DRAFT

THE GHANA HEALTH SECTOR 2006 PROGRAMME OF WORK

Ministry of Health
October 2005

ACRONYMS

ACT	Amodiaquine-Artemisinin Combination
AFP	Acute Flaccid Paralysis
ANC	Antenatal Care
ART	Anti-Retroviral Therapy
ARV	Anti-Retroviral
ATF	Accounting, Treasury & Financial
BPEMS	Budget Planning Expenditure
BMCs	Budget Management Centres
CAGD	Controller & Accountant General's Department
CAM	Complementary Alternative Medicine
CHAG	Christian Health Association of Ghana
CHOs	Community Health Officers
CHPS	Community Health based Planning & Services
CSRPM	Centre for Scientific Research into Plant Medicine
CSO	Civil Society Organisation
CMA	Common Management Arrangement
CMS	Central Medical Stores
CWC	Child Welfare Clinic
CWIQ	Core Welfare Indicator Questionnaire
DA	District Administration
DHMTs	District Health Management Teams
DOTS	Directly Observed Treatments
DPT3	Diphtheria Pertussis Tetanus
EOC	Essential Obstetric Care
EPI	Expanded Programme on Immunization
FDB	Food & Drugs Board
5YPOW	5 Year Programme of Work
GAFTRAM	Ghana Federation of Traditional Medicine Practitioners
GHS	Ghana Health Service
GNFS	Ghana National Fire Service
GOG	Government of Ghana
GPRS	Ghana Poverty Reduction Strategy
GMP	Good Manufacturing Practices
HepB Hib	Hepatitis B
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune-Deficiency Syndrome
HIPC	Highly Indebted Poor Country
ICC	Interagency Coordinating Committee
ICT	Information Communication Technology
IDSR	Integrate Disease Surveillance
IGF	Internally Generated Fund
IMCI	Integrated Management of Childhood Illnesses

IPT	Intermittent Preventive Treatment
ITNs	Insecticide Treated Nets
IPR	Intellectual Property Rights
LAN	Local Area Network
MDAs	Ministries, Departments & Agencies
M & E	Monitoring & Evaluation
MOH	Ministry of Health
MOE	Ministry of Education
MOI	Ministry of Information
MTEF	Medium Term Expenditure Framework
NA	Not Available
NADMO	National Disaster Management Organisation
NCD	Non Communicable Diseases
NDPC	National Development Planning Commission
NGOs	Non Governmental Organizations
NHIC	National Health Insurance Council
NHIS	National Health Insurance Scheme
NIDs	National Immunization Days
OHCS	Office of Head of Civil Service
OPD	Out Patient Department
PA	Procurement Agency
PHC	Public Health Care
PLWHA	People Living With HIV/AIDS
PMCT	Prevention of Mother to Child Transmission
PPM	Planned Preventive Maintenance
PSC	Public Sector Commission
RBM	Roll Back Malaria
RH	Reproductive Health
RHMTs	Regional Health Management Teams
S.A.F.E	Skilled Attendance For Everyone
STI	Sexually Transmitted Infections
TB	Tuberculosis
TBA	Traditional Birth Attendant
THs	Teaching Hospitals
TM	Traditional Medicine
TT	Trichiasis
VCT	Voluntary Counselling Testing
WAN	Wide Area Network
WHO	World Health Organization

MESSAGE FROM THE MINISTER

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1. INTRODUCTION

2. SERVICE DELIVERY

Health services will include promotive, preventive, curative and restorative as well as rehabilitative activities. There is general consensus that most of the interventions needed to make an impact exist and that what is needed is to make these interventions universally available. Health services therefore aim at scaling up the delivery of priority health interventions delivered through community based activities and the use of combinations of CHPS compounds, outreach services health centres and hospitals. The key health interventions are shown in the box below:

SERVICE DELIVERY

- **Priority Health Interventions**
  - Health Promotion
  - Nutrition
  - Controlling Communicable Diseases
  - Preventing and Controlling Non Communicable Diseases
  - Improving Reproductive Health
- **Access and quality of health services**
  - Institutional Care
  - Child Health
  - Accident and Emergency Services
- **Traditional Medicine**

2.1 Priority Health Interventions

2.1.1. Health Promotion

There is evidence that so-called diseases of life style/affluence - obesity, diabetes, hypertension, alcohol related diseases etc, - are on the increase. There is further evidence that changes in dietary habits, physical activity and tobacco control could lead to rapid changes in population risk factors and prevalence of these diseases.

Over the years the health sector has developed a policy framework for occupational health and safety and in 2004 finalised a Health Promotion Policy. The sector has been faced with inadequate health promotional activities aimed at making individuals and households responsible for their health and to demand health services. This is due partly to inadequate resourcing of the health promotion unit. There is also the challenge of improving health communication strategies to address the ever increasing trend of non-communicable diseases.

In 2006 health promotion will focus on strategies to enable individuals and households to make the right choices about healthy lifestyles. These would involve the use of multiple strategies including behavioural change communication (BCC), building public health polices, creating supportive environments, strengthening community actions and promoting inter-sectoral collaboration for health. The aim of this component will be to promote healthy lifestyles to reduce common biological and behavioural risk factors such as overweight, high blood pressure, tobacco use, excessive consumption of alcohol and unhealthy diet characterized by low consumption of fruits and vegetables and physical inactivity.

The priority activities are to:

- Develop a strategic framework for promoting health in schools, work places and communities
- Embark on BCC to promote health and relevant disease control interventions
- Strengthen monitoring, supervision and reporting on Health Promotional activities
- Disseminate the Health Promotion Policy
- Strengthen the Health Communication Resource Centre

Expected Outputs

- Framework for evidence based communication strategy developed
- Communication strategies for new priority health intervention developed with special focus on NCD, Occupational health and sanitation
- Framework strategy for promoting health in schools, work places and communities developed

2.1.2 Nutrition

Malnutrition is a major risk factor for diseases and death in Ghana It manifests as under-nutrition (stunting and underweight) in children, micro-nutrient deficiency such as iodine deficiency and iron deficiency anaemia in pregnant women, Vitamin A deficiency, and over nutrition. Malnutrition is estimated to be an underlying cause of up to 50% of mortality in children less than five years. Yet levels of malnutrition (both stunting and underweight) in children have not changed significantly in the last five years in Ghana. Malnutrition is also higher among lowest wealth quintile and in rural areas thus linking it to poverty. It is therefore unlikely that the country will make much progress in reducing under-five mortality rate unless malnutrition in children is addressed. Malnutrition is also known to be prevalent among women and girls, and has been identified as a major contributory factor to high maternal morbidity and mortality. A nutritional survey in Northern Ghana for instance, found that 69% of pregnant women have iron deficiency anaemia. Additionally, iodine deficiency disorders are prevalent, affecting over 30% of the population in the iodine deficiency zones.

So far a number of initiatives including promoting exclusive breastfeeding, de-worming of children and reducing micronutrient deficiencies through salt iodisation and vitamin A

distribution have been implemented. Vitamin A Supplementation (VAS) achieved a national coverage of 98. 6 percent ranging from 85.6 in Upper East to over 100 in Greater Accra Region in 2004. Policy and guidelines on supplementation to lactating women have been disseminated to regions.

However a lot more remains to be done. The main challenges facing the sector with regards to nutrition includes the limited scope for nutrition interventions at the community level, inadequate weighing scales in the system, lack of enforcement of Food and Drugs Amendment Act 1996, Act 523, lack of appropriate & inexpensive iodisation equipment for small scale salt producers, institutionalization of VAS to children as part of routine service provision, non implementation of food fortification strategy and amendment of food fortification law to cover other foods.

In 2006 the sector will scale up the above mentioned interventions and implement the 'Imagine Ghana Free of Malnutrition' strategy with special focus on community based nutritional interventions.

The priority activities are to:

- Disseminate and undertake continuous advocacy for Implementation of the 'Imagine Ghana Free of Malnutrition' strategy
- Procure and distribute weighing scales and height measures for nutritional assessment and surveillance
- Collaborate in the enforcement of the Food and Drugs Amendment Act 1996, Act 523
- Institutionalize VAS to children as part of routine service provision
- Implement the GAIN/GHS strategy for fortification
- Work with the Attorney Generals Department to amend the food fortification law to cover other foods
- Intensify support supervision and monitoring to regions

Expected Outputs

- Regional and district level dissemination of IGFM completed
- At least 80% facilities have nutritional assessment tools
- Food Fortification law amended

2.1.3. Controlling Communicable Diseases

2.1.3.1 Malaria

Malaria is the leading cause for out-patients attendance and continues to be the leading cause of mortality especially in children under five years. The case fatality for children less than 5 years is 3.5% which is still above the 2006 target of 1%.

The Ministry of Health has adopted the Roll Back Malaria initiative as the strategy for malaria control. The coverage of the malaria control interventions is still far below the 60% target proposed for each of the interventions in the Abuja declaration. Currently, 40% of people with fever are treated correctly, only 20 districts are implementing IPT with 20% of pregnant women in those districts currently on IPT, and 3.3% of household are using ITNs.

In 2005, the new Malaria drug policy was launched and guidelines for Artesunate-Amodiaquine treatment were adopted. Implementing this policy poses important challenges and will be the key thrust for 2006. Issues of drug availability, compliance, cost, monitoring of adverse events needs to be resolved.

In 2006, the new anti-malaria drug policy using ACT (Amodiaquine-Artemisin combination) shall be introduced countrywide in partnership with NGOs, private sector and development partners. The private sector will be supported in their quest for pre-qualification by WHO to enable them manufacture appropriate anti-malaria drugs (including herbal medications) locally.

The priority activities are to:

- Implement the new anti malarial drug policy nationwide. (Capacity building, Public IEC, Sensitization, Pharmacovigilance, monitoring of drug quality and resistance
- Develop and implement strategies for subsidizing the cost of the drug
- Scale up of IPT nation-wide
- Scale up use of ITN
- Explore other integrated vector control strategies (including supporting research into sterilization of male mosquitoes)
- Support local anti malarial drug production
- Procure essential commodities to support Malaria control (eg. ITNs)

Expected Outputs

- Number of patients treated with the new drugs
- Coverage of IPT
- ITN coverage

2.1.3.2 HIV/AIDS and STI Prevention and Control

HIV/AIDS prevalence decreased marginally from 3.6% in 2003 to 3.1% in 2004. Though relatively low, the prevalence is dangerously close to the 5% level at which an exponential increase in prevalence may occur. Notably, HIV/AIDS prevalence above the 5% mark has already been recorded in Central and Eastern regions and in 5 of the 29 sentinel sites, thus creating an uneasy calmness about the relatively low levels of HIV/AIDS.

A window of hope for consolidating the low levels of HIV/AIDS nevertheless exists in the country. The HIV prevalence among adolescents is decreasing. Synergies for keeping this relatively low level in the population could be derived from the greater emphasis the health sector is giving to adolescent health issues. The Ghana AIDS commission has just coordinated a national response for HIV/AIDS and is preparing a revised national strategic framework. Ghana has also adopted the WHO 3 by 5 initiative as the framework for scaling up HIV/AIDS, prevention, treatment and control. A workplace policy on HIV/AIDS has been developed and disseminated.

The focus within this broad framework will be to reduce transmission through scaling up Voluntary Counselling and Testing (VCT), Prevention of Mother to Child Transmission, condom use and STI treatment and access to treatment, care and support. Collaboration with the Ghana AIDS Commission and other stakeholders involved in HIV/AIDS prevention and control will be strengthened in this regard. The HIV/AIDS programme will target high risk groups with services.

Scaling up is however undermined by the slow pace of establishment of ART centres. Currently there are only 5 sites for ARV established (3 in Eastern, 1 each in Ashanti and Greater Accra Regions). There is poor uptake of Nevirapine following screening. Sustaining the provision of ART services at subsidized rate and behavioural change poses a great challenge to control.

For 2006, the policy thrust is to expand the access of ART services, promote behavioural change communication and reduce the incidence of syphilis transmission.

The priority activities are to:

- Procure drugs and reagents for ART, STI, PMTCT, VCT and blood screening
- Build capacity for scaling up of PMTCT, VCT, Management of STIs
- Undertake Behavior Change Communication activities with special emphasis on high risk groups
- Establish/increase number of ART sites
- Reorganise services to include HIV/AIDS services

Expected Outputs

- Establish at least one ARV treatment centre in each region
- Establish at least one VCT/PMTCT site in each district

2.1.3.3 Tuberculosis

Tuberculosis continues to be a major public health problem in the country. Its prevalence in the population is currently estimated to be 0.28%. The case detection rate rose consistently between 1995 and 1998 after which it dropped from 35% to about 30%. It has since then stabilized just above the 30% mark over the last five years which is far below

the WHO norm of 75%. The national TB cure rate has risen steadily from 55% in 2002, 60% in 2003 to 65% in 2004.

The TB control program is faced with the challenge of high defaulter rate and the dual TB and HIV/AIDS infection. There is also weak drug management leading to occasional shortages and expiration of drugs.

The focus for 2006 is to achieve case detection rate of 60% and cure rate of 70 %, build public-private partnership for DOTS expansion and link HIV and TB response to address dual infection

The priority activities are to:

- Build capacity at all levels
- Intensify and support monitoring, supervision and evaluation system for the TB programme
- Establish system of case holding and defaulter tracing with active community participation.
- Provide infrastructure for supervised treatment in some district hospitals.
- Integrate TB and HIV prevention, care and support activities
- Promote behavioural change communication to support TB control

Expected Outputs

- Public and Private-Mix DOTS (PPM-DOTS) expanded from 2 to 6 cities
- Case detection rate increased to 60%
- Cure rate to 70%
- 32 Districts implementing community DOTS

2.1.3.4 Expanded Program on Immunization and Polio Eradication

In 2005 the programme sought to sustain the high levels of immunisation coverage including sustaining the NIDs and targeting the hard to reach areas. This has resulted in high national coverage 73% in 2004 for penta3.

The programme is however challenged with ensuring that services get to the hard to reach including the riverine communities. ***In 2006 EPI will sustain routine immunization coverage and ensure quality of immunization services through Reaching Every District strategy.***

The priority activities are to:

- Increase access to immunisation services in hard to reach areas eg boat services on Volta Lake
- Undertake Campaigns against targeted diseases
- Sustain AFP surveillance indicators

Expected Outputs

- Consistently higher coverage in hard to reach areas
- MNT campaign undertaken in 14 districts
- Campaigns against targeted diseases conducted
- 70% of districts achieve Penta 3 coverage of at least 80%

2.1.3.5 Guinea Worm Eradication

Guinea worm eradication has been a major challenge in the health sector with an increase in cases over 2001, 2002, 2003 and 2004.
In 2005 the sector put in a lot of effort to consolidate the gains in surveillance, improve case management/containment. Currently, 97% of villages target for active targeted for surveillance are submitting surveillance returns, 100% of eligible endemic villages receiving abate and 100% household filter coverage in all eligible villages. There has also been a 53% reduction in Guinea worm cases.

For 2006, the thrust is to interrupt transmission by end of the year and also ensure an active and sensitive surveillance system in all (100%) villages that reported GW in the last three years.

The priority activities are to:

- Strengthen surveillance systems in all villages
- Support case containment activities
- Provide filter distribution
- Advocate for water provision in endemic communities
- Abate ponds and other water sources

Expected Outputs

- At least 80% containment rates
- Number reported cases below 2,000

2.1.3.6 Neglected Diseases affecting the Poor almost exclusively

Buruli Ulcer, Trachoma, Leshmaniasis, Schistosomiasis, Onchocerciasis, Yaws and Filiariasis are the six main diseases that exclusively affects the poor. There is a suspected increase in the incidence of leshmaniasis and a re-emergence of Yaws
In 2005, the sector sought to raise the profile of these diseases and ensure that they are adequately funded within the district budget.Unfortunately funds to implement planned activities for these diseases are still not adequate. In the case of Buruli Ulcer, early detection of the cases is still a problem. ***In 2006 the sector will focus on providing***

adequate funds, building capacity to undertake surveillance and ensure proper case management.

The priority activities are to:

- Incorporate the surveillance of theses diseases into the integrated surveillance system
- Build capacity of district staff in surgical skills in the management of BU Build capacity of DHMTs in BU control
- Provision of essential surgical equipment for surgical management of BU
- Intensify IEC and advocacy activities
- Collaborate with research institutions and other stakeholders on the epidemiological and entomological investigations
- Strengthen monitoring and support systems
- Advocate for improved environmental sanitation
- Strengthen Epidemiological and entomological activities in the special intervention zones

Expected Outputs

- Capacity of relevant clinical staff in all endemic districts built
- Definite epidemiological and entomological information on the disease available
- Guidelines on the control of the diseases developed
- Active surveillance system for the disease instituted

2.1.4. Preventing and Controlling Non Communicable Diseases

Non-communicable diseases are increasingly responsible for outpatient attendance and admission. In 2003, hypertension was the 5th leading cause of outpatient morbidity in all ages, but second leading cause in both male and female adults older than 45 years. At KBTH, between 1990 and 1997, chronic diseases and complications accounted for more than two-thirds of all medical admissions and more than 50% of all deaths.

The major NCDs in Ghana are cardiovascular diseases, diabetes, chronic obstructive pulmonary disease, cancers and sickle cell. These diseases share several preventable biological risk factors (high blood pressure, high blood cholesterol and overweight), and related major behavioral risk factors (unhealthy diet, lack of physical activity and tobacco use). Some of the widest inequalities in the burden of disease are observed with NCDs. Contrary to popular perception, poor households suffer a higher burden of chronic diseases. In one study, death rate from circulatory diseases was more than twice as high among residents of poor areas in Accra as that among those in the more affluent parts. Intentional and accidental injuries in the home, working places and on our roads are also on the increase.

Over the years, the health sector has undertaken several initiatives to control NCD but with limited success. These include integration of NCD surveillance into the public health surveillance system, establishment of a national cancer register and promotion of dialogue among stakeholders towards a coordinated response to injuries and related conditions.

The interventions are often uncoordinated and unsustained. A major challenge is to develop and operationalise a strategic and wholistic framework to address the problem of non-communicable diseases. ***In 2006 the sector will focus on developing and implementing a 5 -year strategic plan for integrated prevention and control of chronic non-communicable diseases.***

The priority activities are to:

- Develop and disseminate policies and a strategic framework for NCD
- Conduct surveys on risk factors for NCD
- Establish national cancer registry
- Develop a national framework for control and management of sickle cell
- Promote BCC and advocacy activities at all levels on NCD

Expected Outputs

- Policies and strategic framework for integrated control and management of chronic diseases developed and disseminated
- Surveys on risk factors for NCD conducted
- National cancer registry established
- National framework for control and management of sickle cell developed

2.1.5. Improving Reproductive Health

2.1.5.1 Family Planning

There has also been a steady increase in family planning coverage. The contraceptive prevalence rate for modern methods has increased from 13% in 1998 to 19% in 2003. (2003 GDHS) There is still however low family planning acceptance in the country

2.1.5.2 Safe-motherhood

Though the official rates of maternal mortality and morbidity is the subject of debate among various stakeholders there is agreement that it is unacceptably high. Institutional maternal mortality ratio has decreased from 205 per 100,000 live births in 2003 to 186 per 100,000 live births in 2004. There is also evidence that maternal death audits are being carried out in more facilities than before. About 55.9% of all institutional maternal deaths were audited in 2004.

Coverage of antenatal care remains at about 90% in all regions. The average number of antenatal visits has increased slightly from 3.1 in 2003 to 3.3% in 2004 as against the target

of four (4). It appears that the exemption policy, which covers antenatal visits, continues to contribute to this. Generally, quality of antenatal care is being improved through the introduction of individualised maternity care. Coverage of supervised delivery, (excluding delivery by TBA), though rising, is still too low at 44.3%, with marked regional variations. Supervised delivery coverage for both skilled attendants and trained TBAs for the year 2004 was 53.4% indicating an increase over the 2003 coverage of 52.1%. This could be attributed to the implementation of the exemptions for supervised delivery nationwide. Post-natal care coverage has declined from 55.7% in 2003 to 53.3% in 2004. The challenge is to document the proportion of women who make 2 visits during the postnatal period

The national RH policy and standards document has been revised to provide new focus for improving access to quality RH services and for reducing maternal and neonatal morbidity and mortality towards achieving the Millennium Development Goal for maternal health. The policy emphasizes preventive and promotive aspects of safe motherhood, improving access to emergency essential obstetric care, increasing coverage of family planning services to reduce unmet need for family planning and unwanted pregnancies, and prevent reproductive tract infections and STIs including HIV/AIDS.

The policy thrust for 2006 is to initiate actions to reduce the high Maternal and neonatal deaths thus increasing access to quality Emergency Obstetrics services and post natal care

The priority activities are to:

- Conduct maternal health study (a community based survey and health facility based maternal mortality and morbidity study) and implement recommendations including establishment of sentinel sites for monitoring. This is to provide a baseline for revising strategies to improve maternal (and child) health indicators
- Develop a 5 year strategic plan for RH (2006-2010) and share with regions.
- Introduce new maternal records book with partograph
- Procure essential equipment, supplies and contraceptives
- Continue advocacy for district assemblies and DHMTs to dedicate a percentage of their resources for MNC
- Build capacity to scale up EOC services and neonatal care
- Develop guidelines for neonatal care
- Establish the process of making maternal death a notifiable event backed by Legislation

Expected Outputs

- Maternal health Study conducted
- 5 year Strategic plan developed (2006-2010)
- .....% of facilities providing delivery services using Partograph
- At least 80 % of Maternal deaths audited
- Guidelines for neonatal care developed

2.1.5.3 Adolescent Health and Development

Adolescents in Ghana are plagued by sexually transmitted infections including HIV, adolescent pregnancy, complications of unsafe abortion and complications of pregnancy and childbirth. 1 in every 7 pregnant women is an adolescent girl (15-19yrs).

The revised National Reproductive Health Policy and Standards incorporates needs of adolescents. The health sector has also progressed steadily in incorporating adolescent friendly services in the public, CHAG, and private health institutions with the support of an established National Adolescent Health and Development resource team in the Ghana Health Service (GHS) and Christian Health Association of Ghana (CHAG). Training of trainers in delivery of adolescent health services have been organized in all regions. A number of institutions have started providing adolescent friendly health services.

Establishment of Adolescent health corners is catching on slowly but steadily and in most of the health facilities in Upper West, Greater Accra, Ashanti, Central and Eastern Regions spaces have been earmarked for the adolescent corners.
The policy thrust for 2006 will be to continue with development of the adolescent health and development programme at the national level and scale-up implementation of adolescent friendly health services at community and facility levels. An inventory of agencies involved in adolescent health services would be undertaken

The key activities for 2006 are to:

- Develop adolescent health profiles as an integral part of district health profiles).
- Establish a database of agencies involved in provision of youth services in both public and private health sectors.
- Orientate young people, families and other stakeholders on their roles in youth programmes.
- Develop and implement action plans for making health facilities youth-friendly ensuring the inclusion of adolescent health corners.
- Integrate adolescent-friendly services into general health services including monitoring and evaluation
- Conduct operations research into adolescent health and development problems.

Expected Outputs

- All stakeholders sensitized on adolescent health issues and orientated to their roles in promoting adolescent health.
- Database of agencies available in districts and sub-districts.
- Adolescent-friendly services integrated into health activities at all levels.
- Adolescent health corners established in 40% of health facilities in both public and private health sectors.

2.2 Access and quality of health services

2.2.1 Institutional Care

The health sector has made some progress in increasing access to health service and meeting client expectations in service delivery. In 2004 outpatient per capita increased from 0.50 in 2003 to 0.55 and hospital admission rates increasing from 35.9 in 2003 to 38 in 2004.

Service delivery however is still inundated with problems which need to be addressed in order to meet our objectives especially in the light of the National Health Insurance. These problems ranges from poorly defined roles of health care facilities at various levels and types in both public and private sectors, lack of clarity in the definition of package of essential services by levels and types of healthcare facilities, inequitable distribution of clinical care services, poor referral systems and weak quality assurance systems in operation in healthcare facilities coupled with poor monitoring and supervision of clinical care services in health facilities.

In 2006 the sector will focus on establishing institutional roles and responsibilities of all levels and types of health care facilities; strengthening and improving the delivery of package of essential clinical care services at all levels.

The priority activities are to:

- Develop a policy to define the roles and functions of all types of healthcare facilities at all levels.
- Develop operational guidelines for implementation of the policy
- Define the package of all essential clinical care services at all levels and types of health facilities.
- Establish a database of health facilities and the package of services they deliver
- Develop guidelines for referrals system
- Provide guidelines for the decentralization and management of specialist outreach services
- Develop mechanisms to identify the specialist outreach services needs in the regions and districts
- Develop a national policy and guideline on siting of healthcare facilities

Expected Outputs

- Policy Document on roles and responsibilities for health care facilities developed and disseminated
- The roles and responsibilities of health care facilities established and institutionalized in all regional hospitals and 20 district hospitals
- Information on package of essential clinical care services available in all health facilities documented
- Morbidity and mortality arising from poor referral system reduced
- Coverage of specialist outreach services increased

2.2.2 Child Health

The 2003 Ghana Demographic and Health Survey (GDHS) reported a lack of improvement in child survival and development in Ghana. Against the expected trends established since 1988, the 2003 GDHS reported increases in Infant Mortality Rates (IMR) from 57 per 1000 live births in 1998 to 64 per 1000 live births in 2003. Two-thirds of these infants die in the first 4 weeks of life (NMR of 43/1000live births) from sepsis, asphyxia and birth-injuries and pre-term complications. Similarly, Under Five Mortality Rate (U5MR) increased from 108 per 1000 live births in 1998 to 111 per 1000 live births in 2003.

If this trend continues, the 5YPOW target of 50 per 1000 live births for IMR and 95 per 1000 live births for U5MR in 2006 will not be achieved. Similarly, the Millennium Development Goal (MDG) of reducing CMR by two-thirds of 1990 levels by 2015 will also not be achieved.

In spite of the worsening IMR and CMR at the national level, the 2003 GDHS also showed significant reduction in IMR and CMR in Upper East region where the Accelerated Child Survival and Development Programme is being implemented in all districts. In the Upper East region, CMR dropped from 155.8 in 1998 to 79 in 2003 while IMR dropped from 81.5 per 1000 live births in 1998 to 33 per 1000 live births. This picture gives hope that with improved packaging, delivery and targeting of child health interventions, the worsening trends in child survival and development in the country may be reversed and indeed the MDGs may be achieved.

The implementation of the complete Integrated Management of Childhood Illnesses (IMCI) would be instrumental in this regard. Currently 56% of districts are implementing the full IMCI package including community IMCI.

The pace of implementation of the IMCI has been rather slow. ***In 2006, the lessons in implementation of ACSD and the constraints to implementing IMCI will be used to guide scaling up interventions for improving child survival and development.***

The priority activities are to:

- Build capacity of non implementing districts to scale up IMCI package including community IMCI
- Monitor key child survival interventions

Expected Outputs

- All districts implementing IMCI strategy
- System for monitoring integrated key child survival interventions in place

2.2.3 Accident and Emergency Services

2.3 Traditional Medicine

Traditional Medicine is a health system that evolved from the experiences of indigenous people over thousands of years in their struggle against diseases. Traditional Medicine continues to be a major source of health care for many Ghanaians. In Ghana, the Ministry of Health continues to support strategies to improve the quality of care provided by Traditional and Alternative Medicine Practitioners in preparation for its integration into national health programmes.

The WHO, Ghana has accepted that to achieve health for all in many developing countries, traditional medicine should be developed and accessed as a distinct complimentary/alternative medical system. However in Ghana, the regulation of the practice and the quality of services continue to pose major challenges to the sector

For 2006, the health sector would continue to promote the integration of Traditional and Alternative Medicine practice into the formal health system and support strategies to improve the quality of care provided by Traditional and Alternative Medicines practitioners

The priority activities are to:

- Produce the second draft of Traditional Medicines list with standard treatment guidelines.
- Pre-test TM/CAM Clinic accreditation tool through monitoring visits.
- Produce draft of intellectual property regulation for TM/CAM products.
- Train TMPs in Entrepreneurship, marketing, GMP and conservation of medicinal plants.
- Assess consumer complaints on TM/CAM products and services including marketing of crude TM products or raw material.

Expected Outputs

- Second draft of Essential Traditional Medicines list produced.
- Accreditation tools for TM/CAM Clinics pre-tested.
- Intellectual property regulation for TM/CAM products produced.
- Consumer complaints on TM/CAM products assessed.
- TMPs trained in Entrepreneurship, marketing, GMP and conservation of medicinal plants.
- IPR regulation and TM policies disseminated nationwide.

3. HEALTH RESOURCES

3.1 Human Resource for Health Development

The issue of imbalances and attrition in the health sector workforce has come out strongly and raised a lot of concern in both local and international circles in view of the negative effect it has had on health care delivery in Ghana.

The sector has attempted to redistribute staff by transferring medical officers from the teaching hospitals to the regional hospitals. The District Assemblies has also been involved in the sponsorship of trainees to ensure they return after completion to serve in the district. The impact of these interventions is yet to be assessed. The training institutions have been expanded resulting in a 38% increase for the 2005 enrolment over the 2004 intake.

There is still the need to scale-up production of all categories of health staff, enhance human resource management practices at the agency level to correct imbalances and pursue strategies that will help retain staff in the country. Arrangements will also be made to ensure that emigration of health workers is controlled and will be to the benefit of the country. Key challenges will be placed in the context of achieving the MDGs, assess the progress made to date and find a way forward to the achievement of the goals of the sector.

The policy thrust for 2006 is to address the issue of imbalance in the health sector workforce through, increased production, retention of trained professionals, redistribution of staff in country to reflect health needs and correct imbalances, elimination of access gap and introduction of performance related rewards system.

Priority activities are to:

- Develop high quality professional training programmes
- Increase intake into the training institutions
- Ensure equitable distribution of human resources to benefit deprived areas.
- Retain trained staff
- Institute performance related reward system
- Foster partnership with non-government providers of health services.

Expected Outputs

- Performance related reward system in place
- Improvement in staff distribution
- High quality professional programmes developed and training in progress

3.2 Heath Infrastructure

The year 2006 marks the end of the five year capital investment plan (2002-2006) for the health sector. Some of the problems associated with the capital investment programme

include inadequate financial commitment, inequity in distribution, weak management systems. The need for a definite plan to address these problems is therefore essential.

It is important to state that programmes and projects proposed at the beginning of the five year plan have either been completed or at the final stages of completion. In addition capacity is being strengthened to facilitate the implementation of the capital investment plan.

A number of challenges currently facing capital investments include meeting the targets of agencies that have adapted the use of the capital investment planning model to identify investment requirements. There is the need to develop a comprehensive capital investment strategy which contains a fuller description of the functions of the agreed projects and a realistic basis for costing. In addition, the delay in finalisation of the equipment policy and ensuring adherence to the equipment policy particularly in turn key projects are a major concern.

Strict adherence to the new procurement code and guidelines to facilitate efficient implementation of the capital investment plan along with streamlining vehicle standardisation with procurement regulations present a key challenge. Also, the absence of a fleet replacement policy and the need to sustain the revolving fund system to strengthen planned preventive maintenance are major areas influencing the successful operation of the capital investment plan.

The policy thrusts for 2006 is to increase geographical access to quality health services, deepen inter sector collaboration; promote efficiency in resource use and strengthening management systems in the sector. The program of work for 2006 will therefore focus on the projects and programs that have not been completed or not started.

The Capital Investment Program will include infrastructure development, replacement of obsolete medical technology devices, equipment shortfall in all hospitals to support particular services, automated laboratory systems for 22 selected hospitals, medical gas supply systems for 30 selected hospitals, supply of ambulances and equipment under the Ghana Ambulance Service and procurement of transport to support health delivery.

The priority activities are to:

- Rehabilitate Health Centers at the Sub District level
- Construct / Complete 14 Health Centers
- Improve dental services countrywide
- Rehabilitate 4 District Hospitals
- Upgrade 6 District Hospitals
- Complete 8 DHMT Offices
- Initiate works on the construction of 2 Regional Medical Stores in Accra and Bolga
- Complete the Bolgatanga Regional Hospital
- Complete two RHMT offices in Ho and Accra

- Complete works on the expansion program for the 16 selected Health Training Institutions
- Complete 20 housing units for staff accommodation
- Continue the maintenance program for the physiotherapy equipments
- Complete the complex offices for FDB, GCPS and NMC and School of Allied Health
- Complete works at the LFC for the GHS
- Complete works for the Accident and Emergency at KATH
- Replace selected categories of equipment at the Regional Hospitals
- Continue the Diagnostic Imaging Project of 41 Hospitals
- Replace conventional clinical laboratory equipment with automated clinical laboratory devices
- Provide Medical Gas Supply System for 30 selected hospitals
- Manage clinical and medical waste
- Complete Blood Transfusion Centers in Korle Bu, KATH and Tamale
- Recruit and retrain staff within the unit on:
    - The National Procurement Law
    - New data collection tools such as GPS and PDAs
    - Capital Investment Planning Model
- Disseminate and Implement Policy Guidelines on Equipment Development Program as well as Equipment Management Systems

Expected Outputs

- Expansion works in the sixteen Health Training Institutions completed
- Works on the rehabilitation /construction of 20 blocks of staff accommodation completed countrywide
- Service Availability Mapping (SAM) completed in all regions to enhance monitoring and supervision of projects
- Practical completion of the offices complex for the GCPS, FDB and NMC
- The upgrade of the three polyclinics in Greater Accra Region completed
- Works begin on the ADBIII project
- All agencies use the National Procurement Law in their procurement practices
- Rehabilitation works on 10 CHAG facilities comp

3.3 Drugs and Essential logistics

In terms of Access to Medicines, a framework was developed and implemented to address affordability, sustainable financing, safety, quality and efficacy of medicines, reliable supply systems and rational use. All these are taking place within the context of the World Trade Organization's TRIPS Agreement and flexibilities as contained in the DOHA Declaration and the August 30th Decision. Under this agreement, for instance, provision is made for the issuance of compulsory licences to manufacture or import generic versions of some drugs for which patents exist provided all the requirements stipulated in the Agreement are met. Currently, there are some antiretroviral drugs that have patents covering Ghana and

therefore can only be imported with the issuance of a compulsory licence. In 2006 the policy thrust is to continue implementing the framework

The priority activities are to:

- Intensify training in Rational Drug Use (RDU)
- Implement the Standard Treatment Guidelines and Essential Medicines List in health facilities
- Develop and execute the National Drug Policy Implementation Plan
- Conduct study on generic prescribing in Ghana to inform pricing policy
- Develop framework of Pharmacovigilance in Ghana in view of the Anti-malaria policy change and scale up of Anti Retroviral Therapy
- Implementation of the Administrative guidelines for issuing Compulsory Licensing, Parallel importation and other TRIPS flexibilities , particularly with regard to certain anti-retroviral drugs

Expected Outputs

- National Drug Policy Implementation Plan developed
- Framework for Pharmacovigilance developed
- Compulsory license issued for the procurement of certain anti- retroviral drugs which have patents covering Ghana

3.5 Information and Communication Technology Development

4. ORGANISATION AND MANAGEMENT OF HEALTH SERVICES

4.1 Health Institutions

In 1996 the health sector embarked on a process of institutional reforms with the enactment of Act 525. This led to the restructuring of the health sector as one of multiple partners and agencies with MOH retaining the stewardship role to ensure maximum efficiency and to strive for more equity and ensure optimal health gains.

Within this framework, MOH is required to coordinate an increasingly pluralistic and complex sector, (public, private, NGO; and within each of these agencies and sub-divisions) in order to achieve greater efficiency and effectiveness in performance. The key functions of the MOH in this leadership position therefore are policy, agency contract arrangement (including M&E) and financial management and regulation.

If properly managed these reforms are expected to create a purchaser/provider split with MOH as the purchaser while the other agencies would become service providers and statutory bodies would enforce the rules.

Some achievements have been made in this institutional renewal process. These include the clear separation of MOH with the creation of directorates to handle its main functions; Performance contracting developed. MOH signed a Performance Contract (PC) with the GHS in 2004. The GHS also signed PC with the RDHS who in turn signed PC with the DDHS.

Though significant progress has been made, there still remains some lack of clarity on the responsibilities for the MOH and its agencies in areas that have significant implications on service delivery. For example, challenges persist with regards to human resource planning and distribution, capital planning and implementation of capital programmes, procurement of health logistics and acquisition and maintenance of equipment.

Additionally, not much progress has been made in putting in place new contracts since the public health sector has little experience in contracting or other forms of service agreements. While an MOU exists that defines the relationship between CHAG and MOH, CHAG has no such document to clarify its working relation with the GHS. Functional linkages between GHS and TH remain blurred and the roles of regional offices are poorly defined. Engagement of the private sector, NGOs and CHAG is weak.
Also multiple regulatory bodies exist.

After eight years of implementing these reforms there is the urgent need to review the process as basis for moving forward under the next 5 year POW. ***The policy thrust for 2006 is to improve on these organisational managements to achieve health sector goals.***

The priority activities are to:

- Review Act 525 in the light of the experience in implementation
- Redefine and clarify responsibilities of MOH, GHS and TH in the areas of human resource planning and distribution, capital planning and implementation of capital programmes, procurement of health logistics and acquisition and maintenance of equipment.
- Review and define lines of communication and accountability
- Complete appointment of staff for MOH
- In line with ACT 525, ensure more compliance with contracting arrangements (especially with CHAG , THB and the private sector) by building the capacity of MOH and its agencies to manage contracts
- Operationalise a formal working agreement between GHS and CHAG, clarifying administrative and communication arrangements and financial contributions from both agencies.
- Strengthen engagement with NGOs, Private sector and CHAG

Expected Outputs

- Act 525 reviewed in the light of the experience in implementation
- Responsibilities of MOH, GHS and TH in the areas of human resource planning and distribution, capital planning and implementation of capital programmes, procurement of health logistics and acquisition and maintenance of equipment redefined and clarified
- Lines of communication and accountability reviewed and defined
- Contracting arrangements complied with in accordance with Act 525
- MOU developed between GHS and CHAG

4.2 Managerial Processes

4.2.1 Planning and Budgeting

As the main national framework for planning and budgeting, the Medium Term Expenditure Framework (MTEF) would continue to provide the platform for planning and budgeting for 2006. The needs based approach together with the resource based approach to planning was used in 2005. The needs based planning allowed the Ministry to have a fair estimated idea of its total resource requirement as against the actual resources allocated to the Ministry by the MOFEP.

The annual programme of work is developed to provide direction in investments in health so as to achieve the objectives outlined in the five year programme of work. The year 2006 is the last year of implementation of the second five year programme of work therefore it is important to document achievements and challenges so as to provide the policy direction for the development of the third programme of work. The planning and budgeting cycle is however faced with problems of inadequate feedback on plans prepared by agencies thereby undermining the quality of work produced. The link between planning and

monitoring is also weak leading to poor feedback to inform future plans and priority setting. This weak link creates imbalance between the budget and expenditure.

Over the years, planning and budgeting has been fully decentralised to the Agencies and district levels ensuring that plans and budgets reflect local needs. The decentralisation has empowered agencies and district levels in two ways i.e. increase in resources and managing financial resources. The adoption of MTEF has also improved planning and budgeting by linking budget to activity thereby ensuring some realism into budgeting. Despite the gains, the sector is still faced with the challenges of priority setting, change in the government planning calendar and implementation of the MTEF. ***The policy thrust for 2006 is to re-organise the sector's planning cycle in the light of the changing national planning calendar and consolidate the gains made by strengthen the linkage between planning and monitoring.***

Priority activities are to:

- Consolidate the needs-based and participatory planning process involving key stakeholders within the health sector and other sectors.
- Continue building capacity of agencies in the development of timely annual plans and budget using the MTEF
- Institute internal feedback systems with the planning process
- Review BMC plans and budget to ensure that they reflect national priorities
- Strengthen the monitoring of the implementation of plans and budget
- Strengthen performance contracting system
- Institute a system to synchronise the health sector planning process with the national planning process
- Develop a national health policy
- Provide training and technical support to agencies in the development of the 2007 MTEF plans and annual programme of work
- Conduct studies on feasibility of identifying actual cost of programmes (eg. malaria, TB) in the regular budget

Expected Outputs

- Timely development of the 2007 plans and budget by August 2006
- A national health policy developed by January 2006
- The 3rd Five Year POW developed by March 2006

4.2.2 Financial Management

The Financial Administration Act 2003, Act 654, the Internal Audit Agency Act 2003, Act 658, the Public Procurement Act 2003, Act 663 and the National Health Insurance Act 2003, Act 650 provide a new legal framework for public sector financial management in general and the Health Sector in particular. The new legal framework has implications that call for re-orientation and re-training as well as revision of procedural manuals used in the sector.

The year 2004 was used to study the new laws and to sustain the existing systems while aspects of the new laws were being clarified. In 2006, the focus would be to equip Finance and Non-Finance Staff in the new financial management procedures; improve Financial Management Monitoring and streamline Stores Accounting systems at Medical Stores at the Central, Regional, District and Facility levels.

Within the framework of the new Financial Management environment, the Medical Stores systems at the Central, Regional, District and facility levels needs to be overhauled and streamlined to effectively account for the medicines and other logistics that are channelled through the Medical Stores system.

Decentralisation of resource management should be deepened at all levels. It has been identified that service outputs can be improved if sub-district level institutions including CHAG institutions receive and manage their operational funds more directly.

The priority activities are to:

- Develop Accounting System for Sub-District facilities including Sub-district CHAG institutions.
- Build in-house capacity and retain IT staff to adequately cope with all components of financial management improvement efforts
- Orient managers on the Financial Administration Act, the Public Procurement Act and the Internal Audit Agency Act- effects on disbursement and financial reporting.
- Produce more timely quarterly financial statements and improve reporting and analysis capacity at all levels.
- Encourage agencies to generate own reports through BPEMS which is a more friendly Financial Management System (FMS) reporting tool
- Strengthen capacity for policy dialogue with the MOFEP to ensure increased resources for MOH and also ensure that expenditure tracking requirements are fully met.
- Agree an annual cash flow schedule with donor commitments and related disbursements
- Operate an integrated fund management that ensures prompt quarterly disbursement to BMCs
- Negotiate with MOFEP for release of GOG administration budget in bulk as is done with service budget
- Comply with the Common Management Arrangements (II) on disbursement and regularly communicate with donors on status of funds & disbursement.
- Work with health partners to channel earmarked funds through the "Aid pool Account" rather than disbursing directly to the regions and districts
- With the support of donors, build capacity and develop the internal audit at all levels.

- Improve quality of internal audit report through regular communication on content & format of audit reports.
- Set up a functional audit report implementation committee (in accordance with the Audit Service Act 2000) to follow up and review responses to specific queries raised by the auditors and ensure compliance with recommendation.

Expected Outputs

- Trained Finance and Non-Finance Staff in new financial management procedures
- New stores accounting procedures completed and staff trained.
- Financial Management Procedures for Sub-District Facilities developed.

4.2.3 Procurement and Supply

Procurement management in the MOH has undergone a significant revolution in the past. The principal procurement drivers of profitability, efficiency and value for money have coincided with significant advances in organizational structural changes, the introduction of the National Health Insurance Scheme and a national Public Procurement Code, which have made it possible to shift from the more mundane procurement era of the past into the current realm of business orientation.

In terms of policy, the MOH Procurement Procedure Manual has been successfully revised to reflect the provisions of the Public Procurement Law (ACT 663). The main thrust are fairness, transparency, economy in the use of resources, level playing field, anticorruption, supply safety and government security.

Even though substantial increase has been chalked over the areas in terms of capacity to implement procurement procedures, there is still an urgent need to link the procurement plan to the MTEF. There is also a need to sensitise all health workers on the key concerns of the new Public Procurement Law with emphasis on its implications, regarding their individual work schedules. There is also a need to train all the different categories of staff, especially the procurement officers on the use of the newly revised Procurement Procedure Manual. To address these needs a Procurement Training Strategy Document has been developed. The Stores System is undergoing the transformation required to support the operation of a franchise system.

In year 2006, the policy thrust is to consolidate the gains of 2005 and to improve existing systems and structures to deepen capacity for procurement, stores and drug management.

The priority activities are to:

- Manage the Procurement plan for 2006

- Training of different cadres of staff in the use of the MOH Procurement Procedure Manual which has recently been revised to conform to the provisions of the newly enacted Procurement Law (ACT 663)
- Monitor performance of procurement officers trained on the use of the Procurement Procedure Manual
- Develop the procurement plan for 2007 and synchronise it with the MTEF
- Develop and implement procurement guidelines for medical equipment and civil works
- Improve existing Data Management Systems
- Continue the major structural rehabilitation at the Central and Regional Medical Stores

Expected Outputs

- 2007 Procurement Plan developed
- Procurement officers at various levels trained in the use of revised Procurement Procedure Manual
- All key staff of the Central Medical Stores trained on new semi automated operating systems
- Central Medical Store, Regional Medical Stores and the Teaching Hospitals networked
- Marketing Strategy developed for the Central Medical Stores

4.2.4 Monitoring and Evaluation

Review of the 2004 POW acknowledged that efficiency in the information management system would strengthen the role of the Ministry of Health in sectoral policy formulation and priority setting. It also identified that the framework for monitoring and reporting on the performance of the sector put in place by MOH was still weak particularly in the assessment of the performance of Agencies within the sector. There is the need to refine the process for revising the sector wide indicators to meet the changing environment.

The need to improve information management continued to receive significant attention. The collection and organization of routine information for performance assessment has been reviewed and steps towards improvements have been proposed. Work on the development of a comprehensive information system has also started and it is expected that an implementation strategy will be in place by the end of 2005. Significant improvement in the coordination of operational research has been achieved within the last two years under the Ghana Dutch Collaboration for Research. Systems for ensuring high quality and relevance in operational research have been put in place. However the link between research and policy still remain weak particularly with the absence of a comprehensive research agenda for the health sector.

In 2006 the sector will work towards the establishment of a performance based monitoring and evaluation system will continue by ensuring that health service delivery

outputs feed into policy development and planning at all levels. The organizational capacity for monitoring and evaluation will be strengthened to provide an evidence based decision making system to support policy development, improvement in quality, planning and budgeting and programme implementation.

The priority activities are to:

- Review the sector wide indicators and propose a framework for the development of indicators for the next 5 year programme of work.
- Develop a sectoral agenda for research in support of the next five year programme of work.
- Establishing a link between data producers and data users and ensuring a close collaboration between Monitoring and Evaluation and operational research.
- Meet the milestones of the implementation strategy for the comprehensive health management information system.
- Guide the implementation of the health sector ICT policy and strategy within agencies.
- Review the interagency capacity, systems and processes for monitoring and evaluation.
- Manage the performance contract system

Expected Outputs

- Clear outline for the development of sector wide indicators developed and a draft of a set of sector wide indicators proposed for the next five year programme of work.
- A clearly defined framework for coordinating, generation and use of health management information data is developed.
- A clear operational link between monitoring and evaluation and operational research established.
- Health sector ICT policy strategies and programmes rolled out as planned.
- Specific milestones for the implementation of a Comprehensive Health Management Information system met.
- Interagency capacity, systems and processes for monitoring and evaluation reviewed and documented.
- 2005 performance contracts reviewed and 2006 contracts signed.

4.2.5 Surveillance and Epidemic Response

The objective of the surveillance system which is to enable the health sector detect and respond appropriately to epidemic prone diseases and emerging diseases and health problems has still not been achieved. In 2005 the health sector adopted the Integrated Disease Surveillance and Response (IDSR) strategy for the period, orientation and training has been the main focus. This has resulted in active participation of DDHS in surveillance. There has thus been an improvement in early case detection especially Yellow fever with 38% of reporting at least one suspected case in the first half of 2005 as compared to 34%

in 2004. Timeliness of monthly reporting improved to 90% compared to 82% and 88% for 2003 and 2004 respectively. The sector is still faced with incomplete reporting, non compliance with policy of free treatment during epidemics. Even though the IDSR has been adopted, active surveillance has not been institutionalised, outbreak investigation limited to descriptive epidemiology and not looking for risk factors. ***In 2006, the policy thrust would be to strengthen community based surveillance for timely detection and response and expand the integrated disease surveillance and response strategies to include NCDs.***

The key activities are to:

- Develop and implement Strategic Plan for CBS
- Introduction of filter paper blood sample collection for measles surveillance
- Conduct training in IDSR and data management
- Establish a surveillance system at ports of entry with particular emphasis on emerging diseases including dissemination of International Health Regulation
- Expand the scope of IDSR to include NCD and conditions
- Develop 5 Year Strategic Plan (2006-2010)
- Intensify support supervision and monitoring to regions

Expected Outputs

- Strategic plan for CBS developed and rolled out in at least 50% of districts
- Port Health Surveillance strategy and guidelines developed
- Guidelines developed for inclusion of NCD and conditions in IDSR
- 5 Year Strategic Plan (2006-2010) developed
- Achieve Non Polio AFP rate of at least > 2 /100,000 in all regions

4.3 Regulation

The statutory/regulatory bodies have a mandate to ensure efficient and quality services delivery. The regulatory environment is challenged with obsolete and inadequate laws leading to non-enforcement and conflicting roles between some of the regulatory bodies. The non-physical presence of the regulatory bodies i.e. absence of regional and sub-regional offices undermines their proper functioning. There is also lack of co-ordination and monitoring of the activities of the regulatory bodies in the MOH.

The 2005 POW sought to prepare the policy on regulatory environment and roles for statutory bodies, and to lay before parliament, the revised legislations of the regulatory and statutory bodies. These activities seem to be on course and are timely. Monitoring activities of professionals have also improved as evidenced by the increased number of professionals sanctioned or appeared before various disciplinary committees. The challenge is to create an enabling environment for the implementation of the revised legislations and ensure quality improvement in health services delivery. ***The policy thrust for 2006 is to implement the revised legislations and plan for effective monitoring and regulation.***

The priority activities are to:

- Continue to review of laws to conform to current standards
- Improve human resource capacity and capabilities
- Computerize the secretariat of regulatory bodies
- Complete membership of Councils and Boards
- Decentralize the functions of regulatory bodies to make them more effective
- Establish an ombudsman for health.

Expected Outputs

- Revised Acts operationalised
- Full complement of council/board membership in place
- Improved supervision, monitoring and dissemination
- Sub-national offices established

4.4 Inter-sectoral Collaboration and Partnerships

Inter-sectoral collaboration and partnerships is one of the pillars of the 2002-2006 Programme of Work. This is because the known determinants of health are the responsibility of other sectors. To achieve the goal of working together for equity and good health for all people living in Ghana, there is the need to develop a platform for inter-sectoral actions in order to foster efficient and effective collaboration. Inter-sectoral collaboration therefore is a means to achieving optimum health outcomes. Some of the key issues that are identified as problems within the health sector would need inter-sectoral arrangements to address them. Examples of these are malnutrition, maternal and child health issues, as well as water and sanitation related problems.

The Ministry continues to acknowledge the importance of inter-sectoral collaboration and partnerships and has made some progress towards the achievement of the objectives stated in the 5YPOW. Guidelines have been developed and sent to the district level on how to plan and implement with other stakeholders. District managers were also trained on these guidelines. It is expected that a focal point or desk for ISC and partnerships will be put in place in the Ministry by the end of 2005. In the last year of implementation of the 5YPOW, efforts towards the achievement of the objectives would be intensified. The Ministry would also improve its advocacy activities with sectors whose activities have significant impact on health sector activities and its goal to ensure a healthy and productive population that is able to contribute significantly to wealth creation.

The guiding principle for 2006 therefore, is to ensure that partners including other Ministries, departments and agencies, private sector, civil society organizations and development partners, communities and individuals would be involved throughout programme development and management cycle. The focal point in the Ministry will be working according to clear terms of reference and a framework that would be developed and would work closely with content/program officers within the sector to provide a

platform for collaboration and partnerships. The health sector has a role in making the population healthy for increased productivity and ultimately to create wealth.

The priorities activities are to:

- Establish and strengthen desk/focal point for inter-sectoral collaboration and partnerships in MOH with clear terms of reference.
- Improve Ministry of Health's advocacy role on the impact of other sectors activities on health of the population.
- Create a platform for taking the ISC agenda forward

Expected Outputs:

- Functioning desk/focal point for ISC in the Ministry with adequate capacity for coordination of inter-sectoral activities.
- Advocacy activities by the Ministry of Health on the impact of other sectors activities on health intensified.