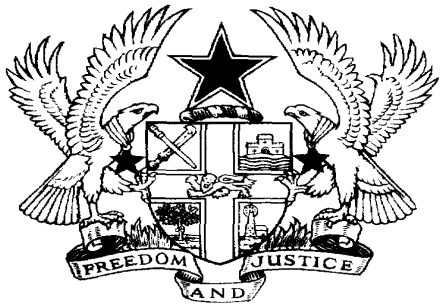

THE GHANA HEALTH SECTOR ANNUAL PROGRAMME OF WORK

2007

MINISTRY OF HEALTH

ACRONYMS

5YPOW	5 Year Programme of Work
AFP	Acute Flaccid Paralysis
ART	Anti-Retroviral Therapy
ARV	Anti-Retroviral
ASRH	Adolescent Sexual and Reproductive Health
BCC	Behaviour Change Communication
BMCs	Budget Management Centres
CAM	Complementary Alternative Medicine
CAN	African Cup of Nations
CHAG	Christian Health Association of Ghana
CHPS	Community Health based Planning & Services
CMS	Central Medical Stores
CSRPM	Centre for Scientific Research into Plant Medicine
DHMTs	District Health Management Teams
EPI	Expanded Programme on Immunization
FDB	Food & Drugs Board
GCPS	Ghana College of Physicians and Surgeons
GHS	Ghana Health Service
GOG	Government of Ghana
GPRS	Growth and Poverty Reduction Strategy
HIRD	High Impact Rapid Delivery
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune-Deficiency Syndrome
ICC	Inter-Agency Coordinating Committee
ICT	Information Communication Technology
IMCI	Integrated Management of Childhood Illnesses
ITNs	Insecticide Treated Nets
KNUST	Kwame Nkrumah University of Science and Technology
MDG	Millennium Development Goal
MTEF	Medium Term Expenditure Framework
NCD	Non Communicable Diseases
NDPC	National Development Planning Commission
NGOs	Non Governmental Organizations
NHIC	National Health Insurance Council
NHIS	National Health Insurance Scheme
PPM	Planned Preventive Maintenance
RBM	Roll-Back Malaria
RHMTs	Regional Health Management Teams
RTA	Road Traffic Accident
STG	Standard Treatment Guidelines
TB	Tuberculosis
TRIPS	Trade Related Intellectual Property Rights
WHO	World Health Organization

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MESSAGE FROM THE MINISTER

In 2007 Ghana will be 50 years since independence. During this period, the country has made progress in improving access to quality health services. Yet, maternal, infant and child mortality are still very high while non communicable diseases are on the increase mainly from changes in lifestyle and nutrition. The country has also recorded progress in the control of vaccine preventable diseases such as poliomyelitis, measles, diphtheria and tetanus; even though communicable diseases such as malaria, tuberculosis, HIV/AIDS and guinea worm are still prevalent. The relatively poor health status in the country today is undermining the productive capacity of human capital and overall socio-economic development.

The Ministry has therefore developed a new policy to speed up health delivery in a holistic, sustainable and equitable manner, and contribute to overall national development. The vision of this policy is to create wealth through health. This is based on the simple premise that Ghana cannot develop to become a middle income country by 2015 unless she saves money on treating avoidable and preventable diseases on one hand and ensure a healthier and more productive human capital to contribute to wealth creation on the other.

The new health policy defines a new paradigm for health delivery that emphasises disease prevention through a lifestyle and behavioural model. This is to be pursued alongside promoting environmental health and safety and ensuring access to traditional biomedical interventions for the prevention, diagnosis and treatment of diseases. The paradigm recognises that health is more than health services and that health is produced in homes, communities and through multi-sectoral action.

Implementing the new paradigm will require consolidating known programmes such as high impact and rapid delivery programmes while at the same time making fundamental changes to the focus of health delivery through the Regenerative Health and Nutrition (RHN) programme. It is for this reason that 2007, the first year in the implementation of the new health policy, will be regarded as a transitional year.

In 2007, key concepts, programmes, systems, processes and capacities required for effective implementation of the policy will be developed. The health sector will also focus on two other activities that have major implications for the country. These are the 50th Anniversary celebration and preparations for hosting the African Cup of Nations in 2008 (CAN 2008).

The 2007 Programme of Work has been designed within the framework of the new health policy while paying attention to the peculiarities of 2007. The document has been structured around four themes:

- Promoting healthy lifestyles and healthy environments
- Increasing access to quality health, reproduction and nutrition services
- Strengthening health system capacity, and
- Ensuring good governance and sustainable financing

The programme and targets defined under these themes are aimed at addressing risk factors driving the high burden of diseases in the country, scaling up health services to address the current burden of diseases, and enhancing productivity and equity in health delivery.

This document has been developed through dialogue and consultation with key partners and stakeholders in the health sector. I therefore wish to acknowledge their individual and collective contributions and call on all partners to realign their support for its full implementation.

Major Courage E. K. Quashigah (Rtd)
Hon. Minister

INTRODUCTION

The 2007 Programme of Work (POW) marks the beginning of the third Programme of Work (2007-2011). This is a year in which the health sector is implementing a new policy direction which has a paradigm shift from curative health care to promotion of health and prevention of diseases. The theme of the 2007 POW is "creating wealth through health" which is derived from the new health policy. This theme attempts to identify the link between poverty and health and how healthily lives could be a source of wealth creation. The 2007 POW is also placed within the context of the Ghana Growth and Poverty Reduction Strategy, National Health Insurance Scheme and what the sector ought to do to achieve the Millennium Development Goals.

The year 2007 will also see the country preparing for two major activities in the country's history. These are preparations towards Ghana's 50th Anniversary celebrations and hosting the African Cup of Nations (CAN 2008)

In the 2007 POW, the sector outlines strategies that would ensure that people stay free from illness and injury, live health lives and those who fall ill are adequately restored to normalcy. The POW also identifies strategies the health sector would adopt to ensure that Ghana's 50th Anniversary is celebrated in a healthy way and the CAN 2008 which poses a number of health challenges are adequately managed.

The 2007 POW is structured around the four thematic areas outlined in the health policy. These are:

- Healthy Lifestyles and Environment
- Health, Reproduction and Nutrition Services
- General Health System Strengthening
- Governance and Financing

The document identifies key results areas for each thematic area as well as priority activities. The document is organised into five chapters. Chapter one outlines the policy framework for health development which looks at the mission, vision, goal, objectives, guiding principles for the achievement of the objectives and the targets the sector must work towards. Chapter 2, 3, 4 and 5 are structured around the thematic areas and the key results areas. Chapter 6 presents the broad roles and responsibilities of the Ministry of Health, its Agencies and Development Partners in the implementation of the POW.

LESSSONS FROM THE PAST

- The country is facing a high burden of diseases that is characterised by premature mortality, high communicable diseases, high pregnancy related diseases and mortality and rising non communicable diseases. At the same time inequalities in health status and access to health services exist in the country.

- Risk factors that can be changed such as cigarette smoking, alcohol, diabetes, obesity, behavioural factors, etc are worsening, while factors that promote people's health such as exercise, eating fruits and vegetables, rest, etc are not popular.

- Health services are over-focused on delivery of medical technology with little attention to behavioural, nutritional and environmental interventions

- Key health care interventions are known and available, but the key challenge is scaling up.

- In spite of investments in the last 10 years, there are huge gaps in access to services and shortage of equipment, consumables essential drugs and supplies

- The brain drain of health professionals is constraining staffing of frontline health facilities and thus making reliable and quality services virtually unattainable.

- There are difficulties in managing the rapid decentralization of health services and donor-driven programmes. The sector is facing high overhead cost, unbundled regulatory environment and difficulties in coordination.

- Catastrophic costs, formal and informal, are disproportionately borne by the poor.

- There are challenges in the introduction and sustaining the National Health Insurance Scheme.

- Financing and resource allocation to the sector have increased but this is still inadequate for the level of investments required to scale up health delivery. At the same time the systems of financing are changing from projects to sector support to budget support. There is also a change from user fees to health insurance.

- In spite of its potential, the health industry is not appreciated, analyzed and there is no strategic focus on its development.

1. POLICY FRAMEWORK FOR HEALTH DEVELOPMENT

1.1 National Vision

The national vision is to attain middle income status with 1000 USD per capita by the year 2015 by creating wealth through health.

1.2 National Vision for Health

Create wealth through health and contribute to the national vision of attaining middle income status by 2015.

1.3 Mission Statement

“The mission is to contribute to socio-economic development and wealth creation by promoting health and vitality, ensuring access to quality health, population and nutrition services for all people living in Ghana and promoting the development of a local health industry.”

1.4 Health Sector Goal

The ultimate goal of the Ministry is to ensure a healthy and productive population that reproduces itself safely.

1.5 Health Sector Objectives

The goal of the health sector will be achieved through pursuing three inter-related and mutually reinforcing objectives. These are:

- To ensure that people live long, healthy and productive lives and reproduce without risk of injuries or death
- Reduce the excess risk and burden of morbidity, mortality and disability especially in the poor and marginalised groups
- Reduce inequalities in access to health, populations and nutrition services and health outcomes

1.7 Strategies

The strategies to be pursued to improve health status, reduce mortality, morbidity and risk factors, and increase productivity and equity in the health sector are:

- Promoting an individual lifestyle and behavioural model for improving health and vitality
- Strengthening multi-sectoral advocacy and actions

- Rapid scaling up of high impact health, reproduction and nutrition interventions and services targeting the poor, disadvantaged and vulnerable groups and bridging the gap between interventions that are known to be effective and the current relatively low level of effective population coverage
- Investing in strengthening health system capacity to expand access, management and quality of health services and sustain high coverage
- Promoting governance and sustainable financing

1.7 Guiding Principles

The objectives of the health policy will be achieved through a combination of programmes and investments underpinned by the following guiding principles:

Health is multi-dimensional in nature and requires partnerships

Programmes design and development will:

- Be people centred focusing on individuals, families and communities in the life settings,
- Recognise the inter-generational benefits of health
- Reinforce the continuum of care approach to health development
- Be prioritized to ensure maximum health gains for limited resources

It is expected that the community will be encouraged and expected to be part of the planning implementation and evaluation of activities aimed at ensuring a healthy and productive population. This is with a view to ensuring effective community ownership and involvement – a key element towards sustainability.

Planning, resource allocation and implementation will be results-oriented paying attention to equity, efficiency and sustainability

2 HEALTHY LIFESTYLES AND ENVIRONMENT

A major prerequisite for a healthy population is how individuals, families and communities take care of themselves and the environment. Information with the specific aim of empowering people to make the right choice for healthy living has been seen as critical. The main disease burden of the country demonstrates a preponderance of diseases resulting from neglect of basic environmental practices and changes in dietary habits, physical activities and adoption of life threatening behaviour.

The overall aim of the health sector is to promote healthy lifestyles and reduce risk factors that arise from environmental, economic, social and behavioural causes. Within this framework 2007 will see increased activity in the area of advocacy, capacity building and enhanced collaboration for a better understanding of the risk factors. In addition, strategies would be developed to enable individuals, families and communities make the right choices for better health.

The link between health promotion and disease prevention is strong and the proposed programmes under healthy lifestyle and environment will be implemented closely with other programmes on the prevention and control of communicable and non communicable diseases and nutrition. The emphasis will be on behavioural change options which will have positive impact on the health. These programmes will be implemented largely by the health promotion unit in collaboration with the Ministries of Local Government, Education, Water Resources and Housing and others sectors. The “Ghana at 50” and CAN 2008 activities offer financing and implementation opportunities for the promotion of healthier lifestyles and improving environmental sanitation. In In 2007 the Ministry of Health will explore and utilise these opportunities and other implementation arrangements and innovative financing for the promotion of healthier lifestyles.

2.0 Result Matrix

Indicator	2006 Performance	2007 Target
Prevalence of hypertension/Mean systolic BP	Not available	Baseline to be established
Prevalence of adult and child obesity	Not available	Baseline to be established
Prevalence of tobacco use	Not available	Baseline to be established
Per capita alcohol consumption	Not available	Baseline to be established
Percentage condom use (current use among women)	20.0% (2005)	22.5%
% Food vendors who are clinically certified	Not available	Baseline to be establish
% of rural population with access to safe water sources	52% (2005)	

2.1 Regenerative Health and Nutrition

The health sector in 2007 will implement a paradigm shift which places more emphasis on improvement in lifestyles, health promotion, disease prevention and restoration of life. The regenerative health programme is focused on healthy eating, improving food safety, regular exercises, drinking potable water, resting, improving environmental sanitation, improving personal hygiene and ensuring lifestyles that promote health. The programme also recognises that the major disease burden of the country can effectively be reduced if individuals, households and the community are empowered to make the right choices.

The concept of regenerative health is however not a new one. The health sector aims at ensuring that the principle of healthy living to promote good health and prevent diseases and injury is made a reality. *In 2007, the focus is on the development of a national regenerative and nutrition programme involving the public and private sector.*

Programmes and Broad Activities

- Analytical work to establish baseline and identify risk factors
- Development of selected programmes on healthy lifestyle and nutrition interventions, focusing on behavioural change strategies
- Train a cohort of health promotion experts
- Strengthen collaboration with the private sector to implement national BCC strategy

- Build capacity Retrain the health workers on Regenerative Health and Nutrition Services
- Promote establishment of agents of change within communities, schools and workplaces
- Set up public information centers (Client services unit) in selected health facilities
- Explore possibilities of setting up “Regenerative Health and Nutrition Centers”
- Advocate for the provision of adequate sanitation in educational institutions and work places.
- Work with employers association to establish health promotion activities in work places, first and second cycle institutions
- Initiate setting up of Regenerative Health and Nutrition Centers

2.2 Public Health Legislation

In Ghana, legislation for protecting the environment exists but is not being enforced. This has lead to massive destruction of the environment which has a major impact on health. For the health sector to make an impact in ensuring that people live healthy in clean environments, efforts must be put in to advocate for the laws to be enforced and also create awareness on the existing laws.

In 2007, the policy thrust will be to ensure strong advocacy in the implementation of the public health laws.

Programmes and Broad Activities

- Review legislation in multiple sectors to assess impact on public health and health promotion
- Educate public on existing public health laws
- Work with regulatory and law enforcement agencies to enforce existing public health laws
- Review, finalise and disseminate the public health laws
- Collaborate with law enforcement agencies to enforce the laws
- Explore opportunities for introducing sin taxes as both a mechanism to reduce demand and also raise additional revenue for health promotion activities
- Disseminate International Health Regulations

2.3 Inter-sectoral Advocacy and Action

In promoting health and preventing disease and injury, it is clear that the health sector can not do it alone. It is also evident that the activities of some sectors impact directly or indirectly on the health sector and if these activities are not well coordinated the impact to health would not be felt. Linked to this is the concept of healthy settings which aims at establishing more effective work relations between the health sector and other sectors, particularly the Ministry of Local Government, Rural Development and Environment (MLGRDE) to create a healthier environment by solving health and related problems closer to their source. This concept recognizes the complex connections and inter-linkages between existing human settings and health risks and places emphasis on the home, neighborhood, place of work, recreation and schools. The concept also recognizes that effective and sustainable solutions can only be achieved if actions are coordinated at all levels. *2007 will focus on strengthening inter-sectoral action around the key health challenges and settings*

Programmes and Broad Activities

- Work with the NDPC to strengthen inter-sectoral activities in the GPRS II.
- Consolidate ongoing inter-sectoral activities such as ICC for EPI, Guniea Worm eradication, RBM, IDD ect.
- Improve utilization of the District Assembly system to promote intersectoral action at the district level.
- Re-orient the health sector towards inter-sectoral action
    - Develop a framework for inter-sectoral collaboration and action in schools work places and communities
- Collaborate with:
    - MLGRDE, WRWH and EPA to improve water and sanitation
    - MoE - healthy schools programme with emphasis on hygiene, physical exercise and school feeding
    - Ensure food safety by promoting collaboration between FDB, Standards Board, MLGRD and Police to develop and enforce standards for the production, storage, sale and handling of foods and drinks in markets, restaurants, vendors, etc.

3 HEALTH, REPRODUCTION AND NUTRITION SERVICES

Health services involve the provision of health interventions to individuals and populations. Services provided to individuals may be preventive, diagnostic, therapeutic or rehabilitative while those provided to populations include mass education and environmental sanitation.

Over the years the health sector has invested a lot of time, money and effort to improve service delivery in the country. These include the current implementation of high impact and cost effective interventions. However, these investments have not resulted in adequate improvements that can enable the country to achieve the millennium development goals.

Service delivery is still inundated with mal-distribution of services with the peripheries still lacking access. Quality of services is below the approved standards in some health facilities and service delivery points. Despite the efforts put in by the sector to provide client-centred care, service delivery is still not responsive to the needs, values and socio-cultural practices of the people.

A large number of the population (about 60% of people living in rural areas) use traditional and alternative medical care. However this component of health services is not adequately regulated and fully integrated in the existing health service delivery system.

The burden of disease is largely borne by women and children and hence there would be emphasis on programmes targeting this vulnerable group. To this end, the implementation of High Impact and Rapid Delivery (HIRD) interventions for improving child survival and maternal health as part of comprehensive and integrated health services would be a priority.

2007 will focus on improving the coverage of priority programmes for the prevention, control and management of diseases of public health importance, within the framework of an affordable, equitable, comprehensive and responsive health system

The following priority programmes would be implemented in the year 2007:

- Communicable Disease Control including epidemic preparedness and response
- Non Communicable Disease Control
- Reproductive Health and Sexual Health Rights
- Nutrition
- Accident and Emergency Services
- Clinical Care

- Traditional and Alternative Medicine
- Rehabilitation

3.0 Results Matrix

Indicator	**2006[1] Performance**	**2007 Target**
Communicable Disease control		
Percentage ITN use in children under five	35%	60%
EPI coverage (PENTA-3, (October 2006)	P (78%);	P (85%)
TB cure rate/ Treatment success rate	67%	60
Number of HIV+ clients receiving ARV therapy	6000	25,000
Incidence of guinea worm	-2600	<1500
Non-Communicable Disease Control		
Number of Districts with established screening programmes	0	2
Reproductive health		
Couple Year Protection	> 800,000	>1,000,000
Proportion of deliveries attended by skilled personnel	40 %	60%
Nutrition		
% of children 6 – 59 months receiving vitamin A (once)	? 80%	80%
% CWC attendants malnourished at 9 months	Not available	Baseline to be established
Clinical Services		
OPD attendance per capita	.23	.60
Institutional Maternal mortality ratio	219 /100,000	180/100,000
Accidents and Emergencies		
Number of Districts with Established Ambulance service	13	25
Traditional and Alternative Medicine		
Number of District Hospitals providing care in herbal medicine	Not available	Baseline to be established
Rehabilitation		
Number of clients accessing care at limb fitting centres	Not available	Baseline to be established

[1] Most of the reported 2006 reported performance are mid-year actual

3.1 Communicable Disease Control

In the area of controlling communicable diseases which would include epidemic preparedness and response, the health sector would continue to provide cost effective and rapid delivery interventions for achieving the MDGs; prevention and control of diseases of public health importance; eradication/elimination of targeted diseases; strengthening surveillance to reduce the frequency and outcome of epidemics; and provide adequate financing for neglected diseases that affect the poor.

The policy thrust for 2007 is to provide cost effective and rapid delivery interventions for achieving the MDGs and control of diseases of public health importance.

Programmes and Broad Activities

- Extend the programme for community management of childhood illness from four regions to all regions within the framework of the HIRD.
- Continue programmes for scaling up interventions for diseases of public health importance (HIV/AIDS, Malaria, Tuberculosis and other endemic diseases).
- Increase nation wide coverage of routine immunisation with emphasis on poorly performing districts promote strategies to reach hard-to-reach areas, conduct mop up for reported cases of polio and begin documentation for polio-free certification.
- Review the surveillance system to incorporate emerging diseases, strengthen the national surveillance, epidemic preparedness and response mechanisms in order to reduce frequency and outcome of epidemics (Cholera, Meningitis, Yellow fever and threats of new epidemics such as Avian Flu)
- Continue to raise the profile and ensure adequate financing of the programme for the neglected diseases programme which almost exclusively affect the poor (Buruli ulcer, Filariasis, Leishmaniasis, Onchocerciasis, Schistosomiasis, Trachoma, and Yaws)
- Organise Child Health Week

3.2 Non Communicable Disease Control

Control of non-communicable diseases continues to pose a great challenge to the health sector with chronic diseases and its complications accounting for more than two-thirds of all medical admissions. *In 2007, the sector will increase awareness of the risk factors associated with non-communicable diseases and ensure early diagnosis and treatment.*

Programmes and Broad Activities

- Design, cost and pilot screening programmes for specific age groups and population cohorts (infants, pre-school, school-going children, adults and elderly).
- Intensify health education campaigns and promote community involvement in the prevention/reduction of NCDs
- Establish screening programme and strengthen clinical management of the major non-communicable diseases

3.3 Reproductive and Sexual Health

Ghana's institutional maternal mortality ratio is still unacceptably high at 197/100,000 live births. Though great success has been chalked in ANC coverage (about 90%), supervised delivery and family planning coverage is seriously undermining the gains and threatens the achievement of MDGs 4 and 5.

Men and women have the right to information and access, to effective, affordable and acceptable methods of family planning as well as other methods of their choice for regulation of fertility which are not against the law. Access to appropriate health-care services will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant.

In the year 2007 the sector will implement high impact rapid delivery strategies that will sustain high coverage, remove barriers (physical and financial) to reproductive health care and ensure the right to attain the highest standard of sexual and reproductive health.

Programmes and Broad Activities

- Improve male involvement in reproductive health care
- Reposition family planning
- Ensure contraceptive commodity security as part of efforts to reduce unmet need and increase overall access to family planning services
- Sustain high coverage of antenatal care while improving the quality of services
- Assess barriers (physical, social and financial) and develop an investment plan for improving supervised deliveries (skilled attendance) including access to emergency and comprehensive obstetric care with priority to deprived areas.
- Implement a programme for strengthening institutional and community capacity in neonatal care within the framework of the maternal and neonatal health care delivery and within the context of HIRD.

- Promote sexual rights including prevention and management of sexually transmitted diseases and strengthen integration of adolescent sexual reproductive health, (ASRH), into existing health facilities to ensure access to quality information and services including counselling on sexual and reproductive health rights.
- Provide comprehensive abortion care within the context of the law

3.4 Nutrition

Nutrition is one of the most important components that determine health, wellbeing and longevity. Over the years this component has not seen much progress in the health care industry despite the number of initiatives that has been put in place to promote exclusive breast feeding, salt iodization and vitamin A supplementation. This is manifested as high levels of malnutrition, with under-nutrition in children, micro-nutrient deficiency in pregnant women and obesity. Most people are not aware of the fact that what they eat today determines the level of health they enjoy tomorrow.

In 2007, the sector will provide the population with information and services to improve dietary habits and nutritional status

Programmes and Broad Activities

- Promote and strengthen Essential Nutrition Actions package: (optimal breast feeding, appropriate complementary feeding, nutritional care for the sick child, women's nutrition, controlling anaemia, vitamin A and iodine deficiencies.)
- Increase the number of baby-friendly health facilities and access to information through outreach services and the mass media.
- Extend and strengthen community based services for promoting optimal breastfeeding and appropriate complementary feeding within the context of the HIRD.
- Develop a position paper on the place of nutrition in the management of diseases
- Collaborate with the Ministry of Education to introduce / strengthen the nutritional component of the school curriculum and improve the nutritional value of the foods provided in the school feeding programme
- Initiate the process of expanding the nutritional component of the curriculum of health workers as part of an overall strategy to recognise nutrition in prevention and management of diseases
- Provide rehabilitation of malnourished children in health facilities and communities and supplementary feeding to communities with high levels of malnutrition.
- Strengthen programmes to control micro nutrient deficiencies (Vitamin A supplementation, iodization of salt, food fortification)

3.5 Accident and Emergency Services

Accidents and emergencies come in various forms such as Road Traffic Accidents (RTA), Domestic accidents, natural disasters as well as medical emergencies like cardiovascular and respiratory emergencies. These are expected to increase with the shift in the disease profile from communicable to non-communicable diseases. Ghana has been experiencing an increasing number of road traffic accidents. It is estimated that road traffic accidents (RTAs) account for 1.7% of both DALYs and mortality in adults. RTAs and related morbidity and mortality levels could increase from the expected increases in vehicular traffic during the 50th Independence Anniversary celebrations and CAN 2008. This requires that the health sector prepares to respond to accidents and emergencies. The National Ambulance Service (NAS) introduced in 2004 by the Government handles pre-hospital emergencies. Currently it operates in 19 locations in five Regions.

In 2007 the sector will improve the outcomes of medical, surgical and obstetric emergencies by deploying a combination of community based first responders, ambulance services and facility based emergency preparedness.

Programmes and Broad Activities

- Consolidate the scaling up of the ambulance service to the regional level with priority on ensuring access to services at the accident prone spots.
- Identify, designate and equip institutions in regions and districts as centres for emergency response.
- Train one thousand community first responders nationwide with priority on remote and under-served areas.
- Strengthen emergency services by reorganising, reorienting and equipping district, regional and teaching hospitals to manage emergencies.
- Improve communication within the facility ambulance service.
- Extend activities of national ambulance service with areas that are not yet covered.
- Link the facility based ambulance service to the national ambulance service.
- Educate communities on accessing and applying for emergency care.
- Collaborate with Ministry of Transportation, the Police Service, the Ghana @ 50 Committee and the CAN 2008 committee to mount a road safety campaign.

3.6 Clinical Care

In Ghana, about 57.7% of households have access to a health facility within 30 minutes of their residence[2]. This is mainly skewed in favour of the urban areas leaving the rural areas deprived of basic health services. Unfortunately the gatekeeper system is not working posing a huge challenge for an effective referral system. Inadequate personnel, lack of adequate infrastructure and supplies for the provision of basic health care still persists in the sector.

Quality of care has not improved significantly as a result of a continuing lack of development in the area of diagnostic and other support services. The key challenges to improved quality of care in health facilities are inadequate standards, non-adherence to existing standards, and inadequate skilled personnel

Universal access to services especially in deprived rural and peri-urban areas still remain a challenge despite increasing National health insurance coverage.. Key policies aimed at improving access to basic health services including policies on exemptions and referrals are not adequately implemented. .

In 2007 the sector will initiate a programme for modernising clinical care that will improve access, quality, safety, treatment outcomes and patient experiences.

Programmes and Broad Activities

- Review service standards and improve their application to include quality and safety issues to make services more responsive to patients' needs and expectations
- Intensify specialised outreach services, especially to deprived regions.
- Increase the quantity of skilled personel (refer section 4.1)
- Develop standards and assess the current state of diagnostic and pathological services and institute regulatory mechanisms
- Promote regional and district networking of health institutions aimed at reinforcing supervision, strengthening the referral system and improving patient care
- Strengthen and extend the implementation of integrated management of childhood illnesses (IMCI) as a strategy for improving the management of children under five years.

3.7 Traditional and Alternative Medicine Practice

The health sector for many years has placed a lot of emphasis on the provision of allopathic medicine with little attention to traditional and alternative medicine which is used by about 60% of Ghanaians especially people living in the rural areas. The services over the years have been supply driven and the time has come for the sector to provide services that the people need and accept. The sector has taken steps to

[2] Ghana 2003 Core Welfare Indicators Questionnaire Survey Report

recognise the role of the non-allopathic providers by setting up a Council to regulate traditional medicine practice. In addition a Directorate has also been set up in the Ministry.

In addition, the Council for Scientific Research into Plant Medicine (CSRPM) has improved its capacity for clinical trials and is also engaged in scientific assessment of herbal medicines. The KNUST has started a programme to train herbal medicine graduates and the first two batches of students have completed and are undergoing an internship at CSRPM and FDB.

In 2007, the sector will continue to promote traditional and alternative practice in the country.

Programmes and Broad Activities

- Establishment the position and ensure placement of the trained herbal medicine graduates to ensure that they complement the existing human resource for service provision. (Move to sub-section on HR. Need to better understand their role and explore options for integrating them.)
- Strengthen the capacity of the CSRPM in the assessment and approval mechanism for herbal products
- Build capacity in the Traditional medicine directorate to provide support to herbal practitioners and to sensitize the allopathic health providers on the integration of services
- Fast track the establishment of the regulatory council for traditional medicines

3.8 Rehabilitation

Rehabilitation of the sick or injured is one of the major components of the health care process. It aims at restoring the skills of a person who has had an illness or injury so as to regain maximum self sufficiency and function in a normal or as near normal manner as possible. Although over the years, the health sector has seen rehabilitation as a very important component of the health care very little has been done to ensure availability and access to the services.

In 2007 the sector will define more clearly its role and expand existing services in the area of rehabilitation.

Programmes and Broad Activities

- Develop a strategic framework for medical rehabilitation of the physically and mentally challenged in response to the Disability Bill
- Reorient health services to be responsive to the needs of the physically and mentally challenged
- Determine the cost implications of the disability bill on health infrastructure and health services

- Expand and sustain the prevention of the blindness programme
- Revamp the limb fitting centres and programme for rehabilitation of the physically challenged in collaboration with Department of Social Welfare's Community based rehabilitation programmes.

4. GENERAL HEALTH SYSTEMS DEVELOPMENT

This refers to the development of capacities in the health system for health delivery. It includes a mix of technical, managerial and logistic capacities required to promote, protect and improve health. Health systems development emphasises on the creation, expansion or upgrading of capabilities in the health system in order to fill capacity and service gaps, improve individual and institutional performance, and achieve objectives of the health sector.

In 2007 there is a need to strengthen capacity of the health system by investing and mobilizing resources, allocating them equitably and ensuring their efficient utilization.

Key challenges will be placed within the context of the new health policy, Ghana's 50th Independence Anniversary celebrations and the Africa Cup of Nations (CAN) 2008. The key result areas would include Human resources (Technical and managerial), Infrastructure, Equipment, Transport, ICT, Drugs and essential logistics and Health Industry.

4.0 Result Matrix

Indicator	***2006 Performance***	***2007 Target***
Health professional density		
Medical Officers	2057	2238
Pharmacists	1550	1645
General Nurses	7,304	11,459
Midwives	2810	2962
Community Health Nurses	3246	4375
Medical Assistant	500	600
Health care assistants	0	0
Trained Herbal Practitioner	0	15
Output of training institutions		
Medical Officers	250	275
Pharmacists	90	100
General Nurses	1500	1650
Midwives	200	399
Community Health Nurses	1173	1388
Medical Assistant	50	103
Health care assistants	0	0
Trained Herbal Practitioner	15	15
% Communities with trained volunteers in IMCI		
Percentage of facilities with 100% tracer drug availability		
% Districts with appointed Health Information Officer	33%	51%
District level capacity index (to be defined based on standards)	Not Available	Baseline to be established
% Districts with minimum health infrastructure (Access to health services)	Not Available	Establish baseline including definition of minimum health infrastructure

4.1 Human Resources

Human resources for health are the stock of all individuals engaged in the promotion, protection or improvement of the health of the population. It constitutes all professionals, non-professionals, skilled and unskilled whose primary function is to produce health and may be categorized into:

- The households as primary producers of health
- Health workers involved in the provision of allopathic, traditional and alternative practice
- Other professionals such as environmental health officers, gym operators, nutritionists, motor traffic units of the Police, school health units, etc. whose activities directly promote health but have hitherto not been included in the definition of human resources for health

The traditional approach to human resources has focused narrowly on the allopathic provider. Households have not been recognized and empowered as primary producers of health and the potential of traditional and alternative health care providers have not been adequately harnessed.

Recently, the brain drain has stabilised, however the health work force remains inadequate. Mal-distribution of health workers persists with trained professionals located in the urban areas and untrained health workers predominantly located in the rural areas. In addition the productivity of health workforce varies substantially across the country. Though human resource management is being decentralised with the appointment of regional HR managers there is the need to further decentralise payroll management.

The skill mix remains skewed in favour of highly skilled trained professionals with an inadequate production of middle level cadres. Investment into training institutions has increased but is still inadequate given our human resource needs. Collaboration with other stakeholders whose activities impact on health has been ineffective.

The policy thrust for 2007 is to increase the production of middle level cadre, continuously refine strategies for retention, equitable distribution and enhance productivity.

Programmes and Broad Activities

- Increase home and community based care components of existing programmes such as roll-back malaria, HIV/AIDS, Community IMCI etc.
- Finalize and implement the HR strategic plan
- Increase the production and recruitment of health workers focusing on middle level health professionals (health/clinical assistants, medical assistants, laboratory assistants) and health aides.
- Retain, distribute equitably and increase productivity and responsiveness of human resources by:

- strengthening systems for supervision, accountability and overall human resource management by piloting decentralization of HR management in 3 regions

- Promoting and enforcing effective legislation and regulation by strengthening support for professional and statutory bodies

- Formation of country HRH consultative group to serve as an advisory body on HR policy direction and other key HR issues
- Collaborate with MLGRD on the effective deployment and functioning of environmental health officers in the promotion of a healthy environment
- In collaboration with GCPS, accredit regional and district health training sites to rapidly deploy post graduate students to rural areas
- Take stock of the current staff strength of public health facilities through head count
- Conduct impact assessment of the new salaries and other incentives

4.2 Infrastructure Development

Health services infrastructure refers to all physical structures and/or facilities required to promote, maintain and restore health and include:

- Hospitals, Clinics, maternity homes, training institutions, CHPS Compounds
- Health enhancing facilities such as gyms, health farms, and regenerative health centres etc.
- Water, sanitation and waste management facilities in homes, communities, schools and other public places

Health infrastructure is inadequate in numbers, is inequitably distributed, is under-utilized and is still out of reach for most of the population, particularly in deprived areas. In general health enhancing infrastructure such as gyms, health farms, and recreation grounds are largely unavailable and their health benefits are generally unknown and not appreciated in the country. Water, sanitation and waste management facilities have not kept up with population growth, urbanisation and development of new communities.

The current role of the Ministry of Health is in the construction of health infrastructure and this will continue. The private sector will continue to focus on the construction of health enhancing facilities while the Ministries of Water resources, Works and Housing and Local government and rural development will continue to be responsible for water and sanitation issues. The MOH will nevertheless advocate for increased access to health enhancing facilities.

In the area of health infrastructure development; various actions have been undertaken within the last 5-year POW aimed at improvements in transparency and

equity in procurement, as well as efficiency in supervision and cost control. Policies on development of primary care services have been strengthened. The capacity for the management of infrastructure has improved, standard designs for facilities, monitoring database and training manuals developed for capital investment and estates management in the sector.

Investment policy and planning and its linkage with service delivery, however, remain weak and inadequate. Besides, the recurrent cost implications of investments in health infrastructure have not been estimated on a regular basis before investment decisions are made.

The policy thrust for 2007 will focus on increasing geographical access, to well maintained health facilities and health enhancing infrastructure with emphasis on deprived and peri-urban areas.

Programmes and Broad Activities

- Complete the Health Services Planning Methodology and Framework for capital investment, disseminate and commence training on the model for implementation
- Develop institutional and managerial procedures for approval and funding of capital investment
- Mobilize financing for the completion of construction of 80 CHPS compounds
- In collaboration with DPs develop and institute a routine progress and expenditure tracking system for capital investment to be operational in 2007
- Reappraise all ongoing and abandoned infrastructural projects to fill gaps in access to service particularly in deprived and hard-to-reach communities
- Conduct a Service Availability Mapping as a basis for rationalising capital development within available financial and human resources.
- Mobilize financing for the renovation and planned preventive maintenance of existing health service facilities
- Promote private sector investments in health services and health enhancing facilities

4.3 Equipment

Medical equipment is an essential input in the promotion of health and includes all materials required for the promotion, protection and maintenance of health. Even though substantial progress has been achieved in equipment management, capacity in areas of acquisition, distribution, installation, use and maintenance, further strengthening remains. Inadequate resources to purchase requisite equipment and to fully implement the maintenance and replacement policy have resulted in the lack and poor maintenance of equipment in health facilities.

Equipment expenditure commitments are undertaken without planning for their recurrent cost implications. A significant proportion of projects have not been completed due to changing priorities or inadequate resources. Despite a number of attempts there is no register of facilities or assets in the sector. *In 2007 the sector will provide health facilities with functional equipment.*

Programmes and Broad Activities

- Improve planned preventive maintenance to increase equipment availability
- Mobilise resources to support the replacement of obsolete equipment
- Improve equipment management systems
- Adopt and disseminate the medical waste management policy
- Upgrade knowledge of procurement staff at regional and district level on PPM

4.4 Drugs and Essential Logistics

Availability of logistics and supplies including essential medicines in health facilities has been improving. The health sector has made substantial progress in the development of procurement capacity and the related standardization of procurement procedures both at the central and peripheral areas. Investments have been made in the procurement management capabilities in all BMCs. There have been improvements in the quality of goods supplied and malpractice has been reduced.

However, the procurement, stores management and distribution systems need modernization and re-engineering. Other key issues that have confronted drug supply management include rational use, financing and the assurance of drugs quality. There is still no systematic approach to pricing at health facility level which currently differs from one region to another. The poor functioning of CMS has led to shortages of essential drugs and supplies and is further compounded by non patronage by health facilities leading to wastages. The indebtedness of the regional medical stores to the CMS remained a challenge and requires immediate interventions to increase availability of health commodities at the CMS.

The changes in TB treatment and envisaged additional treatment for malaria require new regimes of medicines to be added to the Essential medicines list. These actions therefore require a review of the 2004 STG and EML and subsequent printing.

The public procurement law Act 663 and the Cabinet approved drug policy provides the policy and legal framework to ensure an increased access to medicines to improve health outcomes. The development and prioritization of the implementation plan is crucial to increasing access to essential health commodities taking cognizance of the external environment of WTO TRIPS agreement.

The 2007 policy thrust is to continue implementing the framework to address affordability, sustainable financing, safety, quality and efficacy of medicines.

Programmes and Broad Activities

- Collaborate with WHO and other relevant partners on prequalification of locally manufactured medicines.
- Update Standard Treatment Guidelines and Essential medicines List 2004 and harmonize with the NHIL
- Continuously orient health workers in the national procurement laws and procedures to ensure full implementation of the law within the health sector
- Computerize stock management and establish a data base link between regional and central medical stores
- Implement 2007 procurement plan and develop 2008 plan of procurement
- Develop a strategy for debt collection and increase medicines availability
- Institute systems for continuous monitoring and assurance of quality, efficacy and safety of medicines including traditional medicines
- Continue with the implementation of the administrative guidelines for issuing compulsory licensing, parallel importation and order TRIPS flexibilities particularly with regard to certain anti- retroviral drugs and advocate for amendment of the Patent law 2003

4.5 Transport

The general role of transport in health is in the area of: Primary health services (immunization, health education, disease surveillance, rural outreach services, etc), Patient Transportation (Transfers and Pre-Hospital Care), Monitoring and supervision, Haulage of medical logistics, emergency preparedness, Specialist Outreach Services, General administrative assignments. Transport used in the health sector includes general purposes vehicles, ambulances, motorbikes, bicycles and boats.

The sector continues to face a major challenge with transport to support service delivery and management including supportive supervision. Currently about 50% and 65% of the vehicles and motorbikes respectively are over aged and due for replacement resulting in high maintenance and running cost of the vehicles especially

at the district level. The transport situation is therefore likely to get worse in the absence of adequate budgetary allocation for replacing vehicles.

The policy thrust for 2007 is to increase vehicle availability for service delivery and supervision.

Programmes and Broad Activities

- Improve transport management through ensuring adherence to guidelines for transport use and management
- Mobilise resources to implement medium term vehicle replacement plan targeting over aged vehicles particularly in the deprived districts.
- Improve planned preventive maintenance to increase vehicle availability Improve efficiency through the development of skills of transport staff such as defensive driving, accident management and carrier development

4.6 Health Information for policy

Health system governance depends on the availability of quality, relevant and timely information and knowledge. Health information provides the information support to the decision making process at all levels of the health system. Health information is particularly important for resource allocation and public health action in the countries such as Ghana with limited resources because unwise allocation of resource can lead to wastage and the difference between survival and death.

A health information system has six components: (i) Resources comprising human, financial and ICT (ii) Indicators (iii) Data sources including population based and administrative data sources (iv) Systems for data management (v) Information Products and (vi) Dissemination and use.

The challenges to health information system are (i) Weak human resource and institutional capacity for information management (ii) Gaps, duplication and waste among parallel health information systems, (iii) Lack of timely reporting and feedback, (iv) Unstructured investments and deployment of ICT, (v) Poor quality data, vi) Inadequate use of information for decision making and action. Significant progress has been made in the efforts to improve competencies and capacities in ICT particularly at the national level. However a lot more needs to be done to improve efficiency in gathering and dissemination of information.

The policy thrust for 2007 is to generate and use evidence for decision making, programme development, resource allocation and management through research, statistics, information management and deployment of ICT

Programmes and Broad Activities

- Build consensus and establish baselines and refine targets for sector-wide indicators to monitor progress in the health system performance
- Develop and implement a strategic plan to support the development of an integrated and consolidated National Health Information System including a link between financial management and service delivery information
- Collaborate with Ghana Statistical Service to develop strategic plan for improving Vital Registration System
- Continue to support district coverage surveys as a means of validating performance with respect to population based indicators
- Scale up the district wide system for information management to ensure the availability and accurate and reliable routine service based data
- Promote local production and increase access to supplies and logistics including pharmaceuticals and traditional medicines
- Completion and dissemination of Service Availability Mapping
- Develop a comprehensive sector wide health research agenda and explore options for establishing a national health research fund
- Disseminate the multiple indicator cluster survey (MICS) and use results for planning activities in the sector
- Begin planning for 2008 demographic and health survey
- Continuously update the MOH website

4.7 Health Industry

A health industry comprises all firms directly involved in the production of health. These include all firms (both public and private) operating in a health market and are involved in the manufacturing of health products, provision of the health care and health enhancing service and generation of knowledge in support of health.

The health industry as a new concept has not been recognized and analyzed. The capacity of the local manufacturing industry is under-utilized and the potential herbal and traditional medicines is largely untapped.

Apart from the pharmaceutical sector that is fairly well understood, the size and potential of the health industry is not known and appreciated by policy makers and potential investors. The role of this industry in wealth creation is in sustaining health services and creating jobs.

The policy thrust for 2007 is to create a better understanding of the health industry as a basis for enhancing the capacity and sustainability of the health system and contribute to the national economy.

Programmes and Broad Activities

- In collaboration with the Ministry of Trade and Industry, map and analyze the health industry to understand the components, structure, size, barriers and contribution to the national economy
- Create an understanding of the importance of health and the health industry to the national economy among key stakeholders
- Collaborate with the Ministry of Trade and Industry to support the development of micro-enterprises for production of health commodities
- Strengthen collaboration with private sector and NGOs in health delivery

5 GOVERNANCE AND FINANCING

Health sector governance is about achieving results. This has to be done in a participatory manner within available resources and without compromising on safety and quality. Effective governance requires:

- An articulation of a clear and compelling vision
- Provision of an enabling policy and institutional environment
- Establishing a results orientation and accountability
- Improving compliance with internal management procedures and controls
- Aligning activities and incentives of stakeholders around common objectives
- Ensuring predictability and transparency in resource use

Health financing which is at the heart of health sector governance involves a process by which funds are (i) mobilized from primary (households and firms) and secondary sources (Government and donors), (ii) accumulated in fund pools (GOG allocations, NHIF, health fund) and used to purchase services and products that promote, maintain and restore health (priority setting, resource allocation and financial management).

The policy thrust for 2007 is to enhance the performance of the sector by promoting a well coordinated health system and ensuring equitable, efficient and accountable use of resources within the framework of the new national health policy.

The following programmes will be implemented in 2007:

- Policy development, standards setting and regulation
- Priority setting, planning and budgeting
- Financing, budget execution and procurement
- National Health Insurance Scheme
- Decentralization and Institutional Development
- Private sector development
- Partnerships and coordination
- Monitoring and Evaluation, Reporting, Auditing and Accountability

5.0 Result Matrix

Indicator	2006 Performance	2007 Target
Finance		
Total expenditure on health as a percentage of GDP	Not available	Baseline to be established
Per capita total expenditure on health	Not available	Baseline to be established
Per capita NHIS in reserve	Not available	Baseline to be established
Execution rate of GOG and Health fund expenditure for services (item 3) improved	Not available	Baseline to be established
GOG expenditure for services (item 3) for 2007 increased compared to 2006	Not available	Baseline to be established
50% of districts that spend at least 1% of District Assembly Common fund on HIV/AIDS	Not available	Baseline to be established
% GOG budget spent on health	15	15.5
% GOG recurrent budget spent on health	14.5	15.5
Proportion of non-wage recurrent budget spent at district level	48	48
%Donor funds Earmarked	40	40
% Recurrent budget spent on exemptions	8	10
% of the population including the indigents and other exempt categories issued with ID cards	18%	36%
Governance		
Productivity (workforce productivity index)	Not available	Baseline to be established
Equity (index) –Outcomes: 1. Under five morality ratio (rural, urban, regional) 2. Staff population ratios(rural, urban, regional)	Not available	Baseline to be established
CPIA (Country Policy Institutional Assessment) index	Not available	Baseline to be established
PEFA (Public Expenditure Financial Analysis) index	Not available	Baseline to be established

5.1 Policy Development, Standards and Regulation

A new national health policy that defines the focus for the health sector for the next ten years has been developed. This policy provides the framework for the development of programmes by stakeholders, and investments within the health sector. It therefore provides the tool for coordinating the actions of institutions that have direct and indirect roles in health delivery.

This policy is people-centred and emphasises healthy lifestyles and healthy environment as a way of improving health and vitally of the population and promoting productivity. The policy also derives from the GPRS and is therefore pro-poor in its orientation. In that regard, it builds on previous equity oriented policies and programmes that protect the poor while concurrently providing a framework for their continuous refinement into the future. Such policies include; the exemptions, NHIS, deprived areas incentive allowance, targeting communicable and neglected diseases that predominantly affect the poor, promoting maternal and child health and increasing resource allocation and investments in deprived areas including CHPS and gender mainstreaming. These policies remain relevant and would continue to receive attention and investments.

Another focus of the policy is to ensure effective implementation of standards of health development beyond just health delivery. This activity remains weak within the health sector and would need to be strengthened. Similarly the regulatory bodies, which are the agencies responsible for enforcing standards, are weak, under resourced and inadequately coordinated. At the same time collaboration with other sectors involved in ensuring healthy environments needs strengthening.

The focus for 2007 in this area is to enhance policy coordination among the stakeholders, strengthen regulatory bodies and enhance collaboration with other sectors.

Programmes and Broad Activities

- Finalise and disseminate the health policy.
- Define a guidelines for policy development within the sector
- Develop a child health policy
- Develop a policy on nutrition
- Finalise the process of reviewing the existing legislations within the health sector
- Compile a list of existing standards in the health sector and carry out a situation analysis to identify the gaps.
- Establish a mechanism for coordinating and monitoring activities of the regulatory bodies

5.2 Priority Setting, Planning and Budgeting

Planning and budgeting in the health sector continued to follow the Medium Term Expenditure Framework (MTEF) in 2006. The MTEF which is based on a three-year rolling plan provides the framework for linking budget to activities. The decentralized budgeting and planning system also provided scope for each level to reflect their local needs and priorities. The challenge continues to be the alignment of such priorities to the national priorities and for the district level to ensure that adequate allocations are made for these priorities.

In 2006 steps were taken to improve inter-agency capacity for implementation of their annual plans. In this regard, the performance contracting system was expanded to all agencies and directorates at the national level. It is expected that this system will be consolidated in 2007 and based on the lessons learnt, other management levels will be involved.

In 2007 the focus of the planning and budgeting system will be to work towards increased harmonisation of the planning process at national and inter-agency level. Steps would be taken to ensure a better alignment of the budget to national policies and priorities.

Programmes and Broad Activities

- Define priorities for 2008
- Review the performance contract system within the health sector.
- Complete the health sector 5YPOW III
- Review the Health Sector MTEF format and use it for the 2008 plans and budget

5.3 Financing, Budget Execution and Procurement

The health sector continues to face major challenges with financing and budget execution. At the heart of this challenge is ensuring adequate and predictable funding of priority programmes of BMCs. In the last two years, the predictability of funding from government has been improving whiles that from donors has worsened with substantial implications for financing of the recurrent budget. At the same time the proportion of earmarked funds in the sector has increased, the use of earmarked funds is not transparent and not aligned to the health sector priorities and budget.

Budget execution particularly of the government budget has been overwhelmed by the rising wage bill sometimes at the expense of funding for other recurrent expenditure for service delivery and investments. Disbursements to the district and sub-district levels have been below targets within the sector.

In terms of procurement, 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. The Stores System is undergoing the transformation required to support the operation of a franchise system. However, difficulties in implementing the exemptions combined with inadequate funding of free services and weak management of medical stores are contributing to increase the debt within the central and regional medical store system.

In the year 2007, the policy thrust is to increase harmonisation and alignment of the different sources of funds for the health sector budget, improve timeliness and predictability in disbursements and ensure efficiency in procurement and stores management.

Programmes and Broad Activities

- Reallocate resources within the budget to free and exempted services for 2008
- Complete the tool for ensuring harmonisation, alignment, transparency and predictability in the use of all sources of funds, including CHAG
- Continuous dialogue with the MOFEP and Development Partners to ensure timely disbursements of funds, including discussion of the quarterly financial statement at quarterly business meetings
- Make information on financial allocation to individual BMCs available to sub-district managers
- Conduct a Public Expenditure Tracking survey in collaboration with MOFEP
- In collaboration with MOFEP, develop a programme and plan for strengthening overall financial management within the health sector
- Implement the recommendations of the 2006 procurement audit
- Develop and adopt new policy on market oriented operations at the Central Medical Stores
- Review and revise accounting for the centrally procured items and develop a system to trace all government allocations including centrally procured items to the district level

5.4 National Health Insurance Scheme

The National health Insurance Scheme was set up to provide access to health services for all citizens, especially the poor and vulnerable. 134 schemes are functional with 127 schemes providing benefit to its members and the remaining seven schemes are expected to provide benefits by the end of the year 2006. Government disbursed 150 million cedis to eleven new DMHIS to complete the set up process. Additionally, 67 billion was disbursed to provide requisite administrative and logistic support to keep scheme functional. Staff of DMHIS have been trained in corporate governance and financial and claims management.

As of 30th September 2006 a total 2,837,987 (18%) have been issued with ID cards which entitles them to access health services covered by the Scheme.

An ID card data processing centre was established to process cards of fully paid up clients that had not been issued ID cards. Between January and August 2006, Government disbursed 157 billion in subsidies to cover the payment of claims for health care services provided to indigents and other exempt categories. Public education on the benefits of health insurance was intensified. Approaches used included mass media education, interaction with media and adverts on the metro mass transport buses.

In the year 2007, the sector will focus on sustaining the National Health Insurance Programme and expand its coverage nationwide to approximately 55% of the population.

Programmes and Board Activities

- Revise and implement public education to increase awareness of benefits and reduce misconceptions surrounding the national health insurance programme
- Release funds to schemes and providers for claims management as stipulated in the LI 1809
- Establish zonal NHIS offices
- Deploy an integrated information system to allow efficient management of the national health insurance programme including uniform ID system, portability and claims management
- Establish uniform systems for registration and claims management
- Provide adequate funding to support services for exempt categories such as indigents, pensioners, all children under 18 years
- Review the allocation criteria of the NHIS to give more support to financially distressed schemes and service providers to improve the quality of services
- Carry out an ability to pay study

5.5 Decentralization and Institutional Development

In the health sector, decentralization takes the form of delegation of authority to a number of autonomous agencies and to semi-autonomous Budget Management Centres (BMCs). In 1996 the Ghana Health Service and Teaching Hospital Acts gave autonomy to the Ghana Health Service and Teaching Hospitals. The aim of decentralization is to ensure equity, efficiency, quality and financial soundness.

Some of the challenges confronting decentralization in the health sector include inadequate funding of local priorities and the involvement of Local Government structures in the planning and management of local level health sector resources. Although there has been substantial financial decentralization to the districts, the over-all flow to the district level remains lower than expected and the resources do not get to the sub-districts. Whilst efforts are being made to decentralize human resources, this has been slow and there are challenges with ensuring overall coordination and alignment of activities of decentralised units behind a common health sector purpose.

The Ministry of Health still has a large responsibility in the allocation of human, material, and financial resources to its agencies and a major role in the training of personnel for its agencies and some forms of procurement. Sharing of responsibilities between the Centre and the delegated authorities has sometimes led to administrative conflicts.

I*n 2007 the sector will work towards furthering decentralization and enhancing coordination of activities within the sector.*

Programmes and Broad Activities

- Review and apply a criteria for BMC re-certification and establish a programme for certifying sub-district level BMCs
- Finalise laws and related legislative instruments setting up agencies of the Ministry of Health.
- Develop guidelines for increased participation of District Assemblies in the Planning, Management and Implementation of health sector programmes at the district and sub-district levels.
- Strengthen intra-sectoral (Inter Agency and inter BMC) dialogue
- Pilot Personal Emoluments decentralisation in three regions

5.6 Private Sector Development

Government has identified the private sector as the engine of growth. Ghana like most other countries has a pluralistic health system comprising both public and private organizations offering the spectrum of health services from prevention to diagnosis and treatment. The focus of past Governments have for a long time remained on supporting the public health sector with inadequate attention to the private sector with

the exception of the facilities under the Christian Health Association of Ghana. The public health sector however cannot solely attain the health targets of the nation. The important role of the private sector in filling the outstanding gaps has not been adequately explored.

The 2007 POW acknowledges the fact that Health is multi-dimensional and requires partnerships. Concerns have been raised about the involvement and the representation of the private sector in policy dialogue, decision making and agenda setting for the health sector. It is within this background that the MOH wishes to engage the private sector in public-private dialogue and to foster the needed collaboration between the public and private health sectors.

The policy thrust for 2007 is to drive the private health sector to be a significant contributor to the vision of the Ministry of Health which is "Creating Wealth through Health".

Programmes and Broad Activities

- Strengthen the public private partnership of the health sector by including the membership of the private sector in RHMT, DHMT and in national level policy dialogue, decision making and programme implementation
- Develop guidelines for engagement of non-government health care providers
- Review and report the contribution of the private sector to health development
- Operationalise the strategic initiative fund
- Contribute to capacity building in the private sector through proportionate participation in workshops, fellowships and so on
- Explore innovative public-private partnerships including establishing management contracts for publicly funded projects.
- Conduct a private health sector assessment to provide information on the gamut of non governmental providers of health services, numbers, distribution, types of services/activities and population being served and also to develop a database on the private sector
- Facilitate accreditation of private health care providers for the NHIS

5.7 Partnership and Coordination

The health sector has a long history of partnership and coordination with national and international bodies for the development of health and health services. Development partners have been very instrumental in assisting Ghana in its efforts at building a healthy human resource for economic growth and development.

Financial in-flow to the sector had taken the form of 'pooled' resources managed by the Ministry of Health as found under the Health Fund and the Earmarked funding arrangements which involves the direct funding of projects by Development Partners. However since 2006 a number of development partners have shifted their financial support from the health fund to a Multi-Donor Budgetary Support system (MDBS) at the macro level. Within this context of changing financial environment and other emerging developments, it is imperative that the Ministry puts in place effective measures to redefine its relationship with development partners and MOFEP.

The Five Year Programme of Work, the Annual Programme of Work (POW), the Common Management Arrangements and Aide Memoirs have provided the planning and financial framework for the disbursement of Donor funds to the sector.

The health sector has engaged with its partners through monthly partners meetings, quarterly business meetings and bi-annual health summits. In addition there have been regular planning, monitoring and evaluation processes that have strengthened the planning process, policy dialogue and coordination.

Although previous POWs identified Intersectoral collaboration as one of the key means of achieving optimal health outcomes within the sector not much has been achieved.

The policy thrust for 2007 will be to adopt a multi-sectoral and multi-stakeholder approach for policy dialogue, coordination, planning, resource mobilisation and allocation.

Programmes and Broad Activities

- Review the financial environment to maximize resource mobilization to the sector
- Develop a CMA III (2007 - 2011) in collaboration with development partners and other stakeholders
- Ensure effective stakeholder and civil society participation.

5.8 Auditing, Monitoring, Reporting and Accountability

Auditing, monitoring, reporting and accountability are an integral part of performance management and value for money assessment. A system of monitoring and

evaluation is to define criteria for collecting data and information which can indicate progress in programme or project implementation, achievements, failures so that the necessary remedial measures can be applied.

The Ministry of Health and its agencies have a structured system of data collection and collation from the community, to sub-district, to district, to region and, to Headquarters levels.

There are monthly, quarterly, and annual reviews of programmes and projects at all levels of the health sector. These review sessions highlights progress made in programme implementation, outlines challenges, and provides the way forward. The Annual Programme of Work Review also provides a guide for planning the following year.

Despite the mechanisms described above, the collection of primary data, its collation, storage, and analysis is still a problem. There are fundamental problems with the quality of diagnoses, recording of diagnosis, and analysis of data collected at the health facility level which also has adverse effects on the quality of data reported at various levels of the health sector. Apart from this, there is a huge challenge with reporting systems within the sector. Hence data is often not used in defining programme priorities, planning and resource allocation. This fundamentally, creates a gap between data collection and the decision-making process.

Secondly, whilst previously the monitoring and evaluation system focused mainly on generating data from the Ministry of Health and its agencies the scope of data required for moving the sector forward will change from year 2007 and beyond because of the change in the scope of the health policy of the sector. The new health policy with focus on preventive and promotive health requires that the scope of data collection is extended beyond the Ministry of Health to include inter-sectoral agencies such as Community Water, Sanitation, Education and sports, Food and Agriculture since these directly affects health.

A system of Auditing, Accountability, and value for money assessment is an integral part of the programme of work. Audits of sectoral programme are done once a year. However, special audits can be conducted as and when the need arises. Provision of audit reports has often been one of the major reasons for the release of funds from the International Development partners.

In 2007 the sector will work to establish a monitoring and evaluation system that will provide timely, accurate, reliable and valid data for planning, management and decision making. The sector will also work to ensure timely audit reports.

Programmes and Broad Activities

- Train staff to increase capacity for auditing, monitoring and evaluation.

- Provide earmark funding for sector wide reviews, including an analysis of the efficiency of hospital services
- Review the sector-wide indicators.
- Orient councils ,boards and management teams in the POW and develop systems for holding them accountable for performance
- Develop, test and deploy a framework of relevant incentives and sanctions that enable performance and promotes accountability
- Monitor and report on the performance of the health sector, and sub-systems within the sector
- Conduct productivity analysis that links financial and services delivery information

6. 2007 HEALTH BUDGET

The main sources of funding to the Ministry are GOG, Health Fund, HIPC, IGF and National Health Insurance Fund. The total budget for the sector for the fiscal year 2007 is ¢5.6 billion and allocated on the various budget lines. The tables below shows the sources of funding and their contributions and how it is intended to be used to support service delivery.

Efforts have been made to ensure that centrally procured items or ring-fenced items are charged to the beneficiary BMCs to ensure proper accountability. Based on the above the budget is developed to cover line items , programmes and institutions.

Table 1: Budget Ceilings by Item (million cedis)

	GoG	Donor Health Fund	Donor Earmarked	IGF	NHIF	HIPC	Total
Item 1	2,175,550	**-**	**-**		72,530		**2,248,080**
Item 2	102,676	**18,000**	**-**	169,153	60,647		**350,476**
Item 3	100,389	171,000	**365,565**	318,909	1,252,550	80,000	**2,288,413**
Item 4	103,289	**-**	312,225	32,938	373,370	15,000	**836,822**
Total	**2,481,904**	**189,000**	**677,790**	**521,000**	**1,759,097**	**95,000**	**5,723,791**

Budget Allocation Trends

Table 2: Summary of Budget Estimates and Ceilings (million cedis)

	2004 Actuals	2005 Actuals	2006 Approved Budget (Exc NHIS& Earmarked)	2007 Ceiling (Incl. NHIS)
Item 1	1,015,898	1,468,944	2,300,000	**2,248,080**
Item 2	282,324	381,792	243,495	**350,476**
Item 3	619,351	579,018	598,040	**2,288,413**
Item 4	144,143	171,481	374075	**836,822**
Total	**2,061,716**	**2,601,235**	**3,621,327**	5,723,791 **5,637,564**

Item 1 – Personal Emoluments

The expenses under item 1 are for personal emoluments within the Ministry of Health and Agencies.

Table 3: Summary of Personal Emoluments

Activity	**Funded from ceiling**
Established Posts	1,956,675
Recruitment (new entrants)	127,352
Contracts	
Trainee Allowance	75,000
Promotions	0
National Ambulance Service	16,523
Sub-total	***2,175,550***
NHIC Secretariat	28,730
DMHIS	43,800
Sub-total	***72,530***
GRAND TOTAL	**2,248,080**

Table 4: Personal Emolument allocation by Agency

MoH and Agencies	Allocation
Ministry of Health HQ	112,568
Training Institutions	115,543
Subvented Organisations	75,728
Teaching Hospitals	330,136
Ghana Health Service	35,229
Psychiatric Hosp	45,538
Regional	246,887
District	927,832
Christian Health Association of Ghana	286,089
Subtotal	2,175,550
NHIS Secretariat	28,730
DMHIS	43,800
Subtotal	72,530
Grand Total	**2,248,080**

Item 2 – Administration Activity Expenses

The expenses under item 2 are for the running cost of BMCs and are directed towards keeping BMCs functional. They include (i) planned preventive maintenance of infrastructure, vehicles and equipment, (ii) running cost of official vehicles, (iii) office consumables, printing and publications, and (iv) other staff allowances not included in expenses for personnel emoluments such as vehicle maintenance, overtime allowance, fuel allowance, etc. The table below shows the summary of item 2 budget from GOG, IGF and NHIF to the Agencies.

Table 5: Summary of Item 2 by Agency (Million cedis)

MOH and Agencies (Exc NHIS)	
Ministry of Health HQ	24,959
Training Institutions	7,863
Ghana Health Service	70,000
Christian Health Association of Ghana	1,202
Subvented Organisations	5,540
Teaching Hospitals	11,112
Subtotal	***120,676***
National Health Insurance Scheme	
NHIC Secretariat	27,240
DMHIS	33,520
Subtotal	***60,647***
IGF	***169,153***
GRAND TOTAL	**350,476**

A total ¢13.8 billion of the Item 2 votes of Teaching, and Regional Hospitals are to be reallocated to support the Guinea Worm Eradication Programm during the 2007 budget implementation period.

Item 3 - Service Activity Expenses

The expenses under item three are for the recurrent cost of service delivery including research, policy development, planning, supportive supervision overall governance and coordination and fellowships - scholarships and bursaries for training. The budget estimates also recognise the stream of entitlements that have been defined by law and by policy such as the provision of free public health services and exemptions. The budget for item 3 covers the items listed in the table below:

Table 6: Summary of Service Activity Expenses (million cedis)

Activity	Funded from ceiling
Transfers to Budget Management Centres (Cost Centres) for programme implementation	83,695
Central level procurement of vaccines, drugs for public health interventions from GoG, HF and NHIF	246,000
Fellowships	14,000
Local level procurement of drugs and essential logistics from IGF	318,909
Regenerative Health	15,000
Exemptions and other exempt categories under NHIF and HIPC	980,000
Operational cost of NHIC Secretariat	9,920
Operational cost of DMHIS	204,991
Health Assistants training funded from Eearmaked	165,000
Earmarked procurement	**204,108**
Reserved Fund	**46,790**
Total	**2,288,413**

Table 7: Item 2 Allocation by levels

Agency	Operational Budget	Ring fenced (HF NHIS GOG)	Total	%
MoH HQ	10,723	73,100	83,823	0.037
Subvented Org	5,479		5,479	0.002
Training Institutions	6,522		6,522	0.003
Teaching Hospitals	6,983		6,983	0.003
GHS HQ	10,818		10,818	0.005
Psychiatric Hosp	3,969	5,200	9,169	0.004
Regional Health Ser	7,815	10,000	17,815	0.008
Total Dist Ser	31,386	1,485,609	1,516,995	0.663
DMHS operational cost		204,991	204,991	0.090
Operational cost of NHIC Secretariat		9,920	9,920	0.004

Health Assistant		165,000	165,000	0.072
NHIS Reserved Fund		46,790	46,790	0.020
Other procurement		204,108	204,108	0.089
Total	**83,695**	**2,204,718**	**2,288,413**	1.000

Item 4 – Capital Expenses

The budget estimates under item 4 budget are for: (i) infrastructure development (Health facilities, staff accommodation, training institutions and offices), and (ii) procurement of equipment and vehicles for service delivery and management, and (iii) ICT deployment. It also includes capital projects to be financed from NHIF.

Table 8: Summary of Investment Expenses (million cedis)

Activity	**Funded from ceiling**
Health infrastructure (New, expansion and rehabilitation)	634,789
Procurement of Equipment	108,000
Procurement of Vehicles	0
Procurement of ICT for health institutions	0
Subtotal	**742,789**
Construction of NHIS Secretariat building	20,000
Komfo Anokye A&E Centre financed from NHIF and HIPC	128,440
NHIS Secretariat capital expenditure	14,740
Capital expenditure for DMHIS	130,370
Reserved fund	46,790
Subtotal	***340,340***
GRAND TOTAL	**1,083,129**

7 BROAD RESPONSIBILITIES FOR PERFORMANCE

The 2007 POW would be implemented within the framework of the laws establishing the Ministry of Health and its Agencies. Achieving the objectives and outputs in this POW would be the joint responsibility of the Ministry of Health, Ghana Health Service, Teaching Hospitals, Statutory Bodies and Development Partners. It recognises the complementary roles of the public and private sectors as well as individuals and communities in the delivery of quality health services. The involvement and support of communities and other stakeholders in health would be critical for effective implementation.

Ministry of Health

The Ministry of Health (MoH) would provide stewardship to the entire sector. In this regard, MoH would focus on policy and institutional development, strategic planning, resource mobilization, coordination of all Agencies and Partners involved in health development. MoH would coordinate investments in the sector including capital investments and the management of training institutions. To address the broader determinants of health, MoH would engage other MDAs, including the Ministries of Education, Finance and Local Government and Rural Development, Manpower, Youth and Employment, National Development Planning Commission, Women and Children's Affairs, Water Resources, Works and Housing, whose activities impact on health.

The Ghana Health Service

The Ghana Health Service is a semi-autonomous government agency responsible for the provision of health services. GHS would be responsible for ensuring the maintenance of high level of performance in the provision of public health and clinical care services at the sub-district, district and regional levels as well as the management of institutions at these levels. This will require the development of technical guidelines for service delivery and coordination of activities of DHMTs and RHMTs. GHS would also provide tertiary services in selected disciplines like mental health.

The Teaching Hospitals

The Teaching Hospitals would provide tertiary services and ensure that the processes for accepting patients are reviewed to enable them focus on referred cases that require specialist care. In playing this role, The Teaching Hospitals would maintain appropriate balance between service delivery and the training of students.

With the introduction of the NHIS both GHS and Teaching Hospitals would prepare their institutions to meet the requirements of service provision under the scheme.

National Health Insurance Council

The council would secure the implementation of the national health insurance policy that ensures access to basic health services to all residents. The council would

register, licence and regulate health insurance schemes; supervise the operations of health insurance schemes and grant accreditation to healthcare providers and monitor their performance. The NHIC would ensure that healthcare rendered to beneficiaries of schemes by accredited healthcare providers are of good quality.

Statutory Bodies

The Statutory Bodies would manage the regulatory machinery of the sector to ensure that service delivery is more responsive to the legitimate expectations of all people living in Ghana. The Statutory Bodies would monitor and enforce the ethics and standards of practice of various professional and technical groups within the sector. Each Statutory body would also mount comprehensive public relations programme with a specific aim of empowering the public on their rights to seek better service.

Development Partners

All activities of the Development Partners would be within the framework of the 5YPOW and the CMA. Development Partners would support Government in the development and implementation of policies. They would engage in the policy dialogue in the health sector and facilitate the implementation of sector-wide programmes through the provision of technical and financial support. The Development Partners would facilitate access of the health sector to international best practices.

Other Ministries, Departments and Agencies

MDAs whose activities directly or indirectly impact on health such as Ministries of Education, Finance and Local Government and Rural Development, Manpower, Youth and Employment, National Development Planning Commission, Women and Children's Affairs, Water Resources, Works and Housing, etc. would be encouraged to actively participate in the implementation of the health sector program and involve the Ministry in all their health and health related activities and programs.

Annex 1: 2007 Fellowship Plan

	FOREIGN						
	Course/Programme	**Country**	**Long**	**Short**	**Unit Cost (£)**	**Number**	**Total Cost**
1	Cert.Accident & Emerg.	U K		√	8,000	1	8,000
2	Cert.Intensive Care	U K		√	8,000	1	8,000
3	Msc Emergency Medicine	U K	√		20,000	1	20,000
4	MSc Advance Trauma	U K	√		20,000	1	20,000
5	MSc Control of Infectious	U K	√		20,000	1	20,000
	Diseases/Epidemiology						
6	Msc Nutrition & Dietetics	U K	√		20,000	1	20,000
7	Msc Health Financing	U K	√		20,000	1	20,000
	Economics & Insurance						
8	MSc Health Mgt Infor.Sys.	U K	√		20,000	1	20,000
9	MSc Opthalmic Nursing	UK	√		20,000	1	20,000
10	MSc Cm'ty Pschiatry /Nut	UK	√		20,000	1	20,000
	ToTal					**10**	**176,000**
	REMARKS						
	Total cost for 2006 foreign programmes =**£176,000**						
	Cedi equivalent =**¢2,816,000,000**						

	Local Programmes						
1	MSc Clinical Pharmacy	Ghana	√		1,500	3	4,500
2	MPH Health Promotion	Ghana	√		1,500	6	9,000
	and Education						
3	MPH Reproductive Health	Ghana	√		1,500	6	9,000
4	MSc Environmental Sci.	Ghana	√		1,500	1	1,500
5	MPH	Ghana	√		4,000	10	40,000
6	MA HRM	Ghana	√		2,000	2	4,000
7	MSc Health Planning and	Ghana	√		1,500	4	6,000
	Management						
8	MBA HRM	Ghana	√		4,500	3	13,500
9	EX.MA. GOV.&LEAD.	Ghana	√		2,000	2	4,000
10	EX.MA.PUB.ADM..	Ghana	√		2,000	1	2,000
11	PG DIP.EDU	Ghana	√		500	30	15,000
12	B.ED HLTH SCI.EDU.	Ghana	√		1,000	40	40,000
13	Mphil Health	Ghana	√		3,000	1	3,000
	Informatics						
14	Msc Nursing	Ghana	√		3,000	5	15,000
15	Mphil Nursing	Ghana	√		3,000	4	12,000
16	Mphil Clinical Psychology	Ghana	√		3,000	2	6,000

17	Allied Health	Ghana	√		500	30	15,000
	Total					**150**	**199,500**
	REMARKS						
	Total cost for 2006 Local programmes =**£199,500**						
	Cedi equivalent =**¢3,168,,000,000**						

Continuing Students both Local and Foreign = **10,832,000,000**

Grand Total = 3,168,000,000 + 10,832,000,000 = **14,000,000,000**