	2.8	Declining
< 5 Yrs under Bed Net	12.2%	NA	NA	15	DHS 2003: 14.6%
< 5 Yrs under ITN	4.1%	NA	NA	NA	DHS 2003: 3.5%
% of all OPD cases		43.7	45.33	43.5	Stable

The program was hampered by several system issues: lack of human resources, inadequate integration of malaria with other health activities and lack of district-level ownership. The latter was not helped by the fact that planning of Malaria activities is still highly centralized and the districts are not aware of the resources available to them in advance. This means that the actual activities implemented during the year are not specified in the districts annual POW or budget. This may lead to distortion of focus and time allocation when the plans are introduced midstream. The capacity for nation-wide scaling up is questionable, as is the ability to sustain the gains in the 20 pilot districts without the additional inputs.
Best practices that have added value to the Malaria control program are: Public-private partnership on vouchers and on ITN subsidy; Sustained IEC encouraging ITN use; Collaboration with selected programs (e.g. RCH and EPI/NID).

Guinea Worm Eradication (GWE)

Expected output:

- *800 Guinea worm cases*
- *50% endemic communities have potable water*
- *70% Guinea worm cases contained*

Priority activities put in place during 2004 included strengthening of community based surveillance, case containment and more effective inter-sectoral action, especially with the Water Department.

Table 2.10. Guinea Worm indicators 2001-2004

INDICATORS	2001	2002	2003	2004	Observations
Reported Cases	4749	5611	8290	7275	Still high
% Endemic communities with potable water	39	38	38	46	Stable
% Guinea worm cases contained	68	66	51	56	Stable

Despite the plans, reported Guinea Worm cases in 2004 showed only a marginal drop from 2003 and remained the second highest in the last four years: from 4739 in 2001 (baseline) to 5611 in 2002, 8290 in 2003 and 7275 in 2004. In 2004 the highest cases were reported in Northern (4979: 68.3%) and Volta Region (1604: 22.04%). This trend cannot be attributed to better case detection alone and must be due to ineffective interventions. Inter-sectoral collaboration remains weak at all levels and community participation needs further strengthening. There is need to do a thorough review of the whole program build on the slim gains in 2004 and strengthen linkages with other communicable diseases, (especially Malaria and Onchocerciasis) and with the District Assemblies.

EPI - Polio eradication and Measles

Expected output:
- *100% DPT/HepB/Hib coverage*
- *6000 Measles cases recorded*
- *Wild polio eliminated*
- *80% stool from AFP collected within 48 hours*

Although EPI had made significant progress, Polio eradication stalled, with identification in 2003 of 8 (!) new polio cases after two years of polio-free status in the country. Priority activities for 2004 were: Revision of the EPI strategy to incorporate targets for measles and tetanus; sustaining high levels of routine immunization coverage by strengthening static and outreach services as well as targeted supplementary activities; conducting four nationwide NIDs; strengthening Acute Flaccid Paralysis (AFP) and measles case-based surveillance, and; implementing a financial sustainability plan for immunization.

Table 2.11. EPI indicators 2001-2004

EPI related Indicators	MOH 2001	MOH 2002	MOH 2003	MOH 2004	DHS 2003	2004 Observations
Penta-3 (DPT3) Coverage	77	77.9	76	75	76.4	Stable
Measles Coverage	82.4	83.7	79	78	83.2	Worse
# Suspected Measles cases Malaria as % morbidity		14,948 0.2%	4,341 0.1%	2,443 0.01	NA	Down
AFP Non Polio Rate	2.8	2.0	1.3	1.52	NA	(Target 1.0)
Suspected measles cases	13,476	12,130	2,642	2,443	NA	Stable
Wild Polio	0	0	8	0	NA	
% Stool timeliness (80%)	70	85	75	84	NA	Target met

Measles and DPT coverage did not improve in 2004, although fewer cases of measles were reported than the targets. Polio eradication however was stepped up with continuation of four NID per year. Indeed there was no new case of polio in 2004. However, given the effort that goes into NID and the shortage of human resources in the country, it is possible that this activity is taking the focus away from routine immunization, hence the stagnation. The cold-chain system functioned satisfactorily in 2004.

The differentials in resource allocation between NID and other public health activities in Ashanti Region is an indicator of the distribution of investment and efforts. The financial sustainability plan for immunization was not completed in 2004. It is important to note that the routine EPI performed badly in Kumasi and Accra, where service priority was shifted towards the realisation of Global Fund goals.

Prevention of blindness

Expected output:
- *650 cataract surgeries*
- *1300 TT surgeries*
- *85% antibiotic coverage for active trachoma in endemic communities*

Ghana has a high prevalence of preventable blindness that POW II intended to address in 2004. Priority was given to increasing cataract surgery and strengthening the implementation of the 'SAFE' strategy for Trachoma control. Planned priority activities included: Strengthening regional and district capacity to conduct cataract surgery; promoting community based surgery and; implement a program for identifying children with refractive errors and providing corrective interventions. This program is hampered by human resource constraints. The RT was informed about specialist outreach activities by ophthalmologists but was unable to obtain the data.

Non-Communicable Disease control

Expected output:
- *Updated NCD strategy*
- *10% of target health workers trained in management of NCD*

Non-Communicable Diseases (NCD), including mental health disorders and substance abuse are on the rise but have not been given sufficient emphasis in national and district programs. The 2004 POW intended to provide effective public health response by: updating and implementing a national policy and strategy; establishing a cancer register; promoting good practices and strategies for promoting health; establishing systems for surveillance and reporting on NCD; strengthening capacity of health institutions to diagnose / manage NCD. Although the NCD strategy has not been updated, the disease surveillance system has begun to capture these data. Training in management of NCD is in pre-service. The RT was unable to assess the quality of training in this area but noted that continuing updates were rare, especially for rural staff. Given the rapid changes in management of NCD, continuing medical education should be intensified and outreach specialist sessions expanded beyond what is currently happening. It therefore calls for greater collaboration between GHS and TH.

Table 2.12. Selected Non-Communicable Disease indicators 2002-2004

INDICATORS	2002	2003	2004	Observations
# Hypertension cases	195055 (2.7%)	212354 (2.8%)	206925 (2.7)	Stable
# Other Heart diseases	19162 (0.3%)	18445 (0.2%)	14983 (0.2%)	Down
# Diabetes	24716 (0.3%)	28958 (0.4%)	26408 (0.3%)	Stable

2.3.3. Integrated Disease Surveillance and Response (IDSR)

Expected output:
- *80% of districts with epidemic response*
- *3.5% AFP non-polio rate*
- *Revised guidelines for disease surveillance*

The Integrated Disease Surveillance and Response (IDSR) system has been in place since 1998. Activities in 2004 aimed at improving the sensitivity of the system and epidemic preparedness. Activities included: Revision of guidelines to strengthen community based aspects and incorporate maternal mortality; strengthen public health reference laboratories; strengthen district and sub-district capacity to carry out surveillance and; implement the IDSR Reporting strategy.

The IDSR guidelines were revised and progress was made in incorporating maternal mortality into the system. There was significant improvement in IDSR reporting and strengthening of regional and district activities. IDSR has put in place weekly district reports to the regions and from the regions to the centre, using the radio system, computers and hard copies. The focus in 2004 was more on communicable diseases, especially polio, malaria, meningitis, Yellow Fever, Cholera. A high (80%) epidemic response capacity may already have been attained, given that all Districts in Ghana submit routine surveillance data. There are however resistant pockets of poor or late reporting among hard to reach districts (in some seasons) and CHAG institutions. Areas for improvement include strengthening surveillance of non communicable diseases (diabetes, hypertension, cancer etc), improving information sharing across all levels, the feedback loop and capacity for emergency epidemic response. The wide coverage and cheap availability of mobile phones is a booster that should be considered alongside more expensive radio communication systems.
IDSR suffers from several problems such as inaccurate and incomplete reporting by health institutions and a weak community component

2.4. Regional performances

2.4.1. Regional differences in outputs

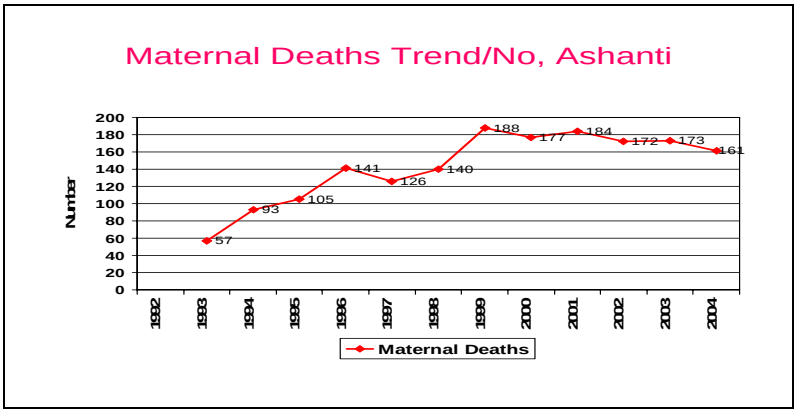
There are marked variations in regional performance. Coverage figures vary substantially as in the TB Case Detection Rates of 20% and 80% in NR and CR respectively. There are differences in FP coverage (47.9% in BAR vs 13% in Ashanti), in ANC (77% in Greater Accra vs 110% in NR); and in Hospital Admission Rate being 52.1% in UWR vs 23.7% in Greater Accra. There are also intra-regional variations in performances in same program areas such as 46.3% TB Cure rate in CR compared to its case detection of 80%.

Table 2.13. Regional performances 2004

Service Output Indicators by Region, 2004										
Region	Reproductive Health				Preventive Services			Clinical Care Services		
	%FP	%ANC	%PNC	% Sup. Del	% DPT3	% Measles	Guinea worm cases	OPD per capita	Hosp. Adm. Rate	Bed Occup. Rate
Ashanti	13.2	79	52.8	56.2	67		85	0.61	37.26	60.4
Brong Ahafo	47.9	90	55	57.8	83		336	0.67	24.99	67.3
Central	33.6	107	70.6	76.3	84		0	0.50	34.42	64.9
Eastern	29.9	81.4	67.1	47.2	78		27	0.53	37.20	49.3
Greater Accra	18.5	77.7	40.9	46.2	55		3	0.52	23.72	99.9
Northern	16.7	110.4	62.9	48.2	93		4979	0.31	35.59	59.2
Upper East	20.2	102	48.4	71.2	86		15	0.59	43.38	41.3
Upper West	44.6	94.7	94.1	71.2	89		222	0.48	52.14	51.9
Volta	25.6	86.1	45.7	39.7	70		1604	0.42	38.65	47.5
Western	23.2	94.7	32.8	46.2	85		4	0.51	38.90	53.4
National	24.3	89.2	53.3	53.4	75		7275	0.52	34.48	63.0
Completeness of Districts reporting.	!00%	!00%	!00%	!00%	!00%	!00%	!00%	!00%	!00%	!00%

More detailed analysis of some regional trends paint an interesting picture. In Ashanti region for example, maternal mortality reporting increased progressively over a decade and stabilized in 1999, though at a higher level than the baseline. The RT recommends in-depth assessment of such regions to understand the dynamics, some of which have been raised in this review, to achieve the desirable results.

Figure 2.3. Maternal deaths trends in Ashanti Region



2.4.2. Performance of the four deprived regions

The table below shows overall an improvement in the performance in the four deprived regions between 2003 and 2004, except in a few areas such as TB control and ANC. NR, as was observed in 2003, remained the weakest performer. CR, NR, UER made little progress in Post Natal Care and FP. UWR made good improvements in these areas. The supervised

delivery rate in the four deprived regions improved considerably, notably in UER; NR however performed below the national average despite the free delivery package.

Access to professional (nursing) staff saw some improvement from 2003 to 2004 in the four deprived regions. Population per doctor decreased considerably in three of the deprived regions and was stable in UWR. Note, however, that there is some uncertainty regarding the comparability of the figures between the two years, due to definitional differences (e.g. 2004 figures include private physicians).

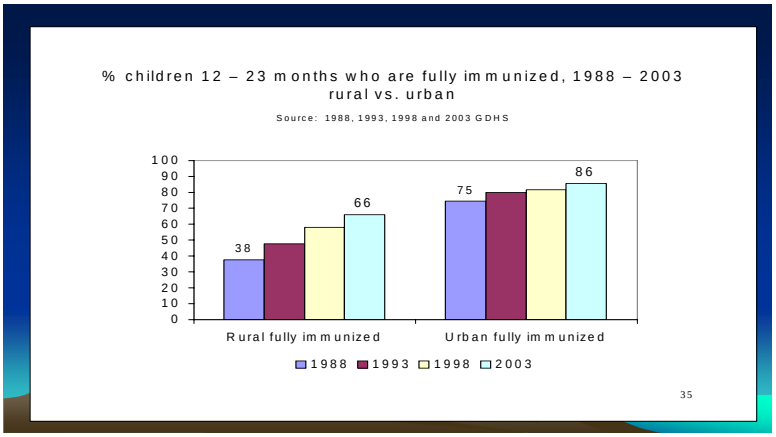
Table 2.14. Performance in deprived regions vs national average 2003-2004

INDIC	INDICATORS	CR 2003	CR 2004	NR 2003	NR 2004	UWR 2003	UWR 2004	UER 2003	UER 2004	Nat 2003	Nat 2004
	% Under five years who are malnourished (Wt/A)	?	31.6	?	48.8	?	34.1	?	31.7	?	29..9
SERVICE	HIV sero-prevalence among pregnant women	5.4	NA	2.1	NA	2.2	NA	3.5	NA	3.6	NA
	Tuberculosis Cure Rate	47	46.3	NR	65	NR	52	41	59.6	53.8	61
	% Supervised deliveries	67	76.3	39.2	48.2	67.3	71.2	44.9	71.2	51.9	53.4
	% FP acceptors (CPR)	26	33.6	16	16.7	36	44.6	19	20.2	22.6	24.3
	% ANC coverage	102.5	107	102.7	110.4	88.7	94.7	100.2	102	91.2	89.2
	% PNC coverage	69.7	70.4	62.1	62.9	75.8	94.1	50.1	48.4	55.8	53.3
	EPI coverage - DPT3	83	84	85	93	87	89	83	86	76	75
ACCESS	Population to Dr Ratio	38,5	23,4	76,0	58,1	32,7	30,8	50,5	30,0	17,4	17,6
	Population to Nurse R.	2900	1695	4070	2941	3169	1786	3159	1408	2598	1513
	Hospital admission rate/1000pop	32.9	33.6	37.7	21.8	50.5	63.9	41.1	41.1	35.9	34.5
QUALITY	% Maternal audits to maternal deaths	84	100	60	0	100	100	100	93.5	85	70.5
	Maternal deaths (Inst)	159		240		100		248		220	
	Under-Five Malaria case fatality rate	NA	2.1	NA	3.4	2.7	2.4	2.4	2.5	3.6	2.8
EFFICIENCY	AFP non polio rate	1.00	1.00	0.80	1.70	0.60	1.67	2.2	2.00	1.43	1.52
	Bed occupancy rate	61	67.3	59	51.9	48	47.5	47	53.4	64.1	63.0

2.4.3. Rural-Urban differences

Rural-urban differences in sector performance persisted in 2004. In depth analysis of child and maternal health outcomes and other priority intervention however reveal a complex picture. The rural-urban gap is getting smaller, partly due to faster improvement of health conditions in rural areas in addition to stagnant or worsening outcomes in urban areas. Increased rural-urban migration with a faster urban population growth than national averages has not been accompanied by commensurate expansion of urban health facilities. The majority of these immigrants are jobless, poor and reside in temporary urban slums that lack basic social amenities and public health interventions. Governments rarely invest in these settlements, since they are illegal and considered temporary. Increasing poverty and lack of health interventions are the primary cause of this trend. The RT suggests that MOH works with urban authorities and undertakes actions to increase coverage of health facilities in these urban slum areas.

Figure 2.4. Rural vs Urban fully immunised children 1988-2003



2.5. Conclusions and recommendations

The performance of each priority intervention has been analyzed in detail above. The RT has identified a number of issues that, almost invariably, apply across the board. Effectively addressing them is likely to have a multiplier effect on all the individual interventions:

Overall, similar to the previous year, most performance targets were not achieved.

- Review the target setting process and inject realism;
- Bring conformity between national priorities and service delivery at the district;
- Focus on improving coverage and increasing utilization of services. Quality and access are critical issues;

Public health related interventions did better than clinical ones.

- Focus on systemic issues that constrain clinical services e.g. HR, QA, infrastructure;
- Integrate the contribution of earmarked funds in the annual planning exercise.

Data quality, completeness, utilization and feedback remain a problem.

- Continue and strengthen the on-going reform of the information system (IME).

Integration of public health programs and linkage with clinical activities inadequate.

- Focus on human and behavioural factors with program managers
- Strengthen central coordination and communication with the districts

National priority interventions are generally not carried through to District activities

- Critical supervision of the “priority intervention chain”;
- Review why earmarked funds define district priorities and are seen as the only resource for scaling up.
- Review sustainability of “pilots” supported by these funds.

Enhance health promotion and mainstreaming of IEC activities.

- Complete approval of the Health Promotion Policy and review strategies
- Include specific sector wide indicators for IEC performance
- Enhance behaviour change communication (BCC) to counter harmful practices

Maternal Health requires sustained attention and investment.

- Increase attention to FP with special focus on CBD and CHPS
- Improve skilled attendance at delivery and access to EmoC in the districts by investing both on HR, the referral system and infrastructure
- Accelerate the National Ambulance service and link it strongly with maternal health
- Improve neonatal care by those who attend to deliveries (TBAs and Midwives)
- Conduct the MM study this year to provide a realistic baseline for Ghana
- Institutionalize maternal mortality audit and make MM notifiable in Ghana
- Mobilize communities and political support for safe motherhood following the PMMN strategy and in line with the 3-Levels of delay
- Take full advantage of CHPS. Improve obstetric skills of CHOs
- Hasten the implementation of relevant recommendations of Ghana Clinical Care Services Review, March 2004.

Child survival activities lack sufficient coverage and are often not sustained.

- Expand IMCI beyond the 62 districts while assuring sustainability
- Place increased attention on nutrition in facilities and in outreach work
- Maximize CHPS to expand child survival activities; strengthen participation.

Gains made in communicable disease control have not yet been sustained

- Intensify continuing medical education on NCD and outreach specialist sessions with a collaborative arrangement between GHS and TH.
- Strengthen regional and district capacity to identify refractive errors, corrective interventions and conduct cataract surgery.
- Thoroughly review the whole Guinea Worm Eradication program, Strengthen linkages with other communicable diseases, (like Malaria and Onchocerciasis) and with the DA.
- Best practices that have added value to the Malaria control program must be sustained and expanded (Public-private partnership on vouchers and on ITN subsidy; Sustained IEC, ITN use; and collaboration with selected programs (RCH and EPI/NID).
- Scale-up innovation with additional intensity and work through CHPS and private sector, but this will require additional sustained investment.

3.1. Introduction

In August 2001, Ghana's health performance was reviewed, almost at the end of the First Five Year Programme of Work (POW I). The executive summary of that document is revealing, as it provides insights in the findings as seen at that moment in time:

Box 3.1. Lessons learned from POW I*

Performance: The overall health status of Ghanaians has improved, but the gains have been slow and unequal. Utilisation has remained constant; some public health services have increased outputs.

Persisting constraints have been:

- Financial barriers to access services have remained
- Targeting of the poor and vulnerable has not been optimal
- The delivery system has not been responsive to beneficiaries
- Potential of intersectoral work and contribution from NGO has remained untapped;
- Building blocks of the organisational reform are in place, but progress to achieve the expected efficiencies has not been realised;
- Human resource strategies resulted in only marginal staff increases. Addressing low salaries remains a dilemma;
- While budgetary targets were achieved, per capita expenditure remained low and the allocation inequitable.

* Reflections on the First Five Year Health Sector POW, 1997-2001.

Based on these findings, the POW II has been written with a clear focus on (i) responsiveness to health needs; (ii) equity considerations and focus on the poor; (iii) a change in roles and responsibilities of the MOH; (iv) an emphasis on establishing good partnerships (under a SWAp mode) and (v) the intention to develop a national health insurance system.

Now, four years later, this review is once more trying to make the balance. We will discuss below physical, human resource, financial and socio-cultural barriers to access of care. At the end we will provide some general reflections on health policy in a broader context.

3.2. Physical barriers

The POW II aims to reduce geographical inequalities by reducing physical access barriers. The aim for infrastructure development is consequently to direct resources to the provision of facilities in the deprived regions, towards district and sub-district community-based care and to staff accommodation in rural areas. Whereas 25% of the population lives in the four deprived regions, 23% of district hospitals, and 27% of health centres are located in the four regions. This apparent 'fair' distribution should, however, be seen in the context of their geographical situation that is characterised by a dispersed population, long distances, difficult terrain and seasonal inaccessibility. Further, the existence of a facility does not tell anything about its condition, its staffing and other resources.

The civil works initiated in 2004 include 7 CHPS compounds, 8 new HC, 9 rehabilitations of existing HC, 3 HC have been up-graded to district hospitals and 5 rehabilitations of district hospitals were undertaken. During the year, 31 HC have been completed and 4 district hospitals were upgraded (with OPEC and SAUDI funds). The expansion of 15 training institutions has also started.

The 4 deprived regions were targeted for 43% of the investment budget for 2004, but the actual expenditures in the four regions by end of November were only 25% of total expenditures, while they contain about 25% of the total population.

3.3. Human resource barriers

The human resource distribution is skewed towards urban and more developed areas. One strategy applied in the POW II to improve access to health services and reducing inequalities is the redistribution of staff. A deprived area incentive package was introduced in June 2004 to address the issue of mal-distribution of staff. The incentive is a 20-35% topping up of salary, varying by the level of deprivation and targeted towards priority staff (doctors, nurses, pharmacists; laboratory and X-ray technicians).

The targeting of staff for the deprived area incentive package was an adjustment of the Ministry of Local Government (MOLG) criteria taking into account also the deprivation in terms of staff numbers, and lack of basic utilities and social facilities. On average 61% of the staff benefiting from the incentive package, work in one of the four deprived regions, and 92% are nurses. It is yet too early to assess the impact of the package. The level of incentive is, however, moderate, for a doctor who can also run private practice, but may provide a relatively stronger incentive to some of the other cadres.

The unit for deprivation assessment to be used for targeting is causing some concern. Targeting by deprivation of regions was some years back refined into targeting by deprivation of district. Even at district level there is, however, considerable variation in deprivation level within the districts and targeting at district level will result in deprived pockets in non-deprived districts not being able to provide similar staff incentives. At the same time some parts of deprived districts, such as district capitals, may not be deprived. The NDPC has developed a poverty map down to sub-district level. Unfortunately, it is currently not used by the MOH in its efforts to mainstream pro-poor targeting. It is recommended that this tool be applied for more precise planning and targeting in the future.

3.4. Financial barriers

The financial barriers to access health care have been a concern for many years. The POW II, in line with the GPRS, aim at ensuring sustainable financing arrangements that protect the poor. The MOH has mainly been pursuing this issue in two areas.

Exemptions
One strategy to reduce financial access barriers for the poor has been exemptions. The success with application of the exemptions scheme for the poor has been limited. However, exemption schemes, targeting children, pregnant women and elderly and specific diseases are in place, although with problems that shall not be reiterated here (see 2002 Technical Review Report). A particular problem is a lack of sufficient funding, for example in 2004 only 67% of free services were reimbursed. This provides a strong disincentive for granting exemptions.

In response to the stagnating health indicators, the MOH decided to introduce exemptions on deliveries in the four deprived regions. Later, this scheme was expanded to two additional regions and from 2005 it will cover the whole country. The number of supervised deliveries has increased in three of the four deprived regions with Northern region as the exception. Physical and socio-cultural access is another major determinant of access in this region. While the exemptions for deliveries appear to have significant effects and the expansion to the whole nation is welcomed, the funding is reportedly not sufficient to cover all deliveries and further targeting will have to be made at local level. It is recommended that criteria for further targeting of these exemptions be developed soon.

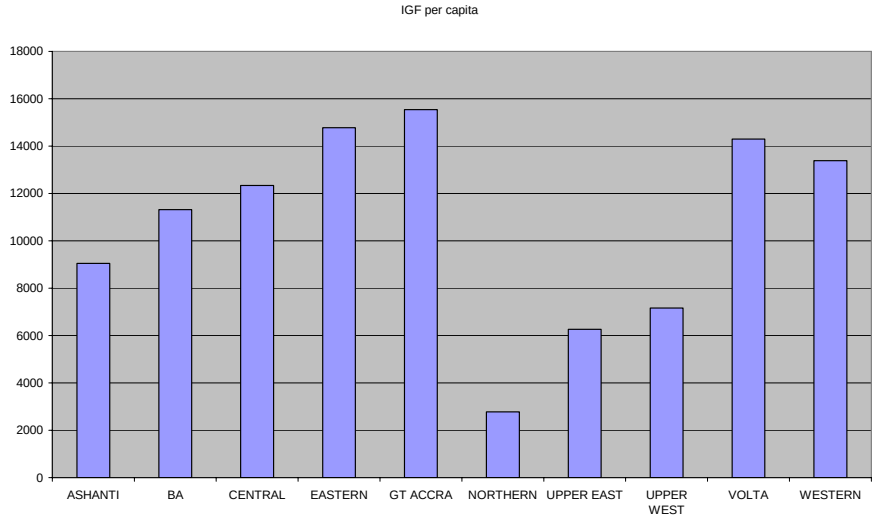
Overall, exemptions are generally higher in per capita terms in deprived regions than in non-deprived regions (Table 3.1). The deprived regions benefited more from the deprivation fund than the non-deprived regions, receiving almost 3 times as much funding per capita as the non-deprived regions. The deprivation fund is targeted at the 55 identified deprived districts and therefore some funds were also allocated to non-deprived regions (deprived districts).

Table 3.1. Exemptions between deprived and non-deprived regions

	Deprived Regions	Non-deprived Regions
Population	5,342,971	15,659,696
Exemptions GHS (B.Cedis)	10,1	15,8
Cedis per capita	1,897	1,013
Deprivation Fund (B. Cedis)	18,0	18,0
Cedis per capita	3,369	1,149

The chart below shows that the burden of IGF is smaller in the three northern regions than in the rest of the country. For NR that can partly be due to low utilisation per capita of health services, but it can hardly account for the whole difference. It therefore seems that exemptions targeted at the deprived regions, result in lower payments charged to patients.

Figure 3.3. Internally Generated Funds (IGF) by region



National Health Insurance

A main strategic initiative aimed at reducing inequalities in health is the scaling up of the NHIS with a view to reduce the financial barriers to health that is caused by the current user fee (cash and carry) system. The priority activities for 2004 were the establishment of the NHI Council and finalising the Legislative Instruments, strengthening of existing district NHIS offices and scaling up implementation of NHIS to districts as well as providing support to the agencies to prepare for their role.

The NHI Council was established in June and the LI was passed only in October 2004. By the end of the year 16 districts (13%) had operational schemes, while 34 (28%) were ready to become operational, falling short of the target to have District Mutual Health Insurance Schemes (DMHIS) established in 60% of districts by the end of 2004 and to have 10% of IGF funded by pre-payment schemes. Following the passing of the LI, administrative instructions for accreditation of providers could be issued. Training of accounts staff in the various agencies has been on-going. It appeared that GHS had developed its own format.

A revised policy framework was developed in 2004 in response to new developments and challenges emerging during the operationalisation of the NHIS. Three types of schemes are allowed (district-wide mutual schemes, private mutual schemes and private commercial schemes), but only the district-wide schemes will be subsidised by the government. Any scheme needs to be accredited by the NHIC. Initially membership is voluntary, but in the longer run (5 years) membership of an insurance scheme will be mandatory. The choice of scheme will be free. The District Mutual Health Insurance Scheme (DMHIS) is open to all. The back side to the free choice of insurance organisation is that a self selection of individuals may occur, such that private commercial insurance will tend to get the better off, healthier clients, thereby not allowing the cross-subsidisation of the poorer and sicker members.

For the informal sector, GOG will subsidise the premiums for poor and vulnerable groups using a sliding scale from 36,000 to 72,000 Cedis per year with six steps depending on income classification. The ‘true indigent’ will be exempted from paying contributions. There are, however, still no clear procedures and formats for classifying the income levels and

identifying the indigent. The plans are to work with the District Assemblies and to ensure documentation of the experience by scheme managers with a view to learning and sharing of experiences. Also, the accreditation of providers may cause problems for the rolling out of the NHIS, as a sufficient network of accredited providers will have to be in place, so that paying members have access to health care.

There will be a transitional phase in which the NHIS will cover some but not all Ghanaians. The coverage to the scheme in that period is currently very low. In that phase (that may be up to 5 years, when membership becomes mandatory), the pool of clients paying IGF will gradually be reduced. At the same time, staff still has to get used to the insurance reimbursement systems and procedures are still developing. Therefore, some delays in reimbursements are likely. It is thus possible that the staff will become increasingly reluctant to grant exemptions. This would pose a particular problem for the poor, if they are not enrolled in an insurance scheme from the beginning, but remain in the declining pool of IGF-paying clients. The RT recommends that the development of identification tools of the indigent be addressed as a matter of urgency, using the experiences from the pilot districts.

The preparation of the tariff structure has begun, but negotiations are still on-going. The insurance will cover only user fees, but user fees vary both within the public sector and between the public and the private sector. It is important to develop and agree on a uniform fee structure that will not just reimburse facilities for user fee rates, set at individual facilities, as these will then have an incentive to increase fees up to a 'closing date'. This would be particularly detrimental to those poor who would not be enrolled in any scheme from day one. The NHIC is currently studying the possibilities of a co-payment arrangement in the private sector. The RT found that dissemination of information about the details on the NHIS is still lacking among health managers. A clear road-map for its implementation is urgently needed.

Resource allocation
In order to improve access to services, MOH has given preference to deprived areas in the allocation of resources. It is therefore relevant to compare the per capita expenditure by region in deprived and non-deprived areas. The draft Financial Statement 2004 does, however, not yet allow a breakdown of all funding by region, as a relatively large part of the expenditures is assigned to the regional level, but not to a particular region. Detailed calculations will take some time that goes beyond this review.
It is therefore recommended that MOH develop the breakdown of expenditures per capita per region to be presented at the Summit meeting in April 2005, as it would be useful to further refine the analysis to look at allocations to deprived and non-deprived districts.

In summary, the table below allows comparison between health outputs and physical, human resources and financial means. It appears that the deprived regions do perform worse than the others, while they have roughly the same numbers of physical infrastructure, but lack the number of doctors and to a lesser extent nurses that are available in the non-deprived regions. However, they have more nurses, when staffing of teaching hospitals are excluded and they do have more financial resources per capita for non-salary recurrent expenditure to deliver services. These sort of comparisons are still very crude and need more detail in order to provide useful information. A district based analysis could help to clarify these questions further.

A trend analysis for a longer period would provide more relevant information about whether progress is made in the deprived regions. Regional breakdown of the indicators was not available in comparable format over a longer period. The RT recommends that such regional trend analysis be undertaken. Comparison of data for 2003 and 2004 shows that supervised deliveries increased in all the four deprived regions from 2003 to 2004. The total exemptions as percentage of total IGF remained around 40% in UER and UWR in both years, but for CR

and NR exemptions as percentage as share of IGF increased (in CR from 11 to 18% and in NR from 36 to 46%).

Table 3.2. Population, health and resources in (non-)deprived regions

INDICATORS 2004	Non-deprived regions	Deprived regions	Total	Comments
Population (mill)	15.66	5.34	21.00	
Health				
% U5 who are malnourished (Wt/A)	22.0	38.4	29..9	Worse
% Supervised deliveries	44.4	64.1	53.4	Better
% ANC coverage	83.4	106.0	89.2	Better
EPI coverage - DPT3	70.7	88.4	75	Better
Outpatient visit per capita	0.5	0.4	0.52	
Resources				
# District hospitals (GHS+CHAG)	109	32	141	Same
# Health centres/polyclinic	777	285	1062	Same
Population per Doctor	8,630	38,043	17,651	Worse
Population per Nurse	1,564	1,949	1,513	Better
Per capita expenditures (GOG/DPF, item 2&3) Cedis	10,054	17,537	11,958	Better
IGF per capita (Cedis)	12,749	7,011	11,289	Worse
Exemptions as % of IGF	8	28	11	Better

Note: Health indicators weighted by population; # Figures including Tertiary Hospitals

3.5. Socio-cultural barriers

Apart from physical and financial barriers, POW II also mentions socio-cultural factors that hamper access to care for specific groups (women and children), for the socially vulnerable (the poor, orphans), the disabled (blind, deaf and other handicapped persons) and for the people living with chronic diseases (mental disorders, diabetes, HIV/AIDS and others). POW II does not address explicitly accessibility to care and prevention for these groups of people. In addition, no explicit mention to these groups is made in the POW 2004, nor are they somehow included in the indicators or in the expected outputs.

For these reasons, gender inequalities (like differentials in access to care among male and females) cannot be detected under the current POW. While gender disaggregated data are collected within the various priority interventions[10], they are not reported upon as part of the Sector Wide indicators. Due to the format of the data collection tool, such a break-down is not requested and thus not provided regularly as part of the annual performance reviews. From many gender-related studies, it is known that access to care for males and females is different for a variety of cultural and financial reasons. It seems therefore high-time to review the available information and determine to what extent women are indeed making less use of services, compared with men (by district and region, by type of service and by socio-economic class). This information is important to improve targeting of the services to those in need that will be one of the main strategies in POW III.

Another important determinant of socio-cultural accessibility is the perceived quality of care, including not only the presence of well trained staff, equipment and essential drugs, but also

[10] The special edition of the Bulletin for Health Information (October 2004) provides an informative chapter on the gender perspective in service utilisation patterns and burden of disease.

referring to the way the patient is treated by the health worker. Respectfulness and issues related to waiting time, privacy and confidentiality all determine to a large extent the 'patient's satisfaction' with the services provided. Does the doctor or nurse provides preferential care for those that are socially and financially better off or does (s)he treat all clients as equal? All these factors, related to quality of care, contribute to the use of services. The GHS made great efforts to create its own 'corporate identity' (Code of Ethics) and to inform the public about their 'health rights' (Patient Charter) and about the costs for the various services provided. However, there are few Civil Society Organisations (CSO) that monitor the quality of care, the performance of the providers or help those that want to make complaints about perceived treatment errors. All these elements are part of the drive towards health as a human right that should be included in the next POW III. In addition, the RT was informed that in health facilities of many districts, exit interviews are conducted as a means to be informed about the quality of care in that facility. Once more, the next POW III might consider the inclusion of some of these quality indicators in the overall SWAp format that will be collected regularly (once or twice a year).

Finally, the POW 2004 hardly pays attention to the complex area of intersectoral collaboration, where specific interventions contribute to improved health of the population. Examples are the education of girls, known to contribute substantially to improved health; the provision of safe water; and the production of foods that contribute to the reduction of malnutrition. MOH and GHS are in the process to define and develop the necessary capacity to effectively manage such collaboration with other sectors, but no specific activity has yet been initiated. They await the nomination of the person to guide these efforts to set-up an 'intersectoral desk' and define the strategies to be pursued. Such initiatives need to be linked to the responsibilities of the District Assembly. Where the DHMT are capable to link with the DA, the potential for relevant and productive interventions could be considerable (Details are given in chapter 7, sections 7-8).

3.6. Health policy and equity

Bridging inequalities, reaching the poor, these are rightly the overarching and fundamental issues that drive the second Ghanaian POW 2002-2006. However, being the final review of the POW 2004 that can make a meaningful contribution to shaping the next and third POW 2007-2011, the question has to be posed: did the POW II achieve – at least partly – this noble goal? Have the efforts undertaken by all that participated in the POW II, contributed to the reduction of these inequalities, have they contributed in a small but meaningful way to bridging the inequalities?

The question is perhaps too difficult to answer in the course of this review. The answer that transpires from our findings is that – for a variety of reasons – the indicators that guide and monitor the reform process do not show clear improvements. The health status of the Ghanaian population seems to have remained stable. The figures do not show a clear improvement in the 'proxy's' to poverty reduction and ill health, like improvements in the use of services, in reduction of morbidity and mortality or in improved quality and efficiency of service delivery. The next chapter will discuss the various factors that have contributed to these limited results. Here, the RT would like to point to a general limitation of health sector policy development not only in Ghana but almost everywhere in the world that has recently been well expressed in the UN Millennium Task Force on Child and Maternal Health[11].

[11] UN Millennium Project, January 2005. Who's got the power? Transforming health systems to improve the lives of women and children. Task Force on Child health and Maternal health (provisional draft);

The provisional draft of that document mentions the general agreement among professionals "that the technical interventions that could prevent or treat the vast majority of conditions that affect and kill children, women and men, can be identified. Effective health interventions for most of the current ailments exist. They are well known and well accepted. They are generally simple and low-tech. They even are cost-effective. Yet, the majority of the population in this world do not benefit from them. For hundreds of millions of people - a huge proportion of those that live in Sub Saharan Africa or South Asia – the health system that should make these services available and accessible, is in crisis".

Behind the failure of the health system lies a deeper and structural crisis, being a disconnect between the technical reality of daily practise and the fundamentally political choices that need to be made. That disconnect relates to access and the distribution of power and resources within and between countries. It has been expressed earlier, in the seventies when WHO initiated its Primary Health Care (PHC) strategy: Public health policy is political in nature, as it decides on the distribution of resources that ultimately define access, use and quality of services. Denying this statement creates a false sense of neutrality, suggesting that the choices to be made are only technical or – at best - policy related, as if they do not need a political environment to become alive and operational.
As the UN report states: "Policy responses to health systems do not follow automatically from the data. Rather, policy-makers face choices. And the choices they make must be fundamentally grounded in the values and principles that members of the global community have agreed should govern the world that we build together".

For Ghana, this could mean that the technical interventions to improve the health of its citizens perhaps are not enough. Technical solutions need to be blended with critical decisions on resource allocations that reach the poor and destitute. Inequity - the gap itself - must be explicitly and squarely addressed. Progress in closing this gap is an intrinsic part of the MDG initiative. It need be addressed in practical and operational terms in the next POW.

3.7. POW III and its links with the MDG

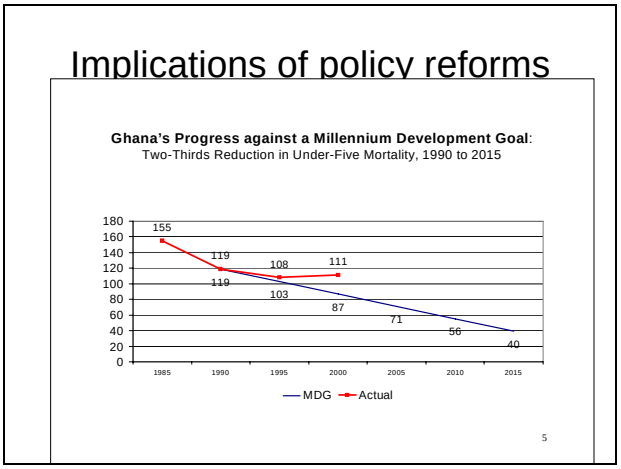
For the next Five Year POW, it is of paramount importance for the sector to align itself fully to the stated MDG. This will allow Ghana to move ahead and - at least for some of the goals – achieve them. For the health sector, Ghana MDG are geared towards six health related MDG Goals: (i) improve nutrition, (ii) reduce child mortality, (iii) reduce maternal mortality, (iv) combat HIV/AIDS, Malaria, TB and other diseases; (v) improve access to water and sanitation and – finally – (vi) increase access to essential drugs.

Table 3.3. Objectives of the Ghana MDG

Goal	Objectives of Ghana MDG	Baseline 1990	Target 2015
1	Reduce overall poverty with 50%	51.7	26
1	Reduce extreme poverty with 50%	36	19
1	Halve the proportion of people with hunger (reduce malnutrition with 50%)	27.4	14
4	Reduce IMR by 2/3 between 1990-2015	77	25
4	Reduce UFMR by 2/3 between 1990-2015	144	42
5	Reduce MMR by ¾ between 1990-2015	210-740	54
6	Have halted by 2005 and begun to reverse the spread of HIV/AIDS and the incidence of Malaria and other diseases	HIV < 2%	HIV < 1%
7	Have halved the proportion of people without access to safe drinking water and basic sanitation (Rural / Urban)	64 / 15	32 / 7
8	Increase access to essential & affordable drugs	NA	NA

Reversing the high levels of child mortality requires intersectoral collaboration, as it implies simultaneously addressing the specific health related interventions, such as immunisation, IMCI and quality of care as well as the low level of female education, nutrition and (breast) feeding habits, safe water supply, sanitation practises and environmental issues.

Graph 3.1. U5MR reduction and its MDG target



Challenges to address the high incidence of maternal mortality include some important Safe Motherhood related activities, such as birth spacing and family planning, Intra- & Post Partum care, a functional referral system and reliable Emergency Obstetric Care (EmOC). Combating HIV/AIDS, Malaria and TB relate – like the other two - to various systems related conditions such as the availability of trained staff, geographical accessibility, the presence of necessary (laboratory and other) equipment, transport and pharmaceuticals and a well articulated and sustained link between the service providers and the community levels. In addition, specific programmes need to be in place – including the collaboration with other partners - that help to ensure the distribution of commodities (condoms, ITN and TB drugs), presence of VCT, ARV PMTCT Centres with counsellors and Malaria treatment and prophylaxis (IPT for pregnant women).

Table 3.4. provides information on the MDG and POW III targets and achievements that relate specifically to the health sector.
At a technical level, the table points to some differences in the definition of the indicators to be used[12]. These differences have to be harmonised in order to arrive at a common decision that will allow Ghana to compare its targets and achievement internationally. Decisions in this regard need to be taken without delay.

[12] * Ghana records malnutrition for children < 24 months, whereas the MDG record children < 5 years.
** Ghana registers "Supervised deliveries", including deliveries conducted by skilled staff AND Traditional Births Attendants. The figures provided here are higher than suggested by the title given in the MDG: "Births attended by skilled health staff".
*** Ghana registers "HIV prevalence among women of reproductive age", whereas the MDG indicators specify "pregnant women between 15-24 years".
**** Ghana mentions the Under Five Malaria Case Fatality Rate (CFR), whereas the MDG refer to the Malaria In-patient Death Rate.
Ghana mentions as a measure of distribution efficiency the number of 'tracer drugs available, whereas the MDG suggest the % of the budget allocated for essential drugs.
These differences make comparison of POW II vs MDG data difficult and to some extent unreliable.

Table 3.4. Ghana's progress towards the MDG Targets 1990-2015

MDG Goal No	Indicators	Baseline MDG 1990	Baseline POW I 1997	Results POW I 2001	Results POW II 2004	Target POW II 2006	Target MDG 2015
	Ghana Population	15.2 M		19.4 M	21.3 M	22.3 M	--
	MDG Outcomes / Outputs						
Poverty	Overall Poverty levels	51.7 (92)	39.5 (99)	NA	NA		26
	Extreme Poverty (< US$ 1/day)	36.4 (92)	26.8 (99)	NA	NA		19
	*Prev. underweight < 5 yrs Wt/A	27.4 (93)	24.9 (99)	22.1 (03)	29.9	20	14%
4. Child Health							
	IMR/1000 by 2/3	77 (88)	57 (98)	64 (03)	64 (03)	50	25
	UFMR /1000 by 2/3	155 (88)	108 (98)	111 (03)	111 (03)	95	42
	% < 1 yr immunised Measles	--	57	82.4	78	90	100
	Neonatal Mortality Rate (/1000)	44 (88)	30 (98)	43 (03)	43 (03)		
5. Maternal, Sexual – Reproductive	MMR /100.000 by ¾	210-740	214	250 (03)	NA	150	54
	**% births attended skilled health staff	--	41	49.2	53.4	60	100
	Total Fertility Rate (GDHS)	6.4 (88)	4.4 (98)	4.4 (03)	4.4 (03)	NA	
	Contraceptive Prevalence Rate (CPR)	5.2 (88)	13.3 (98)	18.7 (03)	24.3	40	
	***HIV Prev. 15-24 yr pregnant women	--	2.2	2.9	(3.6)	2.6	
	% AIDS Orphans			NA	NA	NA	--
6 Disease Control	Malaria Prevalence persons > five yrs		--	--	--		
	****Malaria In-patient Death Rate	--	--	1.7	2.8	1.0	--
	Pregnant women sleeping under ITN % Children <5 yrs sleeping under ITN %		-- --	2.7 (03) 3.5 (03)	NA NA		
	TB Case Detection Rate (sm+) %		34	61	56	65	
	Treatment Completion Rate (TCR) among smear + cases (under DOTS)		38.1	48.9	66.9		
7	Access to safe water (National) (%) (Rural / Urban)	36 / 85	74 (98)	67.2 (03)	NA	55	68 / 93
7	Access to sanitation (%) (Rural/Urban)		43 (00)	78.1 (03)	NA	28	69 / 77
8	% Population Access to essential drugs			70	NA		

The cost of providing these key health interventions have been calculated by the Ghana Institute of Social Statistics and Economic Research (ISSER)[13]. The authors estimate that Ghana will need annually an average of US$ 24 per capita over the 2005 till 2015 period for MDG health interventions. According to their calculations, the cost will increase over these 10 years from US$ 16/pp in 2005 to US$ 31/pp in 2015. The total cost in 2015 is relatively low, which reflects Ghana's low HIV/AIDS prevalence and relatively low levels of malnutrition. Nevertheless it is much higher than health spending today, which is around US$ 13.6 per person, of which about US $ 6 is coming from GOG.

The human resource needs have also been estimated by the same team. They indicate the need for a significant scaling up of doctors, from 1,325 in 2005 to 8,170 in 2015 and of nurses from 26,784 in 2005 to 34,096 in 2015. Unfortunately, with the current rate of production and attrition, the human resource needs of Ghana are unlikely to be met. It is recommended that MOH in its planning for POW III will take these needs into account and include detailed cost calculations to estimate the financial resources required

[13] Ernest Aryeetey, Michael K. Nimo, January 2004. Ghana Country Study for the UN Millennium Development Goals Needs Assessment. Institute of Social Statistics and Economic Research (ISSER), University of Ghana. Recently (March 2005) Sasu Boamah, Dr. Frank Nyonator and Isaac Asiamah have provided detailed figures for the health sector as part of a broader UNDP/GOG sponsored MDG Needs Assessment.

Sector performance directly relates to many factors that may be systemic, management or technical. In this chapter we try to highlight the system issues that in our view underpin the lack of progress in sector performance. This chapter recognizes system issues already raised in the previous chapters.

4.1. Service delivery

The sector provides primary, secondary and tertiary care. As was pointed out in Chapter 2, GHS is the main service provider both for OPD and IPD, followed by CHAG with the specialist services provided mainly by the teaching hospitals.

National level (MOH, GHS)
The RT was impressed with the systems and strategies available within the sector to instil accountability: performance appraisal, promotion and performance agreements. However there cannot be improvement in the sector, unless issues of coordination and accountability are given critical look. Annual tracking of financial decentralisation, meeting the staffing norms in the facilities and stimulating reporting on various specific targets should be considered. The appraisal of senior managers (District and regional directors, other BMC heads) must include tools that look at leadership roles and responsibilities,

Teaching Hospitals
The teaching hospitals have a responsibility to provide tertiary care, besides their teaching and research responsibilities. Congestions were observed in the teaching hospitals at OPD, IPD and at the maternity units. Ineffective 24-hour service delivery, late reporting of consulting physicians, lack of surgical facilities in district and urban facilities are among the factors that explain why clients choose the tertiary facilities. The recent attempt to post specialists out of teaching hospitals should be pursued. These specialists will serve as the catalyst around which child survival, safe motherhood and surgical systems can be established at the primary level. Attempt being made to provide specialist outreach services must be strengthened by setting targets to the teaching hospital directorates. This should be budgeted for. The link between the THs and the Regions must be strengthened and points of interaction should be defined to allow for mutual technical reinforcement, particularly in supportive supervision, continuing medical education and data management.

Regional hospitals
Regional hospitals were found to be of different sizes and capacity. Where the Regional hospital is virtually a District hospital, referrals from districts are not directed there. For these hospitals to perform their secondary role, issues of infrastructure, equipment and staffing have to be addressed holistically.

District referral levels
District hospitals are the referral points at the primary level. We observed that some of these hospitals do not have space, equipment and the human resources necessary to carry out the expected services. There should be a systematic attempt to expand district hospitals to levels that will make it possible for all expected services to be delivered.

Sub-district levels (Health Centres, Clinics and CHPS)
Health Centres are the first point of contact and have direct interface with communities. Expectedly, this is the level where one expects to find a Medical Assistant, a Midwife, a

nurse and PH staff. But the situation is different on the ground. There are HC without medical assistants and some lack midwives. Such observations give reasons for worry, as they undermine efforts to achieve high performances in safe motherhood, child health and other service delivery elements. Laboratory capacity for basic investigations (Malaria, TB, Helminths etc) is needed to strengthen diagnostic service provision. This has human resource implications as well.

It is important to identify underserved areas (use poverty maps) and decide on the establishment of CHPS clinics. Existing HC that lack space should be expanded and inventories should be made of equipment. Gaps should be filled within a well defined time frame. In doing so, levels of district depravity and mortality must be taken to account. Again, human resource requirements should be planned and managed to meet the required needs and improve performance.

4.2. Vertical versus integrated programmes

Through the common basket arrangement, integrated planning, budgeting and funding for service delivery was observed at all levels. These strategies aim to maximize use of human resources to address priority health interventions holistically. In practice however, earmarked funds continue to move in support of priority programmes and projects like NID, HIV, RBM, IMCI and TB. While the RT recognizes the positive contributions being made through the use of earmarked funds, their vertical nature shifts the attention away from other priority interventions and their mechanism for sustainability is usually unclear.

It is important for districts to be informed ahead of time about expected earmarked financial inflow to allow for integrated budgeting. Earmarked funds must also be disbursed in ways that help to strengthen the system a as whole. (e.g. by supporting laboratory units refurbishment and institutional QA).

At the National level, programmes must harmonize their plans to achieve synergy, focus and expected results. By so doing, it will be easy to define performance indicators. In addition new output indicators should be identified, outside the integrated framework. Reporting requirements on the various programmes are still not conducive towards an integrated health management information system in the sector. The RT was informed that MOH in collaboration with GHS is working out a template for coordinating the various information sources, test workability of the template with districts, and feed the experience into a national level integrated design. For this system to eventually take root and improve the current integrated reporting arrangement, stakeholders should provide inputs. The infectious diseases notification requirements from IDSR will require special attention within this integrated framework.

Programmes such as RBM, HIV/AIDS, TB (all three under the Global Funds), and the NIDs work under rather centralistic and vertical approaches which may not be in step with the integrated health planning process nationally. However the additional resources accessible for health through these programmes, challenge national planners to include them in their planning for service delivery. These efforts use significant chunks of staff-time; the critical debate however is their points of concurrence with national priorities in terms of disease and mortality burden, and how effectively they reduce the burden at what cost.
How Ghana could improve its performance indicators in the presence of such programmes has to be examined. One line of inquiry would be to look at coverage and outreach. The second would be to examine changes in workload and use of time and resources for their implementation. The third is to examine how synergy can be improved virtue of the structural arrangements for implementing these programmes.

4.3. Access and Quality

It is a fundamental strategic objective of the sector to ensure universal access to quality care. Several QA activities were observed in the reports and facilities visited. They included % drug availability and client satisfaction reports to stimulate local planning and to improve quality on continuous basis. Problems in use of protocols and compliance to standards have been noted. Gaps have been identified in neonatal care.
In measuring the performance in these areas, critical staff population ratios, IPD and OPD utilization per capita, <5 malaria case fatality rate, among others have been used. Some of the indicators appear irrelevant (like non-polio AFP rate for QA), while others are useful and should be given follow-up to see whether observed weaknesses result in changes and improved performance. The RT recommends a system of performance assessment that links availability, access, utilization and quality[14].

4.4. The link between Public Health and clinical care

The combined role of both public health and clinical care interventions in addressing the health needs of the people of Ghana is well appreciated. The link is observed in the ways RBM, IMCI, and other programmes work together with the Institutional care at the National level to harmonize interventions and messages. However there are still some problems: There are a variety of examples to illustrate the point: There are no opportunities available to midwives to be informed of Child health and safe motherhood outputs. Daily immunization in district hospitals is uncommon and if done, is not done by the clinical staff. Case detection and investigations for conditions targeted for eradication or elimination are not routinely carried out in hospitals and HCs. PH outreach staff does provide immunization and other PH services, but they ask mothers with children to go to the HC for treatment and drug administration. It is important to establish institutional and outreach “do’s and do not’s” and build the appropriate capacity to further the link between public health and clinical care. Hospital performance indicators must include PH indicators, like workload, missed opportunities, and support given to HCs.

Practice of maternal and child health varies between levels of care. At teaching hospitals mother-babe units exist to address neonatal health needs. However, most peripheral GHS facilities do not have such a facility. At primary centres the management of deliveries and immediate post natal care, calls for a renewed commitment and focus, as the appropriate capacity must be built together with the requisite logistics supply.

4.5. Public-Private partnership

Partnership is a key sector strategic objective. As was observed in the previous chapters, the private sector, including CHAG, provides a considerable input in service delivery. CHAG institutions are often located in underserved areas (pro poor), and in some districts are the main service provider at district level. In NR, the laboratory in the district hospital in Savelugu was being operated by a private organization (outsourcing). Under DOT, the GF provides a good opportunity to reach out and strengthen partnership for TB control. While approaches are isolated, they provide excellent opportunities for improving service coverage.

[14] Kyei-Faried S, Ayi MS, Visser LE. Coverage Evaluation of Essential Obstetric Care at the Primary Health Care Level. Ghana Medical Journal (2000) Vol 34, No. 1 pp 2-8.

GHS at the national level has to begin dialogue with the private sector for accreditation and signing memoranda of understanding for service contracting. The framework for partnership must be clearly defined. Regional Health Directorates (RHD) must also position themselves in ways that will allow this partnership to grow. Private sector desks should be created within RHD to allow interaction and to move towards with expansion of service contracting, particularly with CHAG.

Activities of various NGOs seem to be implemented in an uncoordinated fashion, leading to duplication and hence wastage of resources and effecting efficiency. Comprehensive district health planning coupled with sharing and integration of the plan within the DHA should facilitate coordination of NGOs health activities.

Traditional Healers are recognized in Ghana (70% of health care provision). Much progress has been made to provide them with a regulatory framework and standardize their practice for safety and efficacy. The challenge at hand is to attain faster progress on integration with allopathic medicine.

4.6. The role of regulatory bodies

Without mechanisms to stimulate excellence, standards fall. The RT had the opportunity to listen to a staff Nurse in a CHPS clinic who ties the umbilical cord with a string and cuts it with blade because the DHMT had not been providing her with equipment and other needed logistics. This was a CHPS in a sub-district where the Nurse in-charge had not once received funds from the DHMT for five years. Under such circumstances, standards fall and regulation become almost impossible. The RT observed that the regulatory bodies are not on the ground, discussing and supporting implementing Agencies such as GHS to keep standards. This has consequences for performance. To address this shortfall the sector must set specific regulatory targets to link their work with that of THs and GHS. Similarly, there must be a set of GHS and TH indicators to report on the support provided by the regulatory bodies. Autonomy and independence of regulatory bodies versus their collaboration and support to relevant directorates, GHS and TH, is the challenge.

5.1. Human Resource Development

Adequate and well trained human resources are essential for the good performance of the health sector. A detailed HR plan has been prepared at the start of the POW II and impressive measures have been taken to improve the salary base of the health workforce, in particular the medical doctors and – to a lesser extent – the nursing cadres. These measures have been important, but they have not resulted in the presence of the required numbers and mix of staff in the hospitals and health centres.

Nationally, the trend in the doctor/population ratio indicated some improvements during the period between 2001 and 2003, increasing from 1: 22,811 in 2001 to 1:21,086 in 2002 and 1:17,489 in 2003. However this positive trend was not maintained and the data show a slight worsening of the situation with 1 doctor to 17,615 people in 2004. Regional distribution has worsened especially in the Northern region, where there are most needs.
The nurse/population ration has improved from 1: 2,079 to 1: 1,513, being above the target of 1: 1,800 in 2004. This positive result is noted in all the regions. The trend has not been well explained, but might be linked to the expansion of training schools. Nurses are the first-line health providers and this positive trend therefore needs to be sustained to ensure adequate access and coverage in basic health care.

Among the most important challenges in HRD, is their retention and equitable deployment nationwide. From the limited information that the RT received, it appears that their distribution is far from equitable, favouring urban areas against the rural areas and favouring the south versus the northern regions. The distribution of the doctors and nurses per Region obscures inter and intra district inequalities. The majority of the health professionals tend to be posted in the urbanized districts and sub districts. Posting health professionals based on the workload (OPD, Bed Occupancy Rates) may be considered. Initiatives have been taken by MOH to redress this situation (deprived areas incentive, car loan etc), but their effect on the distribution of staff has not been clearly documented. This is an important area of study, as its findings could provide useful feed-back for the drafting of the next POW. Next to doctors and nurses, efforts need to be also made to build capacity in other categories of skilled health workers, in particular those that are less likely to leave the country, like the Medical Assistants. The RT proposes to consider (i) the upgrading of the MA and (ii) the training of a new cadre, the laboratory technicians. These should complement the available nursing and midwifery cadres in providing the minimum package of care at HC levels.

One avenue to improve management of human resources that has been discussed regularly over the past years is the decentralisation of the budget for personnel emoluments. An assessment of options for such decentralisation has reportedly been undertaken very recently. Decentralisation of human resource management and budget has the potential to give local managers tools to alleviate some of the human resource constraints, using local solutions. However, the RT has not had access to the options analysis.

The overall assessment of the human resource situation therefore remains that while commendable measures have been taken, many health facilities lack the required staffing to provide the expected quality services. The Ghanaian health services could perform much better if more health workers of the right type, in the right numbers and at the right places could be made available. POW II has not really made a difference in this domain.

The consequences of this 'systems failure' have been extensively documented in the previous chapters. The RT feels that one of the most important reasons for the stagnating performance of the health sector is due to the complexity of the issue and the in-effectiveness of the sector to respond to this long-standing and overarching problem.

5.2. Human Resource Management

Training, recruitment and distribution of health staff falls under the responsibility of the MOH. Respondents shared with the RT that it is not always clear who is in charge in Human Resource recruitment, deployment and retention related matters. This problem relates to the need for clarification on the responsibilities between MOH, GHS and the TH in the area of staff recruitment and distribution that also was already raised. There are delays in the formal recruitment process hence staff is working for considerable periods (up to nine months) without salaries. Some of the graduates may be retained by Teaching Hospitals unilaterally without engaging the requisite formalities at MOH. Others may opt not to report to their respective Regional Directors and Districts where they have been posted.

Health facilities are not assured of a technically complete team of providers. Only about 50% of the total need for Medical Assistants (MA) at Health Centres (HC) has been met in 2002 and the current situation remains unclear since the policy document (2002-2006) remains ambiguous on the fate of this cadre. The situation analysis does not refer to them; it refers to training 'doctor substitutes' for under-served areas. However the intention to phase out Medical Assistants and replace them with Assistant Medical Officers (AMO) before full coverage of HC has been achieved requires more careful analysis and far-sighted planning. Creating an 'MA or AMO's ladder' is positive in the sense of opening a career advancement opportunity for MA's and strengthening clinical care access at primary facilities. Most importantly, the MA and AMO are likely not to be able to move outside the country, as their qualifications do not apply in Europe or the USA. Therefore, investing in the training of this type of cadre might help the MOH to respond to the needs for highly qualified cadres that will remain in their posts.

The HC level remains half accomplished, when the expected functional teams do not exist. Agreeing on a core of competencies required at each level of health care delivery system is vital. Ghana wishes to have a standardized system with clinical quality assurance and regulated practice. Ensuring that a minimum core of a Medical Assistant, a Laboratory Assistant (new cadre?), an Enrolled Nurse, a Midwife and a Dispensing Technician is available requires a revision of strategy. The HR policy and strategies 2002-2006 should be reviewed as intended in the 2004 POW. The Medical and Nursing Councils should become involved in these critical policy shifts amongst nurses and allied health personnel. Since most targets in the MDG and POW II depend on a well functioning primary health care approach, it is vital to pay attention to the availability of the right mix and numbers of health professionals in management, hospitals, health centres and the emerging CHPS zones.

5.3. Brain drain

Ghana's brain drain for doctors and nurses is substantial and does seriously affect the capacity of the country to improve its human resource base. The numbers below speak for themselves.

Table 5.1. Brain drain in Ghana 1993 - 2004

Cadres	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	½ 04	Totals
Doctors	68	44	58	71	62	61	72	52	62	105	117	40	812
Nurses	207	236	195	182	174	161	215	207	235	246	252	82	2,392
Pharmacists	28	30	29	27	35	53	49	24	58	84	95	30	542
Allied staff	12	9	8	9	4	6	9	16	14	0	NA	NA	NA

The Government of Ghana has recognized the threat of the brain drain and has instituted incentive measures over the past years to stem the flow. The following staff retention measures and incentives have been introduced:

- Additional Duty Hours Allowances (ADHA). This has significantly increased real take-home income for doctors (about 200% of salary), but less so for other health workers (about 80% increase for nurses and other health workers).
- Car Hire Purchase. Cars have been allocated to health workers especially those in the deprived areas (4 regions) based on certain criteria.
- Deprived Area Incentive Allowance. This measure is meant for staff working in the 55 deprived districts who receive about 30% of their salaries as an additional incentive.

In addition to these measures, the following more general options are available to improve staff satisfaction and motivation. They have been used by managers at various levels:

- Staff promotion. Regional Health Directorates can promote health workers after conducting formal interviews.
- Staff promotion has started in 2004 by GHS for staff that have served for a minimum of 3 years in deprived areas.
- Additional training. Ordinarily, staff have serve for a minimum of 3 years to qualify for further training. But those in deprived areas are allowed to work for only 2 years before they can go for such training.
- Scholarships. Each region receives 2 short and 3 long term courses for which staff can apply. The Ashanti Regional Directorate for instance received over 120 applications, scaled them down to three but even then, only one was considered.
- Post Basic Health Training. Some Regions have agreed with the DHMT to sponsor nurses (monthly allowances) for post basic health training. Beneficiaries are bonded to return to the district.
- Annual Awards. At the GHS institutional level, annual awards have been instituted, like Radio Cassettes to motivate dedicated health workers.
- Some Regions have initiated another incentive to retain health professional through the acquisition of Land Banks for sale to staff on a flexible payment system. Possession of a house after retirement is one of the most important attractions (pull factors) for migration by nurses according to a recent study.
- Housing-loan system. This has been proposed by GHS but has not yet been put in practice.

To address the human resource crisis, the MOH has taken other steps to increase the numbers of its workforce (Table 5.2):

- Expanding the capacity of Health Training Institutions. The visit of the RT to the Rural Health Training School in Brong Ahafo Region confirms that the construction of new classrooms has been completed and therefore intake for 2004-2005 has doubled. Construction work on Hostel accommodation will also start soon.
- Ghana College of Physicians and Surgeons has been established. They will train specialists, thus reducing the need for people to specialise abroad.

Table 5.2. Enrolment health professionals 2001–2004

Cadres	2000	2001	2002	2003	2004
Doctors	243	274	228	276	
Gen. Nurses	685	699	851	1,170	1,289
CHN	362	397	509	565	1,043
Pharmacists	111	106	196	146	157
Midwives	140	139	113	140	171

Nevertheless, these solutions - however important - are not enough to remedy the urgent staff shortages at the moment. The most important constraints are:
1. Problems of insufficient accommodation for the increased demand for training; few trainers for training to the increased number of students; absence of staffing norms for hospitals and Health Centres. In addition, there are no rent allowances (or owner allowance) for health personnel to pay for their accommodation.
2. Staff that has left the service is not being replaced, because there is delayed authorization from the GHS. It also happens that staff that is transferred refuses to move, thus creating a negative example for others that – if not swiftly and seriously addressed – could undermine the whole distribution policy of MOH.
3. Poor career opportunities for nursing cadres has never been solved. Nurses often feel blocked from educational and career advancement which makes it difficult for their training and experience to be recognized for university and other post-graduate courses[15].

From this presentation, it is clear that a new human resource strategy is needed urgently. It should inventorise realistically the needs in human resources in numbers and by type and level of care. This is particularly urgent for the primary levels (from CHPS till district hospitals), as there the priorities should be placed to achieve the MDG. Additionally, a cost estimate should be made, to assess the HR needs and what is financially feasible in the coming years.

[15] Dovlo, 2003. Causes of health workers migration – perspectives from Ghana – Voices of health workers.

6.1. Overall financing

Findings Review POW 2004

The percentage of overall government budget allocated for health has been varying over the period 2001-2004. The actual share of the GOG budget spent on health fell to 8.2% - below the 2001 level. This figure is, however, dependent on investment programs in other sectors, which tend to be lumpy by nature. The percentage of government recurrent budget for health was lower in 2004 than in 2003, but the actual share of GOG recurrent spending has remained stable around 11-12% over the past three years. An increase is planned for 2005, which would bring Ghana closer to the Abuja target. The total health sector spending has increased from USD 6.3 per capita in 2001 to USD 13.5 in 2004. Direct GOG funding increased from USD 3.1 in 2001 to USD 5.7 in 2004.

Table 6.1. Sector-wide financial indicators

Indicators	2001	2002	2003	2004	2005	Target 2006
% GOG budget spent on health						
Budget	NA	7.6	9.5	8.2	9.4	10
Actual	8.7	9.3	9.1	8.2	NA	
% GOG recurrent budget spent for health (all items)						
Budget	NA	10.5	12	10.7	13.3	15
Actual	10.2	11.5	11.2	11.9	NA	
% GOG recurrent health spending on items 2 &3						
Budget	NA	12.1	7.5	6	6.6	--
Actual	8.1	5.9	6.9	5.4	NA	
% non-salary items of GOG recurrent for health						
Budget	NA	30	16.1	16.4	11.3	--
Actual	16.2	13.1	13.2	11.4		
% spending on district and below (items 2 & 3)						
Budget	48.5		47.8	45		42
Actual	NA	40.9	35.4	37.9		42
% of earmarked donor funds to total donor fund						
Budget	NA	44.7	40.8	41.3	35	40.9
Actual	62.3	32.8	39.5	26.3		40.9
% IGF from prepayment schemes	NA	NA	NA	NA	NA	NA
Total health sector spending per capita USD	6.3	8.1	10.5	13.5	NA	

Source: Draft un-audited Financial Report December 31, 2004. Ministry of Health, Ghana.

Note: Some figures might change, in particular data on donor funds.

In real terms the GOG recurrent budget (excluding HIPC funds) for health increased from 2003 by 7%, which however masks a 10% increase in salaries and a 12% decrease in real terms on item 2 & 3. This could be expected as the sector strives to increase the number of human resources as well as incentives for retention of staff. Since development partners do not fund item 1, increases on personnel emoluments have to come from the government budget. It will, however, be important that the overall proportional relationship between wage and non-wage recurrent expenditures does not become unbalanced. This will be further discussed in section 6.3 below. Overall expenditures for health in 2004 (including all sources) increased by 20% in real terms.

Challenges
If Ghana is to reach the target of 15% of recurrent government spending on health by 2006 (Abuja), it is important to press for continued increase in the allocation to the health sector.

Further, the demand on the MOH budget can be expected to increase as the NHIS is implemented. Since the NHIS will only reimburse the current IGF, the MOH budget will have to finance its share of the anticipated increase in utilisation. The additional VAT earmarked for health is not likely to be able to cover the reimbursement of user fees, subsidised premiums as well as financing the increase in the budget, if the scheme takes off too fast.

In order to reach the MDGs, it has been estimated that Ghana would need 16 USD per capita in 2005, 25 USD per capita in 2010 and 31 USD per capita in 2015 (2000 USD). In addition, there will still be a demand for other health services and Ghana is embarking on new treatment strategies that are more expensive (ACT and ARV). While these figures represent rough estimates, it does underscore the need to ensure growth in available resources to health. For comparison, the total expenditures in the health sector (all sources) amounted to 283 million USD (draft financial statement) or approximately 13.5 USD per capita, using population figures used by MOH in their half yearly report.

The RT therefore recommends maintaining the pressure for increasing the health share of GOG funds to reach the Abuja declaration of 15%, with focus on increasing the budget for non-wage recurrent expenditure, and a particular focus on restoring the share of spending at district level and below.

6.2. Sources of financing

Findings Review POW 2004
Compared to 2003 the share of overall expenditures financed by GOG was reduced from 49% to 43%. Including HIPC funds, the reduction was from 51% to 48% (Table 6.2). Donor funding increased from financing 25% of the sector to 27%, but there was a significant reduction in the share of earmarked donor funding from earlier years (Table 6.1). The figure could, however, change as the earmarked donor funds are the most difficult for MOH to consolidate at the end of the year.

The shift away from earmarked funding is welcome from the point of view that earmarked funds pose a number of problems for planning, budgeting and financial reporting (see also Chapter 7). However, earmarked funding fluctuates substantially from year to year, making planning and projections difficult.

Table 6.2. Actual expenditure by source and items 2004.

	GOG	Financial Credits	IGF	Health Fund	Earmarked Funds	HIPC	Total	% of Total
	(¢ Bn)	(¢ Bn)	(¢ Bn)	(¢ Bn)	(¢ Bn)	(¢ Bn)	(¢ Bn)	
1. Personal Emoluments	984.0		34.7	0.0	0.0		1018.7	40%
2. Administrative Expenses	31.1		80.8	160.7	0.0		272.6	11%
3. Service Expense	75.7		214.3	271.4	158.5	20.4	740.3	29%
4. Investment Expenditure	7.8	295.1	11.7	111.0	0.0	120.8	546.4	21%
Total	1098.6	295.1	341.5	543.1	158.5	141.2	2578.0	100%
% by Source	43%	11%	13%	21%	6%	5%	100%	

Source: Draft un-audited Financial Report December 31, 2004. Ministry of Health, Ghana.

% by Source 2003	49%	10%	14%	15%	10%	3%	100%
% by Source 2002	50%	11%	14%	18%	8%	0%	100%
% by Source 2001	49%	2%	14%	13%	22%	0%	100%

Source Financial report December 31, 2001, 2002, 2003. Ministry of Health, Ghana

Ghana is receiving general budget support for the implementation of the GPRS through the Multi-Donor Budgetary Support (MDBS) facility through the Ministry of Finance (MOF). Some donors consider shifting their support increasingly to general budget support. The MDBS framework does not contain any conditions as to resource allocations for health, but the disbursements (from the performance tranche) depends on a set of triggers and targets including some for the health sector, which should encourage the GOG to give sufficient priority to the health sector (see chapter 7.3 and the MDBS Matrix in Annex 4). However, it will mean that the MOH has to argue its case vis-à-vis other needing sectors to stronger than today. This could become true if MOF considers MOH relatively 'spoilt' and over-funded by its development partners.

The NHIS will soon be scaled up and become an important source of financing, both through member premiums and the earmarked VAT. As such the financial data from NHIS would have to be reported in order to get an overall view on the resource envelope and expenditures in the sector.

In 2003 there were significant delays in the process from budget release to actual disbursements, resulting in low budget execution rates. As a response to last year's recommendations from the 2003 RT, MOH has been able to speed up the budget release, as the RT could verify from their interviews in the districts.

Challenges

The decreasing contribution of GOG core funding is worrying. HIPC funds will not continue forever. If and when development partners shift some of the sector specific support to funding through the MDBS facility, the development towards the Abuja target may move faster on paper (as allocation from MOF to MOH will be partially funded by general budget support) without necessarily resulting in an increase in the overall resource envelope for health, (since part of the increase would be financed from development partner resources shifted from health sector to general budget support). On the other hand it could also result in proportionately more resources. How it works out will depend on the specific arrangements that will be made. The point to highlight is that focus on the development in the percentage allocation towards the Abuja target should not distract attention from the real figures behind the proportions presented in this chapter.

Recommendation
The RT recommends that MOH/GOG take steps to increase the allocation to health in order to reduce the tendency towards increased dependency on foreign financing.
It also recommends that the financial data of NHIS is included in the reporting on the sector plans and the performance in the future.

6.3. Efficiency: Spending wisely

Findings Review POW 2004
The overall balance between total recurrent expenditure items in the sector has not changed much over the years. In 2003, the RT recommended restraint in the resources allocated to personnel emoluments and investment in order to allow a substantial increase in the non-salary recurrent budget. The percentage of recurrent expenditures for personnel emoluments decreased in 2004 compared to 2003, despite the increase in GOG expenditures on item 1, mainly because of increased funding from development partners for item 2&3. Analysis of sources of funding for item 2-3 over the period 2001-2004 shows that IGF funding has remained fairly stable at around 30%. The percentage of overall budget spent on Personnel Emoluments (PE) is now 50 %, heading back towards the level of 2001 (Table 6.3).

Table 6.3. Percentage of expenditures by item 2001-2004 (all sources)

	Actual	Actual	Actual	Actual	Budget	POW II
Recurrent Expenses	2001	2002	2003	2004	2005	2006
1. Personal Emoluments	42%	44%	45%	40%	32%	48%
2. Administrative Expenses	13%	13%	9%	11%	5%	17%
3. Service Expenses	35%	24%	29%	29%	49%	25%
4. Investment Expenditure	9%	19%	17%	21%	14%	10%
Total	100%	100%	100%	100%	100%	100%
% PE of total recurrent	47%	54%	54%	50%	37%	53%

The untied budget that can be controlled by MOH (GOG & DPF) increased in real terms by 24% as compared to 2003 (see Table 6.4). This is partly due to the shift away from earmarked funding by the development partners; partly it represents a real increase in resources.

Table 6.4. Total expenditure (GOG & DPF) by item 2001-2004

Items	2001 (¢ Bn)	2002 (¢ Bn)	2003 (¢ Bn)	2004 (¢ Bn)	Increase on 2001 (%)	Share of increase on 2001 (%)	Average annual growth
Personal emoluments	590.1	804.5	892.1	984.0	67%	52%	19%
Administration Expenses	127.7	148.0	137.0	191.7	50%	9%	14%
Service Expenses	133.3	214.4	257.7	347.1	160%	28%	38%
Investment Expenses	39.3	110.6	33.1	118.8	202%	11%	45%
Total	890.5	1277.5	1319.9	1641.6	84%	100%	23%
Increase from previous year	-	43.5%	3.3%	24.4%			

Note: Figures in 2004 constant prices, see Annex 10 for details on the calculations.

It is generally more cost effective as well as equitable to treat people at the lower levels of the system, although there is also a need for a functional comprehensive referral system. It has therefore been the objective in the POW II to ensure sufficient allocations to the district health services. In 2004, 46.5% of the budget was targeted for district health services (Table 6.5). Some of the budget items were, however, for efficiency reasons (economies of scale) pooled for administration and procurement at the central level. While part of the expenditures pooled for central administration can be easily distributed to the district level in the accounting, part of it and in particular the drugs procured through CMS cannot. It is therefore not possible at this moment to provide reliable information on how much money was actually spent for the district levels and below.

Table 6.5. Non-wage recurrent expenditure by BMC Groups (GOG & DPF)

	2004 POW without pooled components		2004 POW with pooled components		Actual expenditure		5YPOW Target
Level	Amount ¢ Bn	%	Amount ¢ Bn	%	Amount ¢ Bn	%	%
MOH – HQ	54	11.11%	67	13.79%	72.8	15.10%	8%
GHS – HQ	36	7.41%	111	22.84%	31.75	6.59%	7%
Sum HQ	90	18.52%	178	36.63%	104.55	21.69%	15%
THs	46	9.47%	46	9.47%	38.61	8.01%	13%
Psych Hosp	29	5.97%	29	5.97%	40.48	8.40%	7%
Sum Tertiary	75	15.43%	75	15.43%	79.09	16.41%	20%
Regional Health Service*	73	15.02%	73	15.02%	115.57	23.97%	23%
District Health Service	226	46.50%	138	28.40%	170	35.27%	42%
Subventions	14	2.88%	14	2.88%	12.84	2.66%	
Others**	8	1.65%	8	1.65%			
Total Non-Wage Recurrent	486	100.00%	486	100.00%	482.05	100.00%	100%

* = Regional health services including training institutions; ** = Others include civil service exemptions fund and Innovations fund. Source: POW II, Annual POW 2004, Draft un-audited Financial Report December 31, 2004.

While resources are allocated and budgets spent at district level, it is still an open question how many resources reach the sub-district level. In the past, districts were complaining that funds did not go beyond the region, today funds reach the districts, but sub-districts complain that funds do not reach there, (cf. Box 6.1). So, while progress has been made, still

more needs to be done to ensure that resources reach the lowest level of the health care delivery system.

Box 6.1. Funds to Sub-district Health Centres.

The Medical Assistant in charge of Tolon Health Centre (which also happens to be the "District Hospital") in Northern Region told the Review Team how in the 4.5 years that she had worked in that capacity, she had only once received funds for service delivery from the office of the DHMT. She recounted participating in several operational planning meetings with her team members but "the DHMT spends our money" when the funds arrived. She admitted she had never been told of any allocations under names such as poverty reduction fund, earmarked funds or Health Fund. During all these years she had "never received money to undertake initiatives" that were part of her normal job nor had she ever been receiving any imprest. When asked, she agreed that this probably was the most important impediment to improving her outputs and targets.

The report of the 2003 Review Team contained some crude productivity estimates to stimulate the debate on cost efficiency in service delivery by demonstrating the variations in expenditure per output and output per staff. Earlier studies on hospitals costs undertaken by MOH also found large variations in costs. Such observations should give rise to reflection to what extent there are potential efficiency gains to be made and to what extent such variations are explained by other factors. It should be noted that the target should not necessarily be the lowest expenditure per output, but large variations suggest that there could be significant efficiency gains.

In terms of efficiency improvements, the MOH should be commended for having increased the percentage of generic drugs. However, the low bed occupancy rates in many hospitals remain a concern, while resource allocations (finances and human resources) that relate to hospital size rather than to workload, will result in inefficiency.

Challenges

If and when development partners shift their support partly or fully to general budget support through MDBS, the increase in allocation through MOF should be used to replace donor funding for items 2 and 3. In other words: to maintain the balance in overall funding, a shift in the balance for MOH funding would be needed.
A key question is of course whether the current balance between inputs represents the optimal balance. Such an assessment is not easy to make, as it should be based on a judgment about the resources needed in terms of human resources and other inputs weighted by their costs. The current balance between budget items has been more or less stable over the past four years. It may be timely for the development of the next POW to undertake a more thorough assessment/discussion of what should be considered an optimal input mix. Such a study should start well in advance of the elaboration of POW III.

While increased resources to the sector are important, it is at least as important to use the limited resources as efficiently as possible. There are indications that more could be achieved with the resources available. Thus the lack of performance is not just a question of more resources, but also of using them better. Productivity analysis is one way of identifying differences in output per unit of input and thus areas where there could be scope for savings across units. Results should, however, be interpreted carefully and in particular it should be

clear that low cost per output unit is not always 'better'. Choice of treatment strategies based on assessments of cost-effectiveness or health technology assessments that also take into account broader aspects like organisational constraints are other ways to analyse such questions. Generally, 'informed decision-making' is likely to lead to increased efficiency. This requires two things. Firstly, it is important to continue the development of the monitoring and information systems, to link information on inputs, outputs and outcomes also with financial information, and secondly it is important to continue developing a culture of information use in decision-making at all levels.

Finally, there is a trade off between efficiency and equity considerations. Reaching the un-reached in every corner of the country may be desirable, but also comes at a cost. The marginal cost of increasing immunisation coverage in terms of required resources to cover the additional number of children, will increase with increasing coverage. The cost of reaching a few children living scattered in remote areas are likely to be considerably higher than reaching many in, for example, urban slums. This is put here a bit provocatively of course, but the bottom line is that when the resources are scarce, this is the kind of difficult decisions that need to be taken.

Recommendation
The RT recommends that work is initiated well in advance of the next POW to assess what would be the appropriate balance between resource inputs, so that a target can be set for the next plan and changes in the current balance can be assessed in that context.

The RT wants to reiterate the recommendation of last year to develop the CMS accounts so that they can be linked to the MOH financial reporting system in a way that will allow a breakdown of expenditures by target BMC.

The RT also wants to recommend that work is started on how the financial information can be coded in a way that would facilitate linking with other information databases.

7.1. Organisation of the sector

The structure of the health sector is one of multiple partners and agencies with MOH retaining the stewardship role to ensure maximum efficiency and to strive for more equity and more and optimal health gains. The MOH is the governmental agency charged with the responsibility of providing overall health policy direction for all players in the country's health sector. Like all ministries, it is a civil service organization with functions outlined in the civil service Act 327 of 1993. MOH is required to investigate and formulate policies, undertake development planning; and coordinate, monitor and evaluate the efficiency and effectiveness of the performance of the health sector. It has oversight responsibility for public sector agencies placed under the health sector.

MOH is headed by a minister and assisted by 6 Directorates and one Chief Director to perform the Ministry's main functions. These Directorates are: Finance; Administration; Procurement and Supply; Policy, Planning, Monitoring & Evaluation; Human Resource for Health Development; Research, Statistics & Information Management; and Traditional and Alternative Medicine (Annex 6, Organogram MOH).

The MOH has been gradually building its capacity and orientation to provide leadership for other health sector agencies. Some of the agencies like the GHS and TH have specialised expertise and qualified staff that has implications for the type of leadership that must be provided by the MOH.

There is need for clarification of the responsibilities for the GHS and the MOH in areas that have significant implications on service delivery. There is also need for a fair amount of public relation through press conferences and the media based on a strategically developed programme on public information. The objective of such public relations advocacy is to provide accurate, timely and useful public information about government health policy and programmes that permit households and individuals to make informed choices about such key issues as which provider offers them the best services in a given context.

7.2. Planning in the health sector

Planning process in time
Planning is a major management function which involves deciding what to do about the future and translating the decisions into specific courses of action. Planning for health programmes involves the assessment of present conditions and making decisions about the future direction of health services delivery and the development of health resources.

The planning process in the MOH is decentralized to the Budget and Management Centre (BMCs).Three types of plans are prepared. At the national level, (i) the 5-year strategic plan articulates the policy directive and priorities over the medium term, including a financial framework indicating the resource allocation for the five year period (POW 2002-2006).

The strategic plan then forms the basis for (ii) the annual POW to be prepared each year by the MOH. The third planning exercise is (iii) at the BMS levels itself (at regional and district levels). This planning process involves all institutions under the MOH including TH and Regulatory Bodies. Details of this planning cycle together with the target setting are provided in the planning guidelines of the MOH.

The Annual Planning Process is bottom-up: planning and budgeting is aggregated at regional and national levels to form the basis of the annual budget.
All plans are targeted towards the achievement of the Ghana Poverty Reduction Strategy (GPRS), and also the fulfilment of the MOH's objective of not only improving the health status of all people living in the country but making health accessible to all.
The GHS has embarked on a process of developing a need-based planning and budget. This is aimed at allowing managers to think outside the box and to determine what resources are required to scale up priority services. While this is desirable, the process needs to be redesigned and managed differently to avoid planning fatigue, especially at the lower levels.

Achievements
Planning and Budgeting has been strengthened during the period of POW I through further decentralization of management responsibility to BMCs. Planning formats conform to an uniform national Medium-Term Expenditure Framework (MTEF). Planning guidelines now emphasize key output areas. Guidelines are regularly provided to BMCs to facilitate preparation of standard plans and budgets.

Constraints
The following weaknesses have been identified in terms of overall decentralization:

- Earmarked funding is not presently part of the resource base at the time of BMC level planning. This creates distortions in implementation when earmarked funds are subsequently released for activities that may not have been planned. This is an important issue that needs to be given urgent attention.
- The need to strengthen the annual planning guidelines has emerged, for example to more clearly state national policy priorities, ensure that BMCs identify appropriate outputs and targets to contribute to the achievement of national priorities; and to strengthen procurement planning at the BMC level. The need for more extensive consultations in developing the guidelines has also been identified.
- The Non-involvement of District Assemblies (DAs) and other stakeholders in agreeing health priorities and drawing up plans. The need for health planning to be more clearly integrated with DA Planning process cannot be overemphasized.

Target setting
Now halfway through the POW II, realising that most of the targets set for that period will only partially be reached, the question is being posed how was the process of target setting being done at the time of writing the POW II? The RT finds this question difficult to answer. It is possible that at that time ambitions were just flying high and consequently targets have been set that are not likely to be reached whatever priorities and resources had been used. On the other hand, this argument should not be used too easily to explain the fact that the targets have not been reached. Therefore, the RT has tried to analyse the performance critically and has suggested some technical, financial and management related answers that could explain the disappointing results.

In addition, the RT found that while prioritization and target setting are critical for meeting the goals of the sector. However, regional and district priorities were not always the same as national ones. Equally, district targets were not set against available inputs and were sometimes unrealistic, inspired by the local manager's bias. To hold health managers accountable for their performance, target setting should be a serious process. Bottom-up

target setting, keeping in mind the national priorities, but based on what available resources and capacity can deliver at the sub-district level, is the logical starting point. This should then be brought together to provide district, regional and national targets. This approach would lead to a more realistic contract agreement that matches available inputs with expected outputs. It would allow GHS and MOH to negotiate an agreement based on the expected resource envelop, taking into account limitations in both finances and human resources.

Monitoring and Evaluation
M&E is important for assessing progress towards agreed targets, performance of different stakeholders and identifying systemic weaknesses. As part of the common management arrangements, the MOH has put in place an elaborate framework to monitor and report on the performance of the sector. The system is however still weak on assessment of the performance of the Agencies. This is a priority area for improvement if MOH intends to hold agencies and staff accountable for their performance. Current efforts to integrate vertical programme reports shall help the sector in harmonising information and its use. Efficiency in the information system shall strengthen the MOH role in sectoral priority setting.

Data and information sharing
A well functioning information system should avail health managers a possibility to know how well the health system is performing. The sector has made determined efforts to use information, such as the analysis presented in the GHS Bulletin of Health Information. The bulletin acknowledges that the current state of information in the health sector is slow, incomplete and insufficiently used for planning / monitoring service delivery.
A weak link exists between BMC, monitoring of quality and auditing implemented health interventions, confirming that health managers at operational levels are not using analysed information for decision-making. The ability to track budget performance to key outputs depends on the link between intervention-specific budgets and the reporting/accounting framework. Progress in changing into a culture of analysing and using health information to uncover managerial and technical problems and devise remedies has been generally slow. ICT is increasingly applied at HQ and intermediate levels; increasing its application by having skilled persons at regional and district levels is a challenge for the future.

The RT repeats and endorses the recommendation of the 2003 Review Team for a data repository to harvest all monitoring information of the sector to improve sector monitoring.

7.3. POW II and its links with GPRS / MDBS

The Ghana Poverty Reduction Strategy (GPRS) focuses on five priority areas for the medium term period (2003-2005): infrastructure; modernised agriculture; good governance; private sector development; and enhanced social services, being health and education in particular. While the GPRS makes little reference to the MDG, it does set targets for POW II and GPRS. These have been brought together below to allow comparison between the various indicators. Those with the sign (*) are used as disbursement triggers at MDBS meetings between the GOG and the DP. Others (#) have been proposed at some point in time and are expected to be revised under the next (third) PRSC.

Table 7.1. GPRS and POW II indicators 2003-2005

	GPRS		POW II		
Indicators GPRS	**Baseline 2002**	**Target 2005**	**Results 2003**	**Results 2004**	**Target 2006**
Prevalence underweight children < 5 yrs Wt/A %	25	20	22.1	29.9	20
Infant Mortality Rate	57	50	64	NA	50
Under Five Mortality Rate	110	95	111	NA	95
Maternal Mortality Rate (/100.000)	200	160	204	NA	150
# Districts with model Health Centres %	NS	100	NA	NA	NA
OPD attendance per capita	0.48	0.6	0.50	0.52	0.6
Reported cases of Guinea Worm	3678	0	8,290	7,275	0
Ante Natal Care	96	98	91.2	89.2	99
Post Natal Care	52	58	55.8	53.3	60
DPT3 Coverage	75	90	76	75	85
* Supervised Deliveries (HW + TTBA)	49	55	51.9	53.4	60
Total Fertility Rate	4.6	4.2	NA	NA	NA
#Use of modern method contraception Females % # Use of modern method contraception Males %	13 20	20 35	22.6	24.3	NA
* Prevalence of HIV/AIDS in pregnant women	3.4	< 5%	3.6	3.6	2.6
# Condom use to avoid HIV/AIDS Females % # Condom use to avoid HIV/AIDS Males %	5.8 15.4	15 25	NA	NA	NS
# Health Facilities with adequate arrangements to care for PLWHA (= VCT/PMTCT sites)	22/02	30	30/19	39/52	NS
* Population / Nurse in 4 deprived Regions	1 : 2,000	1 : 1,500	Regional	Table	NS
* Population / Doctor in 4 deprived Regions	1 : 20,000	1 : 16,500	Regional	Table	NS
% GOG Budget on health (figures GPRS & POW not comparable due to differences in definition)	5.7	7.0	9.5 / 10	8.2 / 8.2	10
% spending on Districts and below (Items 2&3)	42	44	47.8 / 35.4	45 / 37	43
Capital spending on Districts and below (item 4)	7	15	NA	NA	NA
* % of budget allocations to 4 deprived regions	32	39	NA	NA	NA
* Financially sustainable NHIS protects poor	--	Prepared	Approved	--	NA

Source: WHO overview, February 2003. GPRS, an agenda for growth and prosperity.

Some harmony is observed in the GPRS and POW II indicators[16]. However variations in indicators and targets exist that require attention, as they are in fact not always comparable or not available at sub-district level. The RT suggests bringing down the number of indicators and including only those output indicators that can be regularly collected and monitored. The outcome indicators (IMR, UFMR) can only be collected reliably once every five years.

The support to the implementation of the GPRS through the Multi Donor Budget Support mechanism is monitored through a Program Assessment Framework (PAF) that relies on the GPRS with its monitoring and evaluation plan as well as on the sector policies and plans. The MDBS policy matrix for health (Annex 4) focuses on two objectives: (i) to bridge equity gaps in access to quality health care and (ii) to ensure sustainable financing arrangements that protect the poor.
Progress has been made in several areas: An options analysis of decentralisation of the management of human resources has been undertaken and recently submitted for approval. Supervised deliveries have increased; the level of financing of exemptions in the four regions has increased in per capita terms. However, Population to doctor and population to nurse ratios have generally decreased in the four deprived regions from 2003 to 2004. Population to nurse decreased in all four regions. Population per doctor decreased considerably in three

[16] The GPRS uses in part the same indicators and targets as defined in the POW II. Some of the financial indicators are not comparable between GPRS and POW. About half of the indicators cannot be monitored on the basis of regularly available information.

of the deprived regions and was stable in UWR. The RT notes, though, that there is some uncertainty about the comparability of the figures.

7.4. Management of the sector

Institutional capacity
The Ghana Health Service Act 1995, Act 525 represents a major change in the health service delivery system. The implementation of the National Health Insurance Act 2003, Act 651 and the adoption of Multi-Donor Budget Support together with some of the collaborating development partners, means the MOH must brace itself for more effective resource mobilisation and efficient and equitable resource allocation to achieve its objectives.
At the time of this review (April 2005), Directors were being appointed to fill vacancies that had existed in 2004. This will certainly improve the MOH's capacity if the necessary institutional relationships are clarified and improved, and office space is made available for officers to operate effectively.

Coordination and communication
The MOH Headquarters has a key role to play in ensuring effective coordination and communication within the sector. The RT observed lack of coordination and communication among the various stakeholders in the sector. This resulted in poor outcomes of activities and inefficient use of limited resources. Efforts are required to ensure that formal - informal and vertical - horizontal communication channels are opened at all levels of the sector. This would enable the sector to marshal all the resources and skills that are available to respond to the challenges that face the MOH.

The RT was glad to observe that at the time of this review the new Minister of Health was engaging all stakeholders of the health sector in a process to clarify their roles and resolve institutional conflicts with a view to enabling the sector to move forward.

Procurement and Central Medical Stores
The MOH has revised its procurement manual in response to the Public Procurement Board Act 2003, Act 663. Entity Tender Committees have been formed in line with the Act.

The timing of completion of the annual procurement plan, the commencement of procurement activity and the procurement lead time continues to challenge the process of integrating planning, budgeting, budget execution and monitoring. This means that the procurement activities of a year will benefit the following year more than the current year.

This environment requires that the storage system as operated through the Central and Regional Medical Stores should have a robust accounting system to ensure that stores products are properly charged to beneficiary institutions when they receive goods from the central and regional stores.
The components of the annual Procurement Plan have been expanded to include Civil Works but the plan is still lean on basic medical equipment. This has also resulted in a situation where central procurement does not reflect some of the basic equipment requirements of health institutions (weighing scales, delivery kits, resuscitation equipment, thermometers, BP apparatus etc).

Procurement and logistic systems
A Procurement Unit has been established under the Procurement and Supplies Directorate. Its main objective is to develop capacity at all levels to establish a system of procurement that is transparent, competitive and accountable, observing fairness and value for money.

Trained Procurement Officers have been appointed at all levels of the MOH. A Procurement Procedures Manual (PPM) has been developed and already reviewed. The PPM is used in all the regions and appears to perform quite well, as problems related to poor supplies of drugs have not been raised. However, poor planning and non-adherence to the planning format, weak linkages between procurement, finance and storage, and lack of systems for monitoring have been reported to occur. These need to be addressed by the responsible department.

Accounting, financial reporting and audit
The delay in full implementation of the Budget and Public Expenditure Management System (BPEMS) continues to pose a challenge to the MOH in its effort to ensure complete, accurate, timely and reconcilable accounting and financial reporting. The new Financial Administration Act 2003, Act 654, requires among other things that all Ministries, Departments and Agencies prepare monthly statements of account for submission to the Auditor-General and the Minister of Finance. While all BMCs of MOH prepare monthly accounts, the process of collating and consolidating these accounts poses a challenge to meeting the statutory requirements.

Activities are being implemented to strengthen Internal Audit capacity and to bring Internal Audit activities under the MOH and its agencies in line with the requirements of the Internal Audit Agency Act 2003, Act 658. A private audit firm has been engaged to help improve the capacity of the Ghana Health Service Internal Audit Unit.

The External Audit of 2003 was completed on schedule in 2004. The procurement of a private audit firm to join the Auditor General to undertake the 2004 financial audit was not completed before the end of the year. This is likely to delay the 2004 financial audit if the process is not expedited.

7.5. Budgeting and expenditure

Coordination and use of funds
The traditional sources of funding health services remained unchanged in 2004, as implementation of the National Health Insurance Scheme started. What is becoming increasingly clear to the Ministry is the need to effectively coordinate and monitor all available sources of funding to ensure that they contribute towards the achievement of its organisational objective. At least it is important to ensure that no source of funding constrains the implementation of planned activities towards the achievement of organisational goals.

The RT heard concerns about the way Earmarked Funds are planned and used. It is thought that an improvement in the management of Earmarked Funds can contribute significantly to the total resource base available for achievement of organisational goals. This can be done by exploring ways of complying with the management arrangements prescribed in the Common Management Arrangements document.

Budgeting in the context of NHIS
The current design of the NHIS provides for a replacement of the source of IGF (IGF accounts for 14% of total Health Expenditure, Table 6.2) from out-of-pocket payment at the time service is required to a prepayment regime that entitles the insured to a package of services at the time of need. This means that, all things being equal, the resource envelope of a health facility will not be affected by the introduction of health insurance. The National Health Insurance Council (NHIC) has estimated that demand for health services may rise by

200% following implementation of the NHIS, at least in the first year. The effect of this expected rise has been factored into the funding mechanisms of the insurance scheme. Clear policy intentions and guidelines are yet to be made to cater for the expected corresponding increase in demand for the other traditional sources of funding the health sector, i.e. Development Partner and GOG Funds.

7.6. Performance monitoring and accountability

Capacity issues at all levels
Performance monitoring and accountability remains one of the weak links in the Ghana Health SWAp. The Ministry and all its stakeholders have done well to decentralise budgets and management responsibility to the BMC. The challenge that remains is to ensure that plans and budgets at all levels reflect organisational priorities and objectives and that resources are efficiently applied to achieve these priorities and objectives. The RT observed very limited performance monitoring capacity at all levels. Expectations of excellent performance can therefore only be achieved by the coincidence of self motivated personnel, receiving resources on time to deliver a defined package of outputs.

Health Service Performance Agreement (PC)
MOH signed a Performance Contract (PC) with the GHS in 2004. The GHS also signed PC with the Regions who in turn signed PC with the Districts. While in theory performance contracts are expected to give commitment to improve performance, there remains a disconnect between the targets set and the resources made available to achieve that target. Both the Regions and the Districts interviewed complained that it was a top down strategy, without any prior consultation with those who are to execute and implement the contract. Another limiting factor is that money releases have not been stipulated in the contract. Target areas are set globally or across the board without considering environmental differences or peculiar difficulties of some regions.
The RT observed that in none of the regions and districts visited, the contracts for this year had been signed. Most of last year's targets had been achieved. But some targets could not be achieved due to human and material constraints.

These PC were to be based on agreed output targets and an approved budget. The RT observed a lack of consistency in the presentation of the expected outputs at all levels (in the various POWs, in the Regional and in the District Health Plans). Each year new expected outputs are included in the plans without evidence of sufficient feed-back and control as to whether the earlier expected outputs have been achieved (Annex 9).

7.7. Intersectoral Collaboration

Intersectoral collaboration is one of the areas where the Ministry of Health has made little progress over the past four years. While the Ministry continues to acknowledge the need for intersectoral action to deliver on some of the agreed sector indicators, the Ministry is yet to progress in this direction.

At the national level there is an Inter-Ministerial Advisory Committee on decentralisation which is supposed to meet at least once a month to discuss issues of intersectoral collaboration. This committee has not achieved much because it has not been able to meet regularly.

At the regional level there is a Regional Coordination Committee made up of the Ministries, Departments and Agencies and chaired by the Regional Minister. This is the forum where consensus is built on major social services and the heads of the MDAs take the opportunity to brief the committee on what they are doing at their respective MDAs. It is useful because it helps the Regional Health Directorate to know more about what other sectors are doing to improve the health status of people living in Ghana. The Regional Coordinating Committee is however undermined by the lack of composite planning and budgeting.

7.8. District Assemblies and intersectoral collaboration

District Assemblies (DA) have been created as part of the decentralization policy of GOG. The policy seeks to establish decentralised administration through the transfer of authority, functions, resources and competencies from the central Government (Ministries, Departments, and Agencies (MDAs) to the sub-national institutions such as the Regional Coordinating Councils and the District Assemblies (DAs) with the intention to enhance the capacity of the public sector to plan, manage and monitor social, spatial and economic development.

The policy aims at devolving central administrative authority and divesting implementation responsibility to the district level. It aims further at fusing governmental agencies at the regional and district levels into one monolithic administrative unit through the process of institutional integration, man-power absorption, composite budgeting and the provision of funds for the decentralized services. Under this policy, development becomes a shared responsibility of the Government, District Assemblies, Civil Society Organisation, Private Sector and Communities.

As the highest political authority in the district with statutory, deliberative, legislative and consultative powers, the DA in terms of section 10 of the Local Government Act of 1993, have been assigned extensive functions and responsibilities. These include inter-alia:

- The responsibility for the overall development of the district as well as playing a role in the formulation and preparation of the district development plan and budget.
- Effective mobilization and utilization of human, physical and financial resources for economic and social development.
- Provision of basic infrastructure, municipal services and works etc.

Below the District Assemblies are the Urban, Town and Area Councils, and at the base there are Unit Committees. These are essentially consultative bodies (without their own budgets) performing functions delegated to them by the DAs. As health care service providers and managers, the MOH is interested in these issues to the extent that the overall health needs of people are engrained in their total development.

Two important arrangements have been made to facilitate the effectiveness of the District Assemblies. The first is the establishment of an Executive Committee in each of the 138 District Assemblies. The Executive Committee, which is the executing secretariat of the District Assembly, operating through five sub-committees. One of these is the Social Services Sub-committee works on health issues. The second arrangement deals with the decentralization of the 11 implementing departments and organisations listed under the first schedule of the Local Government Act, 1993. The MOH has been marked as one of the decentralized departments of the decentralization process. When this process is complete, the MOH will be represented by the District Health Management Team (DHMT) under a new name as an Office of District Medical Officer of Health, being part of the District Assembly.

Discussions with District Assembly Officials during our field trip points to numerous health related projects and programmes the DA have undertaken to promote health development.

According to them, the business of providing and managing health is located within the health sector, but the factors that influence health remain scattered in many facets of life which are far beyond the health sector. In their opinion the establishment of the DA as the highest political and administrative authority with overall responsibility for planning and development for the district, has wide implication for health development. The DA must be seen as one of the mechanisms created by the GOG to ensure that health goals are an integral part of the socio-economic development policies and programmes. The realization of these goals requires a closer cooperation between the District Assemblies, the District Health Management Teams, and other sectoral departments, as well as involving the local people in the provision of important services and decision making.

There is no doubt that given the renewed emphasis within the GHS on the classical ideas of prevention and health promotion, the DAs have a significant role to play in the health sector. Additionally, the DAs also command substantial resources from both the DA's Common Fund and the HIPC Funds, able to promote (health) development in the rural areas. The DAs should take a pro-active approach to enhance collaboration with NGOs and clear the conditions of their collaboration with the DAs. There is room to improve coordination and collaboration with NGOs working in the health sector.

The following activities have been already undertaken by the DA:

- Construction of DHMT offices, theatres, bungalows, nurses quarters, hospitals, health centre renovation of hospital wards, and building of other health facilities.
- Sponsoring candidates to community Health Nursing Training Colleges
- Sponsoring TBA training
- Sponsoring educational programmes organized by the DHMT in respect of:
  - -Maternal and child Health, Family planning, Guinea Worm Eradication.
  - -Teenage pregnancy, Drug abuse etc.
  - -Nutrition
  - -NID
  - -Environmental Sanitation
- Occasional provision of vehicles to support DHMT outreach programmes.
- Construction of public latrines, boreholes and hand-dug wells.
- Construction and renovation of market structures and slaughter houses.
- Mobilization of communities to create Community Health Committees and Community Surveillance Volunteers.
- Rehabilitation of feeder roads to make remote and deprived areas accessible for supervision.

Discussions with some District Assembly officials reveals that given adequate funding, the appropriate guidelines and direction, the MOH can collaborate with the District Assemblies to promote health development in the following areas.

- Provision of infrastructure-buildings to serve as hospitals, health centres, accommodation for health staff and CHIPS compounds.
- Sponsoring and training Community Health Nurses.
- Sponsoring Health Programmes e.g. NID
- Provision of public latrines and incinerators for refuse disposal
- Provision of good drinking water for rural communities-boreholes, hand-dug wells
- Provision of markets, slaughter houses and crèches for children of workers.
- Social mobilization of the communities to facilitate health programmes
- Joint (composite) planning and budgeting

Difficulties of Inter-Sectoral Collaboration

At the district level, intersectoral collaboration between DHMT and decentralized departments has been weak. The following difficulties have been identified:

- Fragmentation of government agencies with different policy inclinations and lack of autonomy mostly at the operational level.
- Differences in professional culture and organisational structure.
- Differences in management styles and planning cycles or procedures.
- Differences in funding levels and sources.
- Different lines of authority of the various sectors.
- Lack of clear understanding of the Local Government Act, 1993 on decentralization and intersectoral collaboration.

Suggestions for overcoming the difficulties of intersectoral collaboration

- Map out clear areas of concessions that must be made for the sake of collaboration.
- Clearly define areas of mutual benefit and use these as the bargaining chips.
- Devote time and energy to learn and know more about potential collaborators.
- A good management information system is essential.
- Community participation is essential.
- Resolve outstanding difficulties created by the establishment of sector public services for health and education in respect of which key functions have been identified.
- Enact legislation to clarify the functions and related powers therefore to be exercised by MDAs at the various levels of the decentralized system
- Develop good interpersonal relationships.
- Finally, develop a long-term collaborative plan and do not confront potential collaborators only when you are stuck.

Overall Recommendations (Table)

The recommendations from each chapter of the report are brought together in the summary table below. For ease of tracking the subsequent implementation of the recommendations, once they have been accepted, we have set them out using a matrix that can be adapted for tracking progress by adding columns.

Conclusions	Recommendations
➢ Chapter 1: Overview of the report	
There is no simple or single answer for the observed low performance in the sector. Lack of synergy between the various parts of the system is the best possible explanation MOH has concluded an intensive, comprehensive and informative bottom-up review process; Results of the external Review of POW 2003 and POW 2004 have not yet brought back into the system.	The various suggestions below should be addressed together with the intention to strengthen their synergy and complementarity. The Performance Review process is essential to give stakeholders the chance once a year to review achievements and constraints. This bottom-up process is unique and should be continued each year, as it provides opportunities to improve sector performance. The Review POW 2004 report should be distributed, shared and discussed at regional and district levels
➢ Chapter 2: Sector performance in service delivery and disease control	
Apart for UER, most child health related activities are not presented as a package	Clinical IMCI case management must be expanded to cover all practicing prescribers in a time frame. Training must be decentralized to District Hospitals to reduce cost and facilitate follow-up after training. Guidelines for neonatal care and "neonatal care kit" must be introduced as part of IMCI case management. Full immunization could become a prerequisite for obtaining a birth certificate, which in turn must be a requirement for school enrolment.
Similarly, RH and SM activities are undertaken at all levels, but are not mutually reinforcing, as they are not combined in a package.	Specific proposals need to be elaborated on a region by region basis, starting with those regions that have the worst coverage of maternity services. Focused antenatal care must be expanded and delivery targets must be allocated to skilled midwives. The concepts in Regional Prevention of Maternal Mortality Network (RPMMN) must be scaled up everywhere (schools, churches etc). Similarly, the referral system needs to be defined and re-established, in particular in poor areas with low EmOC coverage.
The various elements of disease control are well-known, but synergy and coordination between Integrated Disease Surveillance & Response and the other disease control programmes, particularly Malaria control; TB control; HIV/AIDS and Guinea Worm control, is weak and difficult to organise, due to an ingrained vertical way of organisation of some of these respective programmes.	Stimulate collaboration and synergy between: • Malaria control (IPT & ITN distribution, home management of fevers, ACT therapy); • TB control (Community DOTS and facility DOTS, including laboratory facilities for Smear + analysis and blood film for Malaria); • HIV/AIDS, including VCT, Home Base Care (HBC), PMTCT and ARV treatment) and • Guinea Worm control (set realistic targets in plans linked to potable water provision).

Conclusions	Recommendations
	Package these interventions and revisit their targeting (national, regional and district, using the NDPC poverty maps (mainstream pro-poor interventions). Elaborate for both a phased and realistic, comprehensive implementation plan over medium to long-term periods that brings synergy between these programmes.
Health promotion as a cross-cutting element is present in all programmes, but it has no systematic data set related to outputs and Behaviour Change.	These could be delivered through educational and social marketing structures. Context specific health promotion messages could be developed on a region by region basis, exploiting the peer groups and interpersonal approaches in addition to other media/ channels (multiple channels approach). Focus should be on child health messages (danger signs in sick children, diarrhoea, Malaria), Maternal and RH messages (IPF and ITN related) and nutrition-related advice (Expanded Breast Feeding and feeding frequency).
Chapter 3: Bridging In-equalities	
Pro-Poor policies were at the heart of the POW II and received much attention. Yet their practical application in the daily practice of service delivery remains insufficient in areas like distribution of infrastructure, human resources and financial resources. Socio-cultural inequalities persist. Health policies should become more explicit and consistent in their pro-poor focus.	The recently developed poverty maps that identify deprivation down to sub-district level provides an opportunity to plan a more targeted approach to improving services where they are most needed. This would include working with the urban poor that may well in numbers be comparable to the group of rural poor. The focus should be on targeting some very deprived areas step by step with a comprehensive plan that brings all interventions together. The recently developed poverty maps that identify deprivation down to sub-district level should be used to plan a more targeted approach to improving services in all districts. For Ghana, this could mean that the technical interventions to improve the health of its citizens perhaps are not enough. Technical solutions need to be blended with critical decisions on resource allocations that reach the poor and destitute. Inequity - the gap itself - must be explicitly and squarely addressed. Progress in closing this gap is an intrinsic part of the MDG initiative. It need be addressed in practical and operational terms in the next POW.
Comparison between health outputs and physical, human and financial inputs seem to indicate that deprived regions do perform worse. However, comparison of per capita expenditure by region or district is not possible.	A trend analysis for a longer period would provide more relevant information about whether progress is being made in deprived areas. This sort of comparison should ideally be undertaken at district level as soon as a breakdown of all funding by region (and by district) can be provided. Regional figures should be provided at the next Summit.
Socio-cultural inequalities and perceptions of quality of care are not yet included in the sector wide indicators	The next POW should include some new indicators that can be regularly monitored, like indicators on poverty, equity, gender and cost effectiveness indicators (see Review POW 2003) for each of the agencies.
Chapter 4: Delivery systems and performance	
CHPS is a complex but highly relevant concept for the expansion of the Ghana health services.	Agree on the essential elements of the concept and allow adaptation of CHPS to the regional reality. Elaborate a phased introduction of CHPS in the Regional Five Year Plans. The role and contribution of the DA in the construction and maintenance of the CHPS clinic and the training of CHPS staff (bonding arrangements) is essential and must be expanded. Secure the necessary political support at all levels.
The District referral system appears inadequate, as HC often lack equipment and human resources and many of the district hospital have no operating capacity.	It is important to identify underserved areas (use poverty maps) and decide on the establishment of CHPS clinics. Existing HC that lack space should be expanded and inventories should be made of equipment. Gaps should be filled within a well defined time frame. In doing so, levels of district depravity and mortality must be taken to account. Again, human resource requirements should be planned and managed to meet the required needs and improve performance of the CHPS, the HC and the district hospitals
Vertical Programmes: At the National level, programmes must harmonize their plans to achieve synergy, focus and expected	Programmes such as RBM, HIV/AIDS, TB (all three under the Global Funds), and the NIDs work under rather centralistic and vertical approaches which may not be in step with the integrated health planning process nationally.

Conclusions	Recommendations
results. This is not yet the reality.	However the additional resources accessible for health through these programmes, challenge national planners to include them in their planning for service delivery
In many institutions in Ghana, relations between public health and clinical care are poor and not used. Here is potential for further synergy and collaboration	It is important to establish institutional and outreach "do's and do not's" and build the appropriate capacity to further the link between public health and clinical care. Hospital performance indicators must include PH indicators, like workload, missed opportunities, and support given to HCs.
Public-Private Partnerships could be strengthened, give the good existing relationships	GHS has to begin dialogue with the private sector for accreditation and signing memoranda of understanding for service contracting. The framework for partnership must be clearly defined. Regional Health Directorates (RHD) must also position themselves in ways that will allow this partnership to grow. Private sector desks should be created within RHD to allow interaction and to move towards with expansion of service contracting, particularly with CHAG.
Chapter 5. Human resources	
The overall assessment of the human resource situation remains that while commendable measures have been taken, many health facilities lack the required staffing to provide the expected quality services. These deficiencies do impact on the observed decline in performance of the sector.	A new human resource strategy is needed urgently. It should inventorise realistically the needs in human resources in numbers and by type and level of care. This is particularly urgent for the primary levels (from CHPS till district hospitals), as there the priorities should be placed to achieve the MDG. Additionally, a cost estimate should be made, to assess the HR needs and what is financially feasible in the coming years. The RT proposes to consider (i) the upgrading of the MA and (ii) the training of a new cadre, the laboratory technicians. These should complement the available nursing and midwifery cadres in providing the minimum package of care.
MOH should listen carefully to the reasons why doctors and nurses want to leave the country.	There are many other measures that could help to limit the serious brain drain in the country. MOH should listen to them and take other –non financial – measures that also play a role.
Chapter 6: Financing the health sector	
Ghana is still far away from the Abuja target	Maintain pressure for increasing the health share of GOG funds to reach the Abuja declaration of 15%; Focus on increasing the budget for non-wage recurrent expenditure. Sub-district health management teams should be empowered to plan within their budget ceiling, to know their approved budget and to be able to implement against the plan and budget. The financial management system should be developed to allow for linkage of financial information to outputs and objectives.
Compared to 2003, the share of the overall expenditures financed by GOG was reduced from 49 to 43%. Earmarked funds decreased substantially in 2004.	The accounting systems and data extraction for analysis should be further developed, e.g. at CMS to allow tracking of procured items to beneficiary BMCs and in the MOH/GHS to allow easy analysis of expenditure for BMCs at all levels, including sub-districts. The RT recommends that MOH/GOG take steps to increase the allocation to health in order to reduce the tendency towards increased dependency on foreign financing. It also recommends that the financial data of NHIS is included in the reporting on the sector plans and the performance in the future.
MDBS: The indicators used in GPRS, MDG and POW are not yet fully harmonised, giving confusion on the use and interpretation of these indicators	The RT suggests bringing down the number of indicators and including the output indicators that can be regularly collected and monitored. . Technical improvements in the list of indicators should be made at short notice
The NHIS will soon be scaled up and become an important source of financing the health sector, both through member premiums and the earmarked VAT. Exemptions for direct user fees will gradually be phased out, as NHIS is scaled up. The identification of the indigent, the positioning of each member in the six different levels of	During the transitional phase of scaling up NHIS, funding for reimbursement of exemptions should be ensured to continue smoothly. Special attention should be given that the poorest and deprived are to enrol earliest in the scheme. It will be essential that there is sufficient funding to meet the demands, both in the NHIS and in the MOH budget. This should be monitored closely so that adjustments can be made in time, if necessary.

Conclusions	Recommendations
wealth that determines the premium level in the informal sector, remains a challenge	
Efficiency gains can be made at all levels	Efforts to increase efficiency should continue. The emphasis on service delivery at the lowest level of the system should continue. There should be an appropriate balance between the inputs in service delivery - i.e. between human resources, drugs and supplies and other costs - and their results. Specific studies are proposed in the text.
Chapter 7: Organisation, Management and partnership in the sector	
Planning: The Annual Planning Process is bottom-up: resource based planning and budgeting process is aggregated at regional and national levels to form the basis of the annual budget. All plans are targeted towards the achievement of the Ghana Poverty Reduction Strategy (GPRS), and the fulfilment of the MOH objective of improving the health status of all people. The GHS embarks on a process of developing a need-based planning and budget. This is aimed at allowing managers to think outside the box and to determine what resources are required to scale up priority services	Continue the link between plans, budgets and expenditure. Stop needs based planning at the district BMC level. Plan directly with ceilings and work towards result-based planning. Include pro-poor priorities and indicators more explicitly in the planning format of the regional and district plans. Initiate linking financial inputs with real outputs. Bring them together in a short and standardised district reporting format. Clear and realistic guidelines should be established to allow all "BMC-of-record[17]" (Regional BMCs, sub-districts and Zonal CHPS Clinics) access to financial resources to implement the various plans and interventions they make each year. Timeliness of disbursement should also be improved by the implementation of agreed cash flow planning, standardised procedures etc. ➢
Target setting: most of the targets set for that period will only partially be reached. Have ambitions been too high at that time or has performance been below expectations.	District targets were not set against available inputs and were sometimes unrealistic, inspired by the local manager's bias. Target setting should be a serious process. Bottom-up target setting based on what available resources and capacity can deliver at the sub-district level is the logical starting point. This should then be brought together to provide district, regional and national targets. This approach would lead to a realistic contract agreement that matches available inputs with expected outputs. It would allow GHS and MOH to negotiate an agreement based on the expected resource envelop, taking into account limitations in both finances and human resources.
Performance assessments do exist in theory but in reality have little real basis, as the targets have been decided by the central levels with little input and discussion from implementers. Currently, the performance agreements are based on an understanding by the signatories that as long as the resources are not provided, the targets cannot be reached and thus the agreement is not binding to any of them. The Expected Outputs that provide the basis for the Performance Agreement, show little consistency over the last three years (Annex 9).	In order to create ownership and a sense of responsibility, the various performance agreements need to start from what the lowest level thinks it can achieve annually. Only in this way can (s)he be held accountable for the result. Higher levels will have to adapt to that reality and come – through negotiations - to annual target setting for the various output indicators at regional and national levels. When reviewing performance agreements, ensure accountability when looking at plans versus achievements at all levels. Compare the same Expected Outputs and indicators over time to ensure continuity / consistency in monitoring.
Monitoring and Evaluation. As part of the common management arrangements, the MOH has put in place an elaborate framework to monitor and report on the performance of the sector. The system is however still weak on assessment of the performance of the	Review SWAp indicators, linking new monitoring framework with MDG and existing institutional structures (MOH, GHS, TH, separate from PPME). Define authoritative source for each data (see IME report[18]). Include poverty, equity, gender and cost effectiveness indicators (see Review POW 2003) for each of the agencies. Harmonise MDBS, PRSC and POW indicators. Harmonise targets between MOH and GHS. Justify the request for financial resources through

[17] BMC-of-record is a Budget Management Centre allocated with financial resources, but with no authority to spend money without the approval from a spending officer.
[18] Appraisal of the Ghana Information, Monitoring and Evaluation (IME) system for the health sector, May 2004.

Conclusions	Recommendations
Agencies and has not yet been tuned towards GPRS and MDG.	reporting on agreed outputs in the agreement. A weak link exists between BMC, monitoring of quality and auditing implemented health interventions, confirming that health managers at operational levels are not using analysed information for decision-making. The ability to track budget performance to key outputs depends on the link between intervention-specific budgets and the reporting/accounting framework. New developments in ICT might provide solutions for some of these constraints. The RT repeats and endorses the recommendation of the 2003 Review Team for a data repository to harvest all monitoring information of the sector to improve sector monitoring.
Intersectoral Collaboration: Relations between the DA – DHMT are generally weak and complicated. Particularly in the areas of joint planning and monitoring. There appears little transparency in the sharing of financial resources.	MOH should instruct Regions and Districts to build partnerships with DA at all levels and jointly define practical intersectoral activities (Guinea Worm, water & sanitation, nutrition, pro-poor activities); Initiate an Intersectoral desk within MOH and the Regions to coordinate intersectoral work. Regular and open communication will be the important first step towards improving the existing relations. Structured sessions should be introduced to commit DHMT to collaboration with the district authorities. Specific suggestions to enhance collaboration with the DA have been given in the last chapter of the report.
Partnerships between MOH and the various Agencies: There is need for clarification of the responsibilities for the GHS and the MOH in areas that have significant implications on service delivery.	Review the Act 525 in the light of the experience with its implementation. Redefine and clarify the responsibilities of MOH, GHS and the TH in the areas of human resource planning and distribution; capital investment planning and implementation of capital programmes; procurement of health logistics; and the acquisition and maintenance of equipment; Lines of communication and accountability also need to be reviewed and clarified. In order to establish clear lines of responsibility and communication, GHS and TH need to elaborate together a "Cooperation Agreement" that defines the areas of collaboration and the other areas of mutual interest (like human resource development, referral systems and use of equipment and other high cost investments).
There is no Performance contract between CHAG and the GHS, despite good intentions at both sides	The relations between GHS and CHAG needs to be operationalised in a formal 'working agreement', clarifying the administrative and communication working relations and the financial contributions from both sides. Only then a Performance Agreement can be drafted
MOH – Development Partners relations are cordial, but substantial earmarked funds are still not being captured in the funding of the sector.	Review the recent 2002 Management Arrangements (CMA II) between the MOH and the DP, updating ownership, alignment, harmonisation, results and mutual accountability, as defined in the recently adopted Paris Declaration on Aid Effectiveness (March 2005). Actively lobby to increase other partners to join the health fund, by inviting them to participate in reviews and meetings.