Ministry of Health
April 2011 Health Summit

GIMPA Conference Centre, Accra, Ghana

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Lead Facilitator

Summit Report

April, 2011

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The Team of Facilitators
17 April, 2011

Abbreviations

Af	Aflatoxin
ANC	Antenatal Care
ARV	Antiretroviral Therapy
BCC	Behaviour Change Communication
BMC	Budget Management Centre
CD4 .	A blood cell that has molecules called CD4 on its surface; used to measure viral load in HIV/AIDS patients
CHAG	Christian Health Association of Ghana
CHIM	Centre for Health Information Management
CHPS	Community-based Health Planning and Service
CMA	Common Management Arrangement
CSR	Country Status Report
CYP	Couple Years Protection
DALY	Disability Adjusted Life Years
DCE	District Chief Executive
DHIMS	District Health Information Management System
DHMT	District Health Management Team
DHS	District Health Service
DMHIS	District Mutual Health Insurance Scheme
EMS	Emergency Medical Services
EmONC	Emergency Obstetric and Neonatal Care
EPI	Expanded Programme on Immunisation
EU	European Union
FP	Family Planning
GAVI	Global Alliance for Vaccine Initiative
GDHS	Ghana Demographic and Health Survey
GHS	Ghana Health Services
GOG	Government of Ghana

GGWEP	Ghana Guinea Worm Eradication Programme
HA	Holistic Assessment
HIA	Health Impact Assessment
HMIS	Health Management Information System
HO1	Health Strategic Objective 1
HO2	Health Strategic Objective 2
HO3	Health Strategic Objective 3
HSMTDP	Health Sector Medium Term Development Plan
IFC	International Finance Cooperation
IGF	Internally Generated Funds
ILO	International Labour Organisation
IRT	Independent Review Team
ITN	Insecticide Treated Net
JICA	Japan International Cooperation Agency
MBB	Marginal Budgeting for Bottlenecks
MDA	Ministries, Departments and Agencies
MDG	Millennium Development Goal
MDG4	Millennium Development Goal 4
MDG5	Millennium Development Goal 5
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MDBS	Multi Donor Budget Support
MDG	Millennium Development Goal
MoH	Ministry of Health
MLGRD	Ministry of Local Government and Rural Development
MOTECH	Mobile Technology for Community Health
NADMO	National Disaster Management Organisation
NAS	National Ambulance Services
NGO	Non-Government Organisation

NHIS	National Health Insurance System
OPD	Out-Patient Department
PHI	Private Health Institution
PMTCT	Prevention of Mother to Child Transmission
POW	Programme of Work
ppb	Parts Per Billion
PPME	Policy, Planning, Monitoring and Evaluation
SCD	Sickle Cell Disease
SCD-SS	Sickle Cell Disease – SS genotype
SFG	Sickle Cell Foundation
U5MR	Under-Five Mortality Rate
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHA	World Health Assembly
WHO	World Health Organisation

Chapter 1 Introduction

1.1 Background

The Health Summit takes place bi-annually, usually in April and November, with the participation of all key sector partners and health sector stakeholders. The April health summit provides the forum to discuss the results of the annual sector performance review, while the November summit focuses on the sector Programme of Work and budget for the coming year.

The April 2011 health summit assessed the implementation of the 2010 Programme of Work (POW) and took place from 11 to 15 April at the Ghana Institute of Management and Public Administration (GIMPA). Participants were drawn from government ministries, departments and agencies, civil society, private sector, development partners and the media. The total number of participants is listed in Table 1.

TABLE 1 PARTICIPATION IN THE HEALTH SUMMIT

DAY	PARTICIPANTS	FACILITATORS	MEDIA	TOTAL
1	250	21	30	301
2	197	21	0	218
3	76	1	0	77

1.2 Organization and management

Pre-summit meetings, with participation by staff from the MoH, Ghana Health Service (GHS) and development partners, were held weekly in the MoH conference room to plan for the summit. A lead facilitator, supported by a team of facilitators drawn both from within and outside the health sector, was engaged to support the planning and organisation of the summit. Working with the secretariat, the lead facilitator and the Master of Ceremonies oversaw the day-to-day running of the summit. The summit was organized for five days as follows:

- Day 1 and 2 - Opening and technical presentations
- Day 3 - Business Meeting
- Day 4 - Drafting of the Aide Memoire
- Day 5 - Signing the Aide Memoire

At the opening ceremony speeches were delivered by the Hon. Minister of Health, representative of the development partners and other dignitaries.

Since November 2008, the format of the summit has included a combination of plenary presentations and discussions, parallel technical sessions and facilitated round-table discussions within the plenary

venue. Twenty round table sessions, each seating about 15 persons, were organised to discuss issues arising from the holistic assessment and the independent review of the 2010 POW. For each issue the group identified the root causes, proposed actions and analysed the feasibility of those actions.

Technical presentations were made on a range of subjects, including cholera, private sector financing, and the impact of mycotoxins. This was followed by plenary discussion. In addition, four parallel presentations were made in syndicate rooms. Guided by the presenter, the group identified two key issues related to the presentation, discussed two underlying causes, suggested ways to solve the problem, in addition to analysing the political, legal, financial and technical implications of the suggestion. Additionally, poster presentations were made on Guinea worm eradication programme, the impact of oil and gas industry on Ghana and use of uterotonic substances.

1.3 Structure of report

Chapter two gives a summary of the speeches by dignitaries invited to the opening ceremony, including the Chairman of the Council of State, Professor Kofi Awoonor, the Minister of Health, Hon. Yieleh Chireh and the guest speaker, Dr. Moses Adibo, former Deputy Minister of Health.

Chapter three of this report discusses the 2010 independent health sector review report, issues arising from them and recommendations from the round table meetings.

Chapter four covers technical presentations on a range of issues, including cholera, emergency obstetric and neonatal care, equity in health and funding gaps in HIV/AIDS. The presenters gave an update on the subjects and identified policy and programmatic implications of issues related to the topics they spoke on.

Chapter five discusses the presentations made in the parallel sessions. Dr. Zakariah gives an update on the emergency services in Ghana and makes a case for increasing funding to the department in order to prevent avoidable mortality. Mr. Mensah gives a country status report on health infrastructure while Mr. Akyianu highlights the challenges the private sector faces in accessing funds and puts forward some solutions. Finally, Prof Ankrah shares recent findings on the health effect of Aflatoxin.

Chapter six gives highlights of poster presentations, including a study on the use of uterotonic substances, the successful control of Guinea worm disease and the health impact of the oil and gas industry.

Chapter seven discusses the strengths and weaknesses of the April 2011 summit, as well as participants' suggestions to improve future summits.

Chapter eight draws some conclusions on this summit, and suggests ways to improve the health sector's performance as well as the organisation and management of future health summits.

Chapter 2 Opening ceremony

2.1 Chairman's address

By Prof. Kofi Awoonor, Chairman of the Council of State

Opening the summit, the Chairman for the occasion, Prof. Kofi Awoonor, thanked the Ministry of Health for inviting him to chair the meeting. In his closing remarks, he advised the Ministry of Health to be more gender-sensitive in selecting dignitaries to future functions, and he commended all the presenters and advised that copies of the presentations be made available to everybody. However, he worried about over-dependence on donor funding and the elitism and nepotism in medical training. On the cholera epidemic, he advised the health sector --rather than local government-- to take the lead in disease outbreak. Finally, he stressed the sector's impact on tourism, as well as its broader impact on overall socio-economic development of the country.

2.2 Welcome address

By Dr. Sylvestor Anemana, Acting Chief Director, Ministry of Health

Dr. Anemana welcomed all participants to the meeting and, in particular, the Chairman, for accepting the invitation at short notice. He elaborated on the institutional arrangements that led to the organization of the health summit, including the Common Management Arrangement, the sector-wide reviews and the health summit which culminates in the signing of the aide memoire between the Ministry of Health and its development partners. Finally, he encouraged everyone to stay beyond the opening ceremony to contribute to the discussions in order to ensure a successful summit.

2.3 Overview of the summit

By Mr. Fidelis Dakpalah, Director PPME, Ministry of Health

In his presentation, Mr. Dakpalah gave a brief history of the health summits, which started in 1997 following the introduction of the sector-wide approach to health sector reform. The objectives of the summit are to discuss the findings of the independent review on the sector's performance, to identify key areas requiring special focus and to draft and adopt an Aide Memoire on the key decisions that have been taken.

He mentioned that the 2010 review process was peer-reviewed and incorporated significant inputs from the ministry and its agencies, including the holistic assessment, central and district level health outcomes, public financial management, governance, identification of best and worst performing regions, as well as multi-donor budget support indicators and triggers.

2.4 Address by Health Partners

By Dr. Daniel Kertesz, Health Partners' Lead and WHO Country Representative

In his speech, Dr. Kertesz emphasized the need to maintain focus on MDGs 4 and 5 by improving equity, particularly in neonatal and post maternal care, as well as strengthening health systems. He was concerned about the large unmet need for family planning and suggested that family planning commodities be included in the NHIS drug list. Reiterating the need for strong health systems, he suggested the need to create a think-tank to generate ideas to move from strategy to action. On the cholera outbreak, he said Ghana needs to focus on the socio-economic determinants of health. Finally, he informed the meeting that the UN General Assembly will organize a summit on non-communicable diseases soon.

2.5 Speech by Guest Speaker

By Dr Moses Adibo, Former Deputy Minister of Health

In his speech, Dr Adibo complained about the frequent changes in annual report formats and suggested that the MOH maintain a format for 5 years. On health information, he was worried about weaknesses in data validation and use for planning; and commenting on the cholera outbreak, he suggested the need to strengthen the public health systems. Dr. Adibo further expressed concern about the diminishing quality of training following the large intake into health training schools. Finally, he cautioned that the Community-based Health Planning and Services (CHPS) compounds should not be transformed into static clinics, because it defeats the purpose originally envisioned for CHPS.

2.6 Speech by Minister of Health

By Hon. Joseph Yieleh Chireh

The Hon. Minister of Health said that 2011 is a critical year for the health sector, since in four years, the sector would have to account for its performance towards achieving the MDGs. He said the difficulty of the sector was its inability to focus on priorities and this always leads to low performance. He, therefore, called for decentralization of the health care system, the need to address the socio economic determinants of health by engaging effectively with relevant MDAs and strengthening budgetary discipline. He directed that all institutional maternal deaths be audited.

Chapter 3 Independent review of the health sector

3.1 Background

An independent review of the health sector 2010 POW was conducted on behalf of the Ministry of Health (MoH) and development partners by a team of international and Ghanaian experts. The core members of the review team were Philip B. Adongo, Andreas Bjerrum, Leo Devillé (team leader) and Ruud van der Helm. Ghanaian members of the team, drawn from the Ministry of Health, Ghana Health Services, teaching hospitals and academia, were: Isaac Adams, Koku Awoonor-Williams, Georg Dakpallah, Daniel Darko, McDamien Dedzo, Henry Dusu, Kafui Kan-Senaya, Sally Lake, Frank Nyonator and Afisah Zakariah.

Koku Awoonor-Williams, Regional Director of Upper East region presented the overall findings whilst Andreas Bjerrum and Ruud van der Helm presented on the holistic assessment and public financial management respectively.

3.2 Holistic Assessment

The holistic assessment is a structured methodology to assess progress in achieving the objectives of the 2010-2013 POW and also serves as broad evidence for evaluating multi-donor budget support. Based on indicators and milestones specified in the POW, the assessment includes annually measured indicators and --when information is available-- survey indicators (e.g. under-five mortality rate and maternal mortality rate).

The 2010 holistic assessment scores the sector performance as ‘highly performing’, with a total score of 3+, though there is still scope for improvement and some key areas require urgent attention. Although the MOH has made considerable improvement to provide reliable data, challenges with data quality and completeness remain.

3.3 Service delivery

According to the review team the 2010 several service delivery indicators continued the positive trend documented in last year’s review. The coverage of supervised deliveries increased (now at 48%), institutional maternal mortality decreased and the average number of outpatient visits per capita continued previous years’ remarkable increase (now at 0.89 per capita). The cumulative number of patients on antiretroviral treatment also continued to increase. In contrast, coverage of EPI, antenatal care (ANC) and FP services experienced worrying negative trends that need further analysis and action. While three regions have been identified as regions excelling in selected key indicators in

2010 (Upper West Region for supervised deliveries and institutional maternal mortality (IMR); Eastern Region for Penta 3 coverage and family planning (FP) acceptance rate; and Western region for ANC and OPD per capita), Volta region is an outlier regarding many indicators and requires attention. Specific groups --discussed in the following four subsections-- were convened to discuss programme and geographic areas with poor performance.

3.3.1 Expanded Programme on Immunization

During the round table discussion, a number of reasons were given for the drop in EPI performance. Among the primary reasons stated were the erratic release of funds, weak supervision and monitoring, urban community apathy to immunization services and weak social mobilization. But the most important reason was unavailability of funds for activities in the first quarter, a crucial period for immunization activities. In the past, GAVI used to provide funds for immunization activities in the first quarter, a period when government allocations had often not been released. However, since GAVI stopped this assistance, EPI performance has been dropping.

Recommendations:

- MoH should engage the Ministry of Financial and Economic Planning and partners to improve early release of Sector Budget Support component of the funds
- The MoH and GHS should build capacity and provide resources for monitoring and supervision. Regions should do quarterly data validation and districts, monthly validation. Work to bring the private sector on board.
- The GHS should work with schools to ensure children are immunized before admitting them to school
- Districts should be assisted to better align their programmes with the national programmes, especially by receiving the programme interventions on time.
- The GHS should engage other sectors to assist in mobilizing for health.

3.3.2 Family planning

During the roundtable discussion the reasons given for the persistent drop in the FP acceptor rate are well known and include staff attitude (service provider bias), shortage of commodities, inadequate targeting of youth, socio-cultural reasons (myths and misconceptions, low reproductive rights of women) and cross cutting issues (e.g. competition for FP resources by HIV/AIDS, exclusion of FP from the National Health Insurance Scheme (NHIS) drug list, and limited scope for developing the natural FP methods). Some of the recommendations proposed by the group are:

- Train providers on customer care in line with service provision guidelines

- Involve the youth through the provision of youth user-friendly services.
- Intensify BCC particularly using testimonials from satisfied clients
- Involve men and the community
- Improve management of the service (timely reporting)
- Expand provision of the natural methods to cater for those who may prefer such methods
- Cover cost of services under the NHIS
- Consider FP as a developmental issue and allow for greater involvement of communities and other stakeholders

3.3.3 Antenatal care

Although the number of women attending the ANC at least four times during pregnancy continues to rise, the coverage of pregnant women who received at least one antenatal care visit dropped by1.6 % in 2009 to 90.6%, continuing the decline in 2008. No specific reasons are known to account for this drop; therefore, the drop in performance should be investigated carefully.

3.3.4 Volta region

A group analysed the rather poor performance in the Volta region, and concluded that although the region experienced the same systemic challenges like other regions, the most important factor accounting for the poor performance was incomplete data. Evidence from headquarters staff who visited the region during the annual performance review suggested that the region's performance has actually improved.

3.4 Governance

On central level governance, although the MOH has introduced some reforms in National Health Insurance Authority (NHIA) and established the inter agency committee, concerns were raised about conflicts in roles either between the ministry's agencies or between units within the ministry. For instance, there is the need to clarify the accreditation roles between the NHIA and the statutory regulatory bodies such as the Ghana Medical and Dental Council and the Nurses and Midwives Council. Further, the MOH has expedited efforts for the passage of many health bills, and it was suggested that in order to expedite implementation of the bills, the legislative instruments should be developed concurrently as used to be in the past.

At the district levels although the District Health Management Teams (DHMTs) that were surveyed had strong teams with active, skilled and motivated staff, governance challenges included a virtual split between the DHMT and the district hospitals, fragmented district plans and the threat of earmarked funding to the development of integrated programmes. It was suggested that there is the need to re-define the roles of district hospitals within the district health system, learning from experiences in the Ministry of Education. Leadership training would assist to build managerial capacity, but there is the need to strengthen regional and central oversight. Although it was generally

recognized that districts should have comprehensive plans to ensure optimum use of resources, there is the need to clearly define the scope of such plans – whether to limit it to the health sector or expand it to include health-related Ministries, Departments and Agencies (MDAs).

3.5 Financial management

According to the Independent Review Team (IRT), the MOH has strong financial management systems, in contrast to many ministries. However, like other ministries, funding gaps constrain the achievement of programme objectives and largely explains the perennial commodity shortages (e.g. family planning commodities and anti-retroviral drugs (ARVs).

Budget execution was described by the IRT as the "Achilles heel" of the MOH, with delays of 313 days sometimes. Learning from GAVI's assistance to the Expanded Programme on Immunisation (EPI) where funds were front-loaded to cover crucial activities in the first quarter, it was suggested that donors consider front-loading some funds to support programme activities during that period. Apart from this, budgetary indiscipline has been identified as an important problem which demands urgent attention.

3.6 Health information

Complete and reliable data is essential for planning, implementation and monitoring of programmes. During the discussion, shortage of ANC cards was identified as a critical obstacle to the delivery of antenatal care services, and weakness in data validation and analysis accounts for the perceived poor performance of Volta region. Participants emphasized the need to establish data validation teams at all levels, in addition to prioritizing funding for District Health Information Management System (DHIMS) II implementation.

Chapter 4 Plenary technical presentations

4.1 Sickle Cell Disease

Sickle cell disease and the attainment of the MDG 4 and 5 in Ghana by Dr. Sylvester Anemana, Acting Chief Director, Ministry of Health

Sickle cell disease (SCD) is caused by an abnormality of the haemoglobin, which leads to sickling of the red blood when oxygen concentration is low and results in complications such as haemolysis and circulatory obstruction. SCD is characterized by attacks of pain, tissue destruction, increased susceptibility to infections and a low life expectancy. Undiagnosed and untreated, 98% of children with Sickle Cell Disease–SS (SSD-SS) born in rural Africa would die by five years of age. In Ghana, prevalence of SCD among newborns is estimated to be 2% (24,000), and if diagnosed and untreated, it is estimated to contribute 23,500 deaths to the annual child mortality – an important issue for achieving MDG 4.

Newborn screening for SCD was introduced in Ashanti region of Ghana in 1993 by Professor Kwaku Ohene-Frempong in Kumasi (urban area) and Tikrom (rural area). The screening programme is managed by the Sickle Cell Foundation of Ghana (SFG), whose five administrative components are: Education and Counselling, Screening, Screening Laboratory, Clinical and Clinical Laboratory.

From 1995 to 2010, a total of 324,843 neonates were screened for SCD, about 2% of whom were found to have the disease and about 25-30% had traits of the disease. Fortunately, new technologies (pneumococcal and rotavirus vaccines) and the research finding that L-glutamine improves oxygen retention in red blood cells and minimizes sickling, offer bright future prospects for managing SCD.

Considering the high incidence of SCD (2%), the MOH has to develop strategies to reduce the contribution of SCD to deaths of children under-five in order to rapidly attain MDG 4 targets. Dr. Anemana suggested a number of policy and programme initiatives to help control the disease, including scaling up newborn screening, establishing SCD clinics in major hospitals, educating and counselling affected families, protecting affected children with vaccination (rotavirus, pneumococcal, etc.), giving ACTs for malaria and administering L-Glutamine.

4.2 Equity in health

Equity: Progress towards achieving MDGs in Ghana – Narrowing the gaps to meet the goals by Dr. Anirban Chatterjee, Country Representative, UNICEF

Presenting on the research, Dr. Chatterjee indicated that equity requires everyone to have the opportunity to access the same resources, and that the goal is to eliminate the unfair and avoidable circumstances that deprive children and women of their rights. Equity-focused programming is an approach to budgeting and service delivery, rather than a specific initiative or project.

The Government of Ghana has placed equity at the forefront of the Health Sector Medium Term Development Plan (HSMTDP 2010-2013). The GHS and UNICEF examined two issues: 1). Has access to health services become more or less equitable over the last decade? 2). If Ghana focused funding on the equity-based elements of the HSMTDP, what could be achieved? The Marginal Budgeting for Bottlenecks (MBB) tool was used to model the impact of the HSMTDP policy objectives, focusing on equity and in the context of maternal, neonatal and child health (mainly health strategic objectives HO1 and HO3 of the HSMTDP).

Ghana has made good progress in reducing under-five mortality since 2003, but each region is progressing differently and progress has benefited some income and age groups more than others. While preventive services such as ANC and EPI have become more equitable across socio-economic strata, the distribution of skilled delivery services is less equitable. Besides, households falling into the middle wealth quintiles – generally urban and peri-urban households – are an emerging "high risk" group that deserve special attention. Relatively equitable progress across wealth quintiles in ITN use for children and immunization coverage does not carry over to care-seeking for fever. Although good progress has been made in reducing underweight, acute malnutrition may be getting worse, especially in the middle quintiles with certain regions at substantially higher risk than the rest of the country (Central, Ashanti, Upper West, and Northern).

Focusing on the HSMTDP's equity-based strategies could enable Ghana to reach MDG 4 in all but the poorest parts of the country; the poorest parts would achieve ~70% of the target (a substantial acceleration). The equity-based portions of the HSMTDP represent just 25% to 30% of the total costs of the plan, leaving space in the budget for other priorities. They would, however, require fast action and some "strategic shifts" in the health sector. HSMTDP cost estimates forecast a large funding gap; therefore, evidence-based policy options are needed to make maximum impact with less spending.

One limitation of the study is that grouping large geographic areas could mask pockets of vulnerability, for instance, the urban poor. Besides, where there is absolute shortage of resources,

using equity-based interventions to shift resources would only create reverse inequality. Consequently, some participants suggested the need to further conduct small area analysis to inform policy. Another limitation is that data were largely from the 2008 Ghana Demographic and Health Survey (GDHS), yet intervention coverage has changed since then.

Ghana's progress in reducing poverty, hunger, and under-five mortality in the last decade has not touched all populations equally. The health sector should continue to track progress towards reducing health disparities on a regular basis. Ghana has proposed a number of viable, evidence-based strategies to reduce health disparities under the HSMTDP 2010-2013. These strategies should be prioritized to more effectively harness the potentially sizable and equitable impacts.

4.3 Community- based Health Planning and Services (CHPS)

CHPS – Impact on service delivery and health system development: The case of Upper East Region by Dr. Koku Awoonor Williams, Regional Director of Health Services, Upper East Region

This presentation described the CHPS implementation in Upper East Region, including coverage, challenges, innovations, inter-sectoral action and lessons learned. The CHPS initiative is aimed at providing basic health care at the community level with the full participation and support from community members. Conceived as a close-to-client service delivery system, the vision is to ensure that community-based services are made available and accessible to all Ghanaians who need it.

Initiated on the success achieved in the 1994 Navrongo community-based service delivery pilot, the CHPS strategy is a national health reform that mobilizes volunteerism, resources and traditional institutions to support community-based primary health care. By reducing geographic barriers to health care, the CHPS strategy enables the GHS to reduce health inequalities and promote equity of health outcomes.

Upper East Region remains the centre of excellence for CHPS in Ghana and has sustained effort to reduce health inequalities and become more responsive to client and community needs. The region has demarcated 188 CHPS zones, of which 91 are fully functioning, with coverage increasing from 24% in 2005 to 36.1% in 2010. However, there have been significant challenges, including lack of water supply in some CHPS compounds, inadequate CHPS compounds, poor state of some CHPS compounds, lack of security and inadequate logistics.

4.4 Emergency obstetric and neonatal care

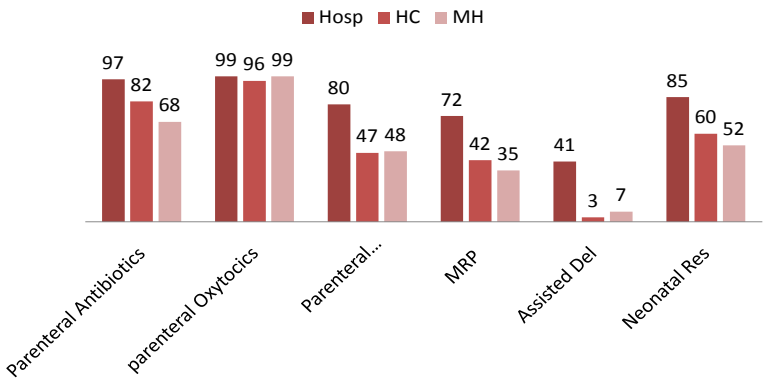
Dr. Patrick Aboagye, Deputy Director, Reproductive Health, Ghana Health Service

According to the World Health Organisation, emergency obstetric and neonatal care (EmONC) refers to the care of women and newborns during pregnancy, delivery and the time after delivery. Women in emergency situations must have access to EmONC as it is essential for saving lives.

A cross-sectional survey of 1271 private and public hospitals and clinics as well as health centres country-wide was done to assess their capacity for providing EmONC services. The rationale for the survey was to provide evidence for developing policies as well as implement and monitor the national strategic plans for achieving MDGs 4 & 5.

The study revealed that while 27% of hospitals offered comprehensive EmONC services and 2% of maternity homes offered basic EmONC services, none of health centres surveyed offered the basic services (Figure 1). From the study, 84% of the hospitals offered Caesarean Section while 76% offered blood transfusion services. Although 78% of facilities surveyed had partograph sheets, many participants wondered why most midwives, even when trained, were reluctant to use the partograph, often giving the excuse that most patients came in the second stage. Whereas some participants identified lack of skill in drawing a graph, others suggested heavy workload; therefore, the meeting agreed to conduct an exploratory study into the issue.

FIGURE 1 AVAILABILITY OF BASIC EMONC

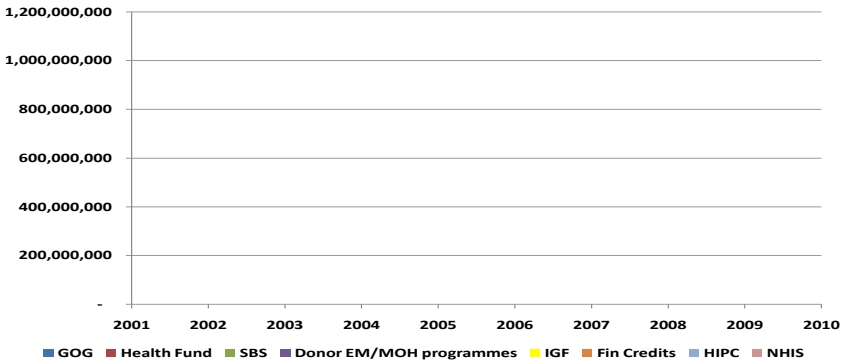


4.5 Utilization of Internally Generated Funds

Utilization of Internally Generated Funds by Fidelis George Dakpallah, Director, Policy, Planning, Monitoring and Evaluation Directorate, Ministry of Health

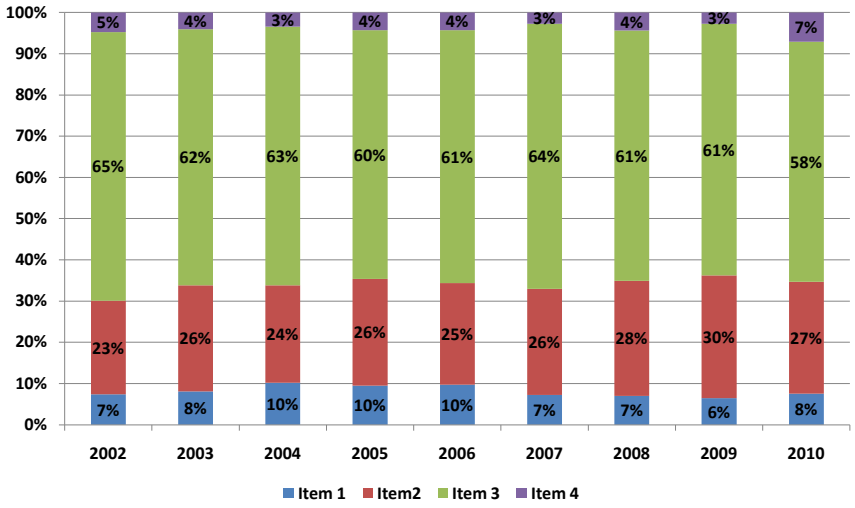
Internally generated funds (IGF) consist of fees for services (cash & carry) and reimbursements through the National Health Insurance Scheme (NHIS). Although all IGFs are formally considered as income generated on behalf of government, in practice, all public health institutions are entitled to retain them. Apart from improving access to care, the introduction of health insurance has mobilized considerable IGFs for health facilities (Figures 2). While district hospitals and lower level service providers seem to have revenues in excess of expenditure, tertiary facilities seem to be in perpetual indebtedness (i.e. their expenditure is greater than revenue). Contrasting with the non-drug component of the IGF, the 2010 independent review team observed large balances on the drug account, which is a ring-fenced, revolving fund used solely for drug procurement.

FIGURE 2 RELATIVE GROWTH OF IGF



It was suggested that part of the IGF be used to support district-wide activities; however, it was noted that the balances might not be real, given that the Regional and Central Medicals have been complaining about facility indebtedness. Giving a historical perspective, the Deputy Director of Ghana Health Service suggested the need to continue to ring-fence the drug account in order to avoid the costly expense of recapitalizing it. Nevertheless, the meeting agreed that there is the need to enforce the guidelines and ensure budgetary discipline, given the high expenditures on personal emolument, workshops and other non-direct service provision activities (Figure 3).

FIGURE 3 ANNUAL IGF EXPENDITURE, BY ITEM



4.6 Mobile technology and health

Mobile Technology for Community Health (MOTECH) by Dr Anthony Ofosu, Deputy Director PPME, Ghana Health Service

Mobile Technology for Community Health (MOTECH) is a partnership between Ghana Health Service, Grameen Foundation and Columbia University. Launched in July 2010 in Kassena-Nankana West District, and with plans to replicate in Awutu Senya district, the project aims to use mobile phones to increase the quantity and quality of antenatal and neonatal care in Ghana.

MOTECH consists of two interrelated mobile phone applications. MOTECH's Mobile Midwife service sends pregnant women weekly voice or SMS messages that provide time-specific information about their pregnancy. Messages contain guidance about how to stay healthy during pregnancy, practical advice such as how to prepare for delivery, information which addresses local myths and fun facts like foetal development milestones. Voice messages are in local languages and content is tailored to the specific challenges and beliefs of each region.

MOTECH's Nurses' Application enables healthcare workers to track care delivered to women and newborns. Each facility is equipped with low-end phones on which the MOTECH application is installed. Nurses enter data about clients' clinic visits into the application and send this to the coordinating unit. The MOTECH system checks patients' records against Ghana Health Service protocols for scheduled care. If the system identifies that a patient has missed an appointment, Mobile Midwife sends the client a message reminding them to go to the clinic. Meanwhile, nurses are alerted when their clients default for care so that they can follow up. MOTECH uses the submitted data to automate many of the nurses' monthly reports, saving time and increasing accuracy.

4.7 HIV/AIDS

Funding gap for ARV and PMTCT activities by Dr. Nii Akwei Addo, National Programme Manager, National AIDS Control Programme

The introduction of new WHO guidelines for Prevention of Mother to Child Transmission (PMTCT) and the revision of national targets for treatment (Table 2) have increased the funding gap for PMTCT (Table 3) in relation to existing resources. According to WHO, clients with a CD4 count of more than 350 are now eligible for prophylaxis while those with a CD4 count of less than 350 are eligible for full treatment. In addition, new guidelines have been developed on prophylaxis for pregnant women and treatment of infected infants.

TABLE 2 PMTCT SERVICE TARGET

	Year 1 OLD	Year 1 New	Year 2 Old	Year 2 New
Pregnant women tested	200,000	744,000	250,000	860,000
HIV+ pregnant women receiving ARV	4,000	22,800	2,500	24,940
Early infant diagnosis	150	22,800	250	24,940

TABLE 3 FUNDING GAP PMTCT

	Year 1	Year 2
Need	10,050,592	10,713,438
Funds assured	1,962,747	564,600
Gap	8,087,845	10,148,838

Discussing the issue at the roundtable, participants expressed concern about the absence of any dedicated government budget for HIV/AIDS treatment. Given the risk of over-dependence on a single funding source, the MoH should make provision for a dedicated and incremental budget for treatment complemented by donor funding. Although the health sector currently has severe funding gaps for most programmes, it is necessary to set aside this budget, however small, in order to maintain focus on HIV/AIDS treatment. In addition, preventive efforts such as public education on the disease should

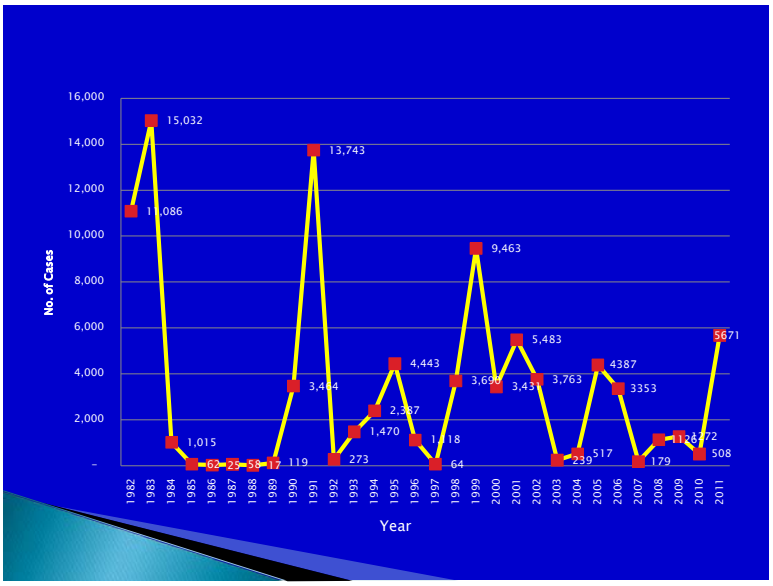
be intensified to reduce the number of new cases. Given that the MOH was unsuccessful with its Global Fund Round 10 proposal, it was suggested that a team be re-constituted to strengthen that proposal.

4.8 Cholera outbreak

Emerging health issues: update on cholera situation in Ghana by Dr. Joseph Amankwa, Director, Public Health, Ghana Health Service

Cholera is an acute bacterial enteric disease caused by *Vibrio cholerae* which is transmitted by contaminated food and water. Although case fatality in untreated cases ranges from 30% to 35%, if treated promptly and appropriately, it drops to less than 1%. Over the years, Ghana has been experiencing periodic outbreaks (Figure 4), particularly along the coast and in the rainy seasons. Starting in week 38 (September) of 2010 at Bawjiase in Awutu-Senya district of Central Region (Figure 5) and spreading to Eastern, Greater Accra, Upper West and Northern regions (Figure 6), the current outbreak has been fuelled by deteriorating waste management in the country, erratic supply of potable water, especially in urban and peri-urban areas, poor food and personal hygiene, and heavy and prolonged rain in 2010 which extended to 2011.

FIGURE 4 REPORTED CASES OF CHOLERA IN GHANA, 1987 TO MARCH, 2011



By 3rd April, 2011, a total of 6,187 cases had been reported in 32 districts with 79 deaths, registering a case fatality of 1.3%. Challenges to control of the current outbreak have been poor clinical and mass case management, as well as limited multi-sectoral action to address the risk factors that promote cholera transmission. According to Dr. Amankwa, in the short term, there is the need to strengthen surveillance and case management, intensify public education using multiple media and

involve communities in the control effort (e.g. limiting large public gatherings), but in the medium term, there is the need to improve waste management systems, food hygiene and supply of potable water. Finally, Dr. Amankwa informed summit participants about the outbreak of yellow fever in parts of the country: one confirmed case of Yellow fever was reported in Ledzekuku-Krowor municipality in Greater Accra region and two cases have been confirmed in Wa East district of Upper West region. A request has been made to ICG for reactive mass vaccination campaign.

FIGURE 5 SOME FINDINGS: BAWDWIASE ZONGO COMMUNITY

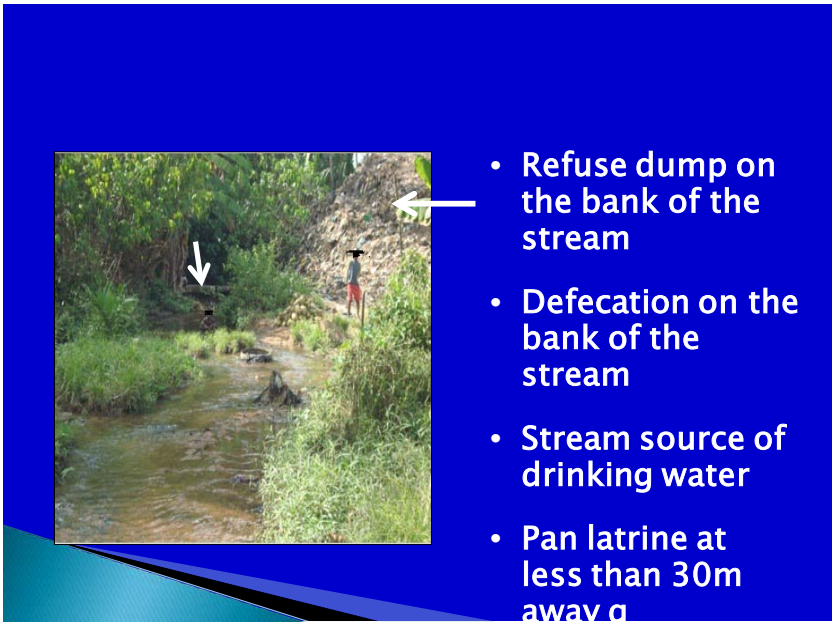


FIGURE 6 CHOLERA CASES AND DEATHS BY REGION, AS AT 3RD APRIL, 2011

Greater Accra	4,958	46	0.9
Eastern	611	9	1.5
Central	558	24	4.3
Upper West	8	0	0
Northern	52	0	0
National	6,187	79	1.3

Chapter 5 Parallel technical presentations

5.1 Emergency services

Current Status of Emergency Services in Ghana by Dr. Ahmed Zakariah, Director, National Ambulance Service

A medical emergency is a sudden unforeseen medical crisis (usually involving danger) that requires immediate action. Although Ghana has made progress towards achieving MDG 4, progress towards MDG 5 has been slower than expected. Delay in reaching a health facility contributes to high maternal mortality; therefore, improving access to appropriate health care services in emergency situations can greatly improve survival chances. The National Ambulance Service (NAS) seeks to address this issue, among others, at the community level.

A critical component of the health care system, designed specifically to handle time-sensitive health care emergencies, is the nation's Emergency Medical Services (EMS) system. EMS is a unique discipline at the intersection of health care, public health and public safety. The core components are: Care in the community/First Responder System, Pre-Hospital Emergency Care and Hospital Emergency Services.

The objectives are: 1) reduce delays in getting to a health facility; 2) reduce delays in getting appropriate health care; 3) make pre-hospital emergency services readily available to all those in need; 4) provide a continuum of care for emergency cases from site of emergency to health facility level; 5) increase the number of institutions with trauma care systems that maximize survival and functional outcomes of trauma patients and help prevent injuries; and 6) increase the number of districts that have implemented guidelines for pre-hospital and hospital emergency care.

Currently, challenges are: 1) lack of adequate ambulances in the community; 2) lack of adequate technical staff to handle emergency cases both at pre-hospital and hospital levels; and 3) financial constraints, including the cost of transporting emergency cases.

Looking forward, NAS will: 1) procure more ambulances to increase the fleet of ambulances; 2) train more technical staff to handle emergencies; 3) build capacity of staff, and provide adequate resources for institutions to handle emergencies; 4) capture pre-hospital care under the NHIS; 5) make referral patterns bi-directional so that patients in larger facilities can be referred back to lower facilities to continue care; and 6) strengthen cooperation at the levels of pre-hospital and hospital emergency care systems to help achieve MDGs 4 and 5.

5.2 Health Infrastructure

Country Status Report on Health Infrastructure Management Mr P. K. Mensah

During January-March 2011, an independent expert team conducted a review of infrastructure management in Ghana, assisted by a dedicated technical sub-committee. This infrastructure review is part of the Country Strategy Report (CSR) that describes the current status of the health sector. Other studies carried out in the context of the CSR include the following domains: human resources development, private sector development, decentralization, pharmaceutical sector, Ghana health commodities supply and security systems review, and health economics and financing (in progress).

The infrastructure management review focused on: 1) health services planning and financing of the capital investment programmes; and 2) the management of infrastructure programmes and projects. The situation analysis included a broad historic overview of relevant development, with specific attention for the current Capital Investment Plan III (2007-2011). Furthermore, the review focused on the management of infrastructure projects: buildings, equipment, transport and ICT. Existing data related to health services planning and the financing of capital plans were analysed to describe future scenarios for priority setting. Specific recommendations were provided with regard to infrastructure management.

After the development of the Hospital Strategy in 2001, relevant infrastructure investments have been made in the Ghanaian health sector. During the review, available data on bed capacity and bed utilization were analysed to assess their evolution. Available data show that average bed capacity is rather favourable, both currently as well as for the next 5-10 years. Although hospital efficiency indicators show an upward trend, especially after 2006, there are opportunities for efficiency gains in the utilization of beds. This, however, requires that current imbalances in service delivery be adequately addressed. Available data suggest that the primary care uptake at the sub-district level is lagging behind. From the health services planning point of view, priority should be given to investments at the sub-district level.

Financial analysis of capital investments shows that there has been consistent under-performance of reported capital expenditure against budget in recent years. Furthermore, there has been an increased reliance on use of Financial Credits and other Earmarked Funds to develop new infrastructure on turnkey project basis; this was 73% of reported capital expenditure in 2010.

Assumptions on available funding (optimistic scenario) for the Health Sector Medium Term Development Plan (2010-2013) are difficult to realize. Fiscal space analysis assumes an 18% annual

increase in sector funding as of 2011. It also assumes an increase in the relative share for capital investments in the public health budget (15% in 2009, to over 40% in 2013).

This report suggests that efficiency gains could be achieved, for example, by:

- Establishing efficient public-private partnerships with CHAG and the for-profit sector, to ensure that available resources are optimally used;
- Shifting human resources to the primary care level, not only at the level of health centres, but also at the community level (CHPS expansion);
- Strengthening the 'gatekeeper' function of the system; and,
- Identifying and securing new sources of funding for infrastructure investments in primary care

Shifting future investments during the next years towards strengthening sub-district health services, especially health centres. This scenario is consistent with the priorities as described in the HSMTDP 2010-2013 (Costing Exercise of September 2010).

5.3 Private health sector

The private sector contribution to health service provision across Africa by Samuel Akyianu

The private sector's contribution to health service provision across Africa continues to grow, and according to McKinsey's 2008 study funded by the International Finance Corporation (IFC), the private sector contributes more than 50% to service provision; nevertheless, the sector is constrained by limited access to funding and customized advisory services.

The Health in Africa Initiative Market Survey series is part of IFC's activities to support the development of private healthcare with the goal to improve access to quality healthcare in Africa. The survey builds on the broader McKinsey "Red Book" study and aims to deepen understanding for country-specific issues related to the contribution of the private health sector to healthcare delivery and the financing and advisory service needs of the private health institutions (PHIs).

The survey was conducted in Accra, Kumasi, Sekondi-Takoradi and Tamale. Questionnaires were administered to a sample of 65 PHIs, including hospitals, clinics, pharmacies, pharmaceutical distributors and manufacturers, medical laboratories and diagnostic centres, health training institutions, maternity homes, herbal clinics and health insurance companies. Interviews were also conducted with six financial institutions. In addition, Deloitte held stakeholder discussions with the key regulatory agencies and stakeholders in the health sector.

From the study, the total financing needs of the PHIs surveyed is US$21.3 million. From this estimate, and based on a combination of what is bankable and national numbers of PHIs, approximately US$116.8 million is the national projected bankable need. The survey revealed lending by Financial Institutions ("FIs") to the private health sector is very low, with their portfolios showing an average of 1% exposure to the sector. IFC is negotiating with FIs to explore lending to the private health sector and plans to launch a program for both advisory and financial support to PHIs.

5.4 Implication of Aflatoxins

Challenges and health implication of mycotoxins by Prof Nii-Ayi Ankrah

Aflatoxin (Af) is one of the mycotoxins formed naturally by moulds in food. Toxic to humans and animals, Af affects health, reducing animal performance and causing substantial economic losses. Human exposure to Af at 2000ppb or more for a few days results in acute Af poisoning (aflatoxin mycotoxicosis), resulting in death primarily from liver failure. However, sustained Af exposure at relatively lower Af levels results in chronic Af poisoning, though this is largely unreported because it has no clear symptoms. In Ghana, human exposure to Af continues to be high (exceeds internationally permissible level of 20ppb).

Chronic Af poisoning is characterized by oxidative stress, which has been shown to cause liver inflammation and biliary damage. Moreover, in the presence of Hepatitis B virus infection, Af increases human liver cancer risk by six-fold. Chronic Af poisoning has significant adverse effect on human nutrient and immune systems, which could impede intervention strategies such as Primary Health Care programs to improve health and thus play important role in the sub region's poor health status as reported in the WHO world health Disability-adjusted Life Years (DALYs). It is in the interest of sub-Saharan African countries to recognize Af poisoning as a major impediment to promotion of health and take steps to reduce human exposure to this toxin.

Controlling human Af exposure and improving water safety, sanitation and health care in other areas of the world has yielded positive health outcomes. Discovery of NovaSil, a safe clay-based enterosorbent raises hope for a feasible intervention strategy to reduce Af bioavailability and eliminate Aflatoxin poisoning's negative effect on public health. In Ghana, there is a critical need to reduce human exposure to Af by strengthening the regulatory oversight of the Food and Drug Board in setting standards and monitoring Af levels as well as assist the Nutrition Division and Health Promotion units of GHS to integrate Af issues into their programmes. However, the messages should be packaged appropriately to avoid panic.

Chapter 6 Poster presentations

6.1 Guinea worm

Ghana Guinea Worm Eradication Programme: Current Status, Dr. Seidu Korkor, Guinea Worm Programme Manager, Ghana Health Service

At the World Health Assembly (WHA) in 1988, the global initiative to eradicate Guinea worm disease, Resolution 1988, was launched which set the tone for the Ghana Guinea Worm Eradication Programme (GGWEP). In response to this initiative, Ghana's health authorities conducted a national case search during 1988-1989 to determine the extent of the problem. The survey revealed a total of 179,556 cases from 6,515 endemic villages in the whole country; consequently, the Ghana Guinea Worm Eradication Programme was established to lead the eradication effort.

As a collaborative effort between the Government of Ghana and some major development partners, the programme is co-led by the Ministry of Health and Ghana Health Service with financial, technical and logistical support from The Carter Center, the WHO, UNICEF and other development partners such as JICA, the European Union and NGOs in the water sector. The Ministries of Water Resources, Works and Housing, Local Government, Rural Development and Environment, and Agriculture and Education are some of the MDAs collaborating in the eradication effort.

Relying on a cadre of village-based volunteers for surveillance, case management, education, filter use and vector control, the programme has reduced the annual incidence from nearly 180,000 in 1989 to 8 in 2010. During the last 5 years, interventions were intensified through the introduction of case containment centres, "soka" pumps, and social mobilization/education supported by eminent Ghanaians such as Miss Ghana 2005 and famous musicians. Enforced through laws, dam guards were deployed in collaboration with Ministry of Local Government and Rural Development (MLGRDE) and the National Disaster Management Organisation (NADMO) to prevent water contamination, and under the GOG/EU/UNICEF project, community water services have been expanded to Guinea worm endemic villages.

The last uncontained case was 17 months ago in October 2009, while the last reported indigenous case was 10 months ago in May 2010. Indeed, Ghana is on the verge of breaking transmission of the disease after twenty-two (22) years though there have been a few interruptions in programme activities as a result of ethnic conflicts, health reforms and break downs in water infrastructure. It is our hope that in July 2011, we will officially declare transmission broken, 14 months after the last indigenous case was reported.

6.2 Uterotonic substances

Perceptions, Knowledge, Use and Quality of Uterotonic Substances in Ghana by Patience Cofie, Alissa Koski and Ellie Mirzabagi

This research was undertaken to explore the perceptions, knowledge and attitudes of community members and health providers regarding the use of uterotonic substances during pregnancy and childbirth, and to assess the availability and chemical potency of oxytocin and ergometrine in three regions in Ghana.

Administration of a uterotonic agent immediately following childbirth is highly effective at reducing the risk of postpartum haemorrhage (PPH), a leading cause of maternal death worldwide. Efforts are underway to test expanded use of pharmaceutical uterotonics at the peripheral level. Evidence from some studies indicates that access to uterotonic drugs at the community level may be associated with unsafe use of these drugs for labour induction and augmentation. However, little is known about the use of biomedical uterotonic drugs to induce or augment labour in the home setting.

In-depth interviews were conducted with 210 participants, consisting of health providers and mothers across three districts in Ghana. A simulated client approach was used to assess the availability of pharmaceutical uterotonics to the public. Samples of oxytocin and ergometrine collected via this activity were also tested for chemical potency.

Results indicate that cross-over between traditional and allopathic health systems is common in Ghana, and that to ensure smooth delivery, pregnant women will often use both traditional and allopathic substances believed to have an uterotonic effect throughout pregnancy and during labour. Traditional Birth Attendants (TBAs) and mothers are unaware of associated risk.

Results of the simulated client research indicate that pharmaceutical uterotonics are available to the public from both public and private sources. Despite policies requiring a prescription for purchase of these substances, research assistants were able to purchase both oxytocin and ergometrine from a variety of sources without prescription. No evidence of community-based use of pharmaceutical uterotonics was found during this research.

There is need for ongoing monitoring to ensure safe and appropriate use of uterotonics. A behaviour and social change program should be carried out to minimize the increasing expectation that traditional preparations are necessary to facilitate smooth and timely labour, and create awareness about associated risk for both mother and baby. Further, market surveillance and testing of drug quality is warranted.

6.3 Impact of oil and gas on health

Strategic Health Impact Assessment (HIA) and the Oil and Gas Development in Ghana

Dr. Edith Clarke, Programme Manager, Occupational & Environmental Health, Ghana Health Service

The health impacts of large scale development projects such as oil and gas are often considerable and predominantly affect the weakest segments of society, i.e. poor women and children living and working close to extractive industry operations. At the same time, such projects can generate significant and tangible health benefits if investments in local health services (including those by the private sector) are aligned with the health sector's development plans.

As drilling of the substantial reserves of oil and natural gas progresses off the western shores of Ghana, the health sector needs to plan for and develop an appropriate governance structure to deal with health impacts that inevitably ensue from social, demographic and environmental changes that accompany the development.

As a first step to introducing a governance framework, a sectoral, strategic, Health Impact Assessment (HIA) should be done to provide an overall understanding of the wider public health and health systems issues likely to be impacted by the oil and gas development activities. The results of the HIA will among others be used to inform the development of a strategic health management plan and a related monitoring and reporting system. This will inform subsequent investment activities and indicate which core capacities and systems will be needed.

Chapter 7 Summit evaluation

The purpose of the evaluation was to assess the effectiveness of the summit in order to draw lessons for improving future summits. Questionnaires were administered to participants at the close of the first and second days. While 58 participants completed the form on the first day, 61 did so on the second day. The questions asked in the evaluation tool were:

1. What did you like most about the day's programme?
2. What did you like least about the day's programme?
3. How can the day's programme be improved?

The responses from the participants are summarized below according to content, organization, time management, group work, as well as accommodation and meals.

Content

While most participants found the presentations relevant and the delivery good, a few complained that some presentations were either not legible or contained too many jargons and abbreviations. Other participants complained that the presentations were biased towards the public sector and public health.

Organization

Most participants indicated that the summit was generally well-organized.

Group work

Whereas most participants found the group work interesting and interactive, a few complained about the large number of groups. A few also complained that the group work should have been facilitated by technical experts.

Time management

Time management was the issue raised most by participants. While most participants complained about the late start and closure of the meeting on the first day, a few complained that the discussion times were short. Also, some chairpersons did not manage the time properly; as a result some presenters exceeded the time allotted.

Accommodation and meals

Unlike the previous year's evaluation no participant complained about the venue, though a few complained about inadequate cups during the snack breaks.

Participation

Most participants felt that participation was broad enough, though some were unhappy that few people from the operational level participated in the summit.

Participants' suggestions to improve future summits

1. Reduce the number of presentations in order to have more time for group discussion
2. Give adequate orientation to the chairpersons on time management and identify an individual to give cues during sessions
3. Identify people with relevant knowledge of the issues to facilitate group discussions
4. Inform presenters to explain abbreviations and avoid jargon in their presentation.

Chapter 8 Conclusion and recommendations

The bi-annual health summits have become important fora for reviewing health sector performance and proposing policies and programmes to improve the nation's health. Drawing on a large number of participants from the ministry, its agencies, the private sector as well as other ministries, departments and agencies, the 2011 April summit has provided some insights into the underlying reasons for the poor performance in programme areas such as the Expanded Programme on Immunisation, Antenatal Care, and in the geographic area of Volta region. Enriched by technical and poster presentations as well as roundtable discussions, this summit has drawn attention to existing and emerging health problems such as cholera, aflatoxins and sickle cell disease. Nevertheless, like all meetings, the summit should continue to evolve in order to more effectively achieve its objective of strengthening health policy dialogue in addressing Ghana's health problems.

Recommendation to improve the sector's performance

- MoH should engage the Ministry of Financial and Economic Planning and partners to improve early release of Sector Budget Support component of the funds
- The MoH should procure ANC cards in order to improve the delivery of antenatal care services. In addition, a study should be conducted to explain the drop in ANC performance between 2008 and 2010.
- The GHS should prioritize funding for District Health Information Management System (DHIMS) II implementation as well as establish data validation teams at all levels.
- There is the need to strengthen surveillance and case management, intensify public education using multiple media and involve communities in the control of cholera.
- Although it is necessary to continue to ring-fence the drug component of the IGF, there is the need to strengthen budgetary discipline in the management of IGF.
- Previous independent reviewers' reports have identified many of the issues reported on the 2010 POW; therefore, there is the need to speed up implementation of recommendations in order to minimize repetition of the same issues over the years.

Recommendations to improve future summits

- A number of important studies have been done which could have enriched the review, but these were not made available to the review team. Therefore, the MOH should put together relevant literature prior to the review.

- Although the MOH has made commendable effort to broaden participation by all key stakeholders in the health summit, some participants felt that the summit presentations

focused almost exclusively on the Ghana Health Service. It is suggested that the MOH invite other partners, especially in the private sector to make presentations at the summit.

- The purpose of the April summit is to assess the sector's performance in achieving the previous year's POW. Therefore, after the independent review team (IRT) has debriefed the MOH and its agencies, the summit planning committee should build consensus on the key issues for discussion at the round table meetings. It would be desirable for heads of programmes or regions where key problems have been identified to make presentations to the summit to explain the performance gaps.

- A draft standard operating document has been developed, but so far only development partners have submitted comments on it. There is the need to build broad consensus on the draft document among the MOH and its agencies in order to foster broader ownership.

References

Aide Memoire, Joint Ministry of Health - Partners Business Meeting, GIMPA, Accra, 16th to 18th November 2009

Ministry of Health, Independent review of the health sector programme of work 2009

Ministry of Health, Independent review of the health sector programme of work 2010

Appendices

Appendix I: Summit programme

Day 1, Monday 11th April 2011

08.00	**Arrival and Registration**
Session 1:	**Opening Ceremony: Chairperson**
08.30	Arrival of Dignitaries
09.00	Opening prayer by Mr. Herman Dusu, Financial Controller, MOH
09.05	Introduction of the chairperson and other Dignitaries by Dr. Maureen Martey, Head, Private Sector Unit, PPME/MOH
09.15	Chairperson's response
09.20	Welcome address by Dr. Sylvester Anemana, Acting Chief Director, MOH
09.30	Overview of summit by Mr. George Fidelis Dakpallah, Director, Policy Planning Monitoring and Evaluation, MOH
09.45	Address by Health Partners' Representative: Dr. Daniel Kertesz, Health Partners` Lead
09.55	Address by Guest Speaker : Dr. Moses Adibo, Former Deputy Minister of Health
10.10	Key note address by Minister of Health, Hon. Joseph Yieleh Chireh (MP)
10.30	Chairman's closing remarks
10.40	Vote of Thanks by Dr. Afisah Zakariah, Head, Monitoring and Evaluation, PPME, MOH
10.45	Refreshment Break
Session 2:	**PLENARY TECHNICAL PRESENTATIONS**
	Chairperson: Prof. Ofori Adjei, Ag. Rector, College of Physicians and Surgeons
11.00	Introduction of Chairperson by MC
11.05	**Presentation 1 - Holistic Assessment**
11.40	Plenary Discussions

12.00	**Presentation 2 – 2010 Independent Review of the Health Sector**
12.40	Plenary Discussions
13.00	Lunch Break
Session 3:	**GROUP DISCUSSION**
14.15	Introduction to group discussion - Plenary
14.30	Round table discussion
15.30	Plenary Discussion
16.50	**Presentation 3: Emerging Health Issues: Update on cholera situation in Ghana** by Dr. Joseph Amankwa, Director Public Health, GHS
17.10	Plenary discussions
17.25	Chairperson's closing remarks
17.30	Closing

Day 2, Tuesday 12th April 2011

08.30	Registration
Session 4:	**PLENARY TECHNICAL PRESENTATIONS**
	Chairperson: Dr. George Amofah, Deputy Director General, GHS
09.00	Introduction of chairperson by MC
09.05	**Presentation 4 – Equity: Progress towards achieving MDGs in Ghana, narrowing the gaps to meet the goals** by Dr. Frank Nyonator, Director, Policy Planning Monitoring and Evaluation, GHS/Dr. Anirban Chatterjee, UNICEF
9.50	Plenary Discussions
10.20	**Presentation 5– Community-Based Health Planning and Services (CHPS) and its impact on service delivery, the case of the Upper East Region by** Dr. Koku Awoonor Williams, Regional Director of Health Services, Upper East Region
10.40	Plenary Discussion
11.00	Refreshment Break
Session 5:	**PARALLEL TECHNICAL PRESENTATIONS**

Chairperson: Dr. Gilbert Buckle, Executive Secretary-CHAG

11.30 **Parallel Presentations**

12.30 Plenary-observations from parallel session

13:20 General Discussions

13.40 Lunch

Session 6 **PLENARY TECHNICAL PRESENTATIONS:**

Chairperson: Mr. Sylvester Mensah, CEO, National Health Insurance Authority

14.30 **Presentation 6 – Mobile Technology for Community Health (MOTECH)** by Dr. Frank Nyonator, Director, Policy Planning Monitoring and Evaluation, GHS

15.00 Discussions

15.30 Mobility Break

16.00 **Presentation 7 – Utilisation of Internally Generated Funds (IGF)-a rapid appraisal** by Mr. George Fidelis Dakpallah, Director, Policy Planning Monitoring and Evaluation, MOH

16.30 Discussions

17.30 Closing

Wednesday 13th Aril 2011

9.00 Business Meeting

Thursday 14th April 2011

09.00 Drafting of the Aide Memoire

Friday 15th April 2011

15.00 Signing of the Aide Memoire

Summit presentations

	Topic	Brief outline of presentations	Presenter
	Plenary Presentations		
Presentation 3	Emerging Health Issues: Update on cholera situation in Ghana	Update on cholera situation in Ghana	Dr. Joseph Amankwa
Presentation 4	Equity: Progress towards achieving MDGs in Ghana, narrowing the gaps to meet the goals	Findings of a study that looked at the progress made towards achieving the health -related MDGs	Dr. Frank Nyonator/Dr. Anirban Chatterjee
Presentation 5	Community-Based Health Planning and Services (CHPS) and its impact on service delivery the case of the Upper East Region	Brief situational analysis, including current coverage, its contribution to service delivery, challenges, innovations, inter-sectoral action, etc.	Dr. Koku Awoonor Williams
Presentation 6	Mobile Technology for Community Health (MOTECH)	Mobile Technology for Community Health (MOTECH) is a project that aims to use mobile phones to increase the quantity and quality of antenatal and neonatal care in Ghana.	Dr. Frank Nyonator
Presentation 7	Utilisation of internally generated funds (IGF)-a rapid appraisal	With the advent of the NHIS, more monies are coming into the health sector. This presentation looks at how internally generated funds are being managed and seeks to chart a new course in ensuring a more prudent management of such a resource.	Mr. George Fidelis Dakpallah
	Parallel Presentations		
1.	Challenges and health implications of mycotoxins in Ghana	Despite efforts to reduce neonatal deaths in Ghana, the number of still births remains high. A recent study has identified mycotoxins as other causes of still birth in Ghana and the need to share the findings with participants.	Prof. Nii-Ayi Ankrah
2.	Current Status of Emergency Services in	Discusses the current status of emergency services in the country, including challenges and way	Dr. Ahmed Zakariah

	Ghana	forward.	
3.	CSR (infrastructure)	Discusses findings of the infrastructure component of the country status report.	Mr. P.K. Mensah
4.	Financing needs of the private sector: A Market survey of the private sector.	Looks at the financing needs, and contribution of the private sector. Also identifies financial institutions interested in providing financial support to the sector.	Mr. Samuel Akyianu,
5	Non communicable Disease control: the case of sickle cell disease	About 2% of all children born in Ghana have sickle cell. The presentation seeks to look for ways of addressing this.	Dr. Sylveste Anemana
		POSTER PRESENTATIONS	
1.	HMIS Improving information management, the human factor	Discusses how the personnel attitude, knowledge and behaviour that influence the management of our health information management system.	Dr. Kofi Issah
2.	Anti Microbial Resistance	No description(need to be consistent With others).	Professor J. Mercy Newman
3.	Status of the Guinea Worm eradication programme	Discusses the status of the Guinea Worm eradication programme and how the successes chalked can be sustained.	Dr. Seidu Korkor
4.	Water and Food safety in public health	Presents findings of a study on food poisoning.	Mr. Odame Darkwa
5.	Strategic Health Impact Assessment (HIA) and the Oil and Gas Development in Ghana	A strategic HIA of the oil and gas sector was done in Ghana to provide an overall understanding of the wider public health and health systems issues likely to be impacted by the oil and gas development activities.	Dr. Edith Clarke

Appendix II List of Facilitators

1. DR. KOBINA. ATTA. BAINSON (lead)
2. MRS. VERONICA DAAKU
3. MRS. PATRICIA AGYEIWAA
4. MRS. THEODORA ACQUAH
5. MR. KURT KRAUSSE
6. MR. KWAME QUANDAHOR
7. DR. L. K SENAYA
8. DR. YAW OFORI IYEBOAH
9. DR. JOSEPH NUERTEY
10. MRS. SOPHIA KESEWA AMPOFO KUSI
11. DR. JOAN AWUNYO-AKABA
12. MR. SALASSI AMAH D'ALMEIDA
13. DR. ERASMUS YAO KLUSTE
14. MS. ALSWELL AFFULBA APPIAH
15. MRS. SIADEY M. W TORGBENU
16. MRS. NACY EKYEM
17. MR. KENNETH KELL ESSUMAN
18. MRS. GLADYS TETTEH – YEBOAH
19. MR. EMMANUEL OWUSU –ANSAH
20. MR. DANIEL DEGBOTSE
21. MR. GEORGE AWUYA