



THE GHANA HEALTH SECTOR

2008 PROGRAMME OF WORK

**MINISTRY OF HEALTH
NOVEMBER 2007**

ACRONYMS

AFP	Acute Flaccid Paralysis
ART	Anti-Retroviral Therapy
ARV	Anti-Retroviral
ARI	Acute Respiratory Infections
ASRH	Adolescent Sexual and Reproductive Health
ATF	Accounting, Treasury & Financial
BCC	Behaviour Change Communication
BMC	Budget Management Centres
BPEMS	Budget, Public Expenditure Management Systems
CAM	Complementary Alternative Medicine
CAN	African Cup of Nations
CEO	Chief Executive Officer
CHAG	Christian Health Association of Ghana
CHPS	Community Health based Planning & Services
CMS	Central Medical Stores
CMR	Child Mortality Rate
CPR	Cardio Pulmonary Resuscitation
C/S	Caesarean section
CSRPM	Centre for Scientific Research into Plant Medicine
DHMTs	District Health Management Teams
DP	Development Partners
DEENT	Department of Ear, Eye, Nose & Throat
ENT	Ear, Nose & Throat
EPI	Expanded Programme on Immunisation
FDB	Food & Drugs Board
5yPOW	Five-year Programme of Work
GCPS	Ghana College of Physicians & 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
HMIS	Health Management Information System
HR	Human Resource
ICC	Interagency Coordinating Committee
ICT	Information Communication Technology
IGF	Internally Generated Fund
IMCI	Integrated Management of Childhood Illnesses
IPT	Intermittent Preventive Treatment
ITNs	Insecticide Treated Nets
KATH	Komfo Anokye Teaching Hospital
KBTH	Korle Bu Teaching Hospital
MDAs	Ministries, Departments and Agencies
MDGs	Millennium Development Goals
MOESS	Ministry of Education, Science & Sport
MOH	Ministry of Health
MRI	Magnetic Resonance Imaging
MTEF	Medium Term Expenditure Framework
NCD	Non-Communicable Diseases
NDPC	National Development Planning Commission
NGOs	Non-Governmental Organisations
NHIC	National Health Insurance Council
NHIF	National Health Insurance Fund
NHIS	National Health Insurance Scheme
OPD	Out-patient Department
POW	Programme of Work
PPM	Planned Preventive Maintenance
RBM	Roll-Back Malaria
RHMT	Regional Health Management Teams
RHN	Regenerative Health & Nutrition
RTA	Road Traffic Accident
SARS	Severe Acute Respiratory Syndrome
STD	Sexually Transmitted Diseases
STG	Standard Treatment Guidelines

TB	Tuberculosis
TRIPS	Trade Related Intellectual Property Rights
TTH	Tamale Teaching Hospital
WHO	World Health Organisation

ZERO DRAFT FOR DISCUSSION NOT FOR QUOTATION

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MESSAGE FROM THE HON. MINISTER OF HEALTH

The past year saw the introduction and implementation of a new health policy that defines a new paradigm for health delivery. It also aims at placing health within the overall framework of socioeconomic development and thus contributing to the national agenda of transforming this country into middle income status. An imperative of the new policy is the acceleration of improvements in health status through drastic reduction of the disease burden in the shortest possible time.



As some of you are aware, I have been a leading advocate for behaviour and lifestyle changes based on my conviction that the disease burden we carry is the result of choices we made and continue to make in our everyday lives. Most of these diseases are preventable and avoidable and could be dramatically reduced by simple changes in nutrition, physical activity and hygiene. It is for this reason that we have introduced the Regenerative Health and Nutrition Programme.

The 2008 POW is one step in the build up toward the attainment of our set objectives of fast tracking health delivery in a holistic, sustainable and equitable manner. The focus is, therefore, to consolidate the unfinished agenda of high impact and rapid service delivery by expanding to all regions, strengthening the weak and fragmented health system, scaling up the programme of regenerative health & nutrition and expanding the coverage of the National Health Insurance Scheme; while bringing unto the centre stage issues of equity, efficiency and financial sustainability.

In 2008 the sector will address health risk factors through the promotion of healthy lifestyles and behaviours. We will also focus on strengthening the health systems and training of middle level health professionals. We will accelerate the implementation of the high impact health, reproduction and nutrition interventions and services targeting the poor and vulnerable groups and emphasize the improvement of quality and coverage of clinical care focusing on the provision of emergency and essential obstetric care. Efforts will also go into promoting good governance, partnerships and sustainable financing.

Additionally, the sector will introduce a number of new strategic initiatives. These include:

- The Productivity Improvement Initiative following the improvement in salaries of health workers
- New approaches to identifying the poor under the National Health Insurance Scheme as a way of reaching the poor not covered under the narrow definition of indigents under the current provisions in the National Health Insurance Law.
- A general screening programme for the population including screening for breast and prostate cancer in order to facilitate early detection and prompt treatment of diseases

This programme of work will be funded by multiple sources including the consolidated fund, donor funds, NHI and Internally generated funds. Though these are traditional sources of funding, in 2008 the sector will experience a major shift from donor funding through the health fund to budget support through Ministry of Finance and Economic Planning. In addition there will be a substantial reduction in out of pocket payment for health services and an increase in funding under the NHIS. These shifts will require that

we ensure effective coordination and complementarity between the different sources of funding, put in place mechanisms to engage MOFEP in enhancing public financial management and ensuring predictability in government funding and improving timeliness and systems for claims management under the NHIS. In addition the sector will ensure effective budget execution including strengthening systems for internal controls and external audit functions.

Obviously the implementation of the POW will call for greater collaboration, harmonisation and alignment of efforts of all stakeholders in the health sector. This is the only way we can ensure synergy in our actions and rapidly accelerate the reduction of the overwhelming disease burden of communicable and pregnancy related diseases as well as the rising non communicable diseases including trauma.

I wish on behalf of the government of Ghana to invite all stakeholders to appraise themselves of the content of this document and join the Ministry of Health and its Agencies in its execution. In particular I request your support to implement the innovations and address the challenges to scaling up priority health interventions.

Major Courage E. K. Quashigah (Rtd)

1. INTRODUCTION

The health sector in 2007 began implementing a new health policy and five year programme of work (2007-2011) with a focus on achieving three inter-related and mutually reinforcing objectives namely:

- (a) ensuring that children survive and grow to become healthy and productive adults that reproduce without risk of injuries or death;
- (b) reducing the risk and burden of morbidity, disability, and mortality especially amongst the poor and marginalized groups
- (c) reducing inequalities in access to health, reproduction and nutrition services, and health outcomes.

The five year Programme of Work (POW) was woven around the under-listed four objectives that have guided annual programmes of work.

- (a) promotion of healthy lifestyles and environment to reduce risk factors that emanate from environmental, economic, social and behavioural causes
- (b) improvement of access to quality health, reproduction and nutrition services
- (c) strengthening capacity of the health system in the regulation, management and provision of health services
- (d) fostering good governance, partnerships and sustainable financing.

The 2008 POW presents a portfolio of policies, broad programmes, outputs and actions that are required to be implemented by the health sector in the second year of implementation of the third Five-Year Programme of Work. It derives from the five year POW and its strength lies in the fact that it has been developed through collective work, continuous dialogue and consultation with key partners, agencies and stakeholders in the health sector.

The 2008 POW builds on achievements of the 2007 POW. In that regard it continues and consolidates the priorities identified in 2007. These are scaling up the High Impact and Rapid Delivery (HIRD) and Regenerative Health and Nutrition (RHN) programmes, continuously refining the health worker incentive package and consolidating the NHI programme. Like the 2007 POW, the 2008 POW is focus on a limited set of priorities. These are

- Food safety
- Quality of clinical care
- Expansion of middle level training and enhancing productivity
- Intersectoral collaboration

Additionally, the sector will introduce a number of new strategic initiatives. These include:

- The Productivity Improvement Initiative following the improvement in salaries of health workers

- New approaches to identifying the poor under the National Health Insurance Scheme as a way of reaching the poor not covered under the narrow definition of indigents under the current provisions in the National Health Insurance Law.
- A general screening programme for the population including screening for breast and prostate cancer in order to facilitate early detection and prompt treatment of diseases

The 2008 POW however makes a point of departure from previous POWs in its design and orientation. It is operational in its orientation and may be described as an Agency-based Programme of Work since it has been developed and authored largely by the implementing agencies in response to the Sector's Health Policy Framework, GPRS II, Millennium Development Goals (MDGs) and third 5-yr POW (2007-2011). In this context it creates a better alignment between the POW and budget structure thus laying the basis for accountability within the health sector.

In a nut shell the 2008 POW maintains the central theme of creating wealth through health with a significant focus on the promotion of individual lifestyle and behavioural change, scaling up of high impact health, reproduction and nutrition interventions, continuing investments in health systems development with emphasis on strengthening district health systems and the promotion of good governance including sustainable financing and partnerships. The document recognises the important role of other stakeholders and consequently emphasises the promotion of intersectoral action to improve health outcomes. Indeed all sectors that contribute to health development will therefore be brought on board in efforts to accelerate progress towards the achievement of the MDGs and GPRS II objectives.

2. POLICY FRAMEWORK

The sector's policies and priorities are located within the context of Government's overall development agenda as spelt out in the GPRS II, the National Health Policy and the five year POW. It aims at contributing to national efforts of transforming Ghana into a Middle Income Country by 2015.

2.1. VISION

The vision of the health sector is to create wealth through health and in so doing contribute to the national vision of attaining middle income status by 2015.

2.2. MISSION

Our mission is to contribute to national socio-economic development and wealth creation through (i) the promotion of health and vitality; (ii) ensuring access to quality health and nutrition services for all people living in Ghana; and (iii) facilitating the development of a local health industry.

2.3. POLICY OBJECTIVES

2.3.1. SECTOR GOAL

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

2.3.2. STRATEGIC OBJECTIVES

The goal is to be achieved through four strategic objectives that provide a more balanced approach to the known challenges of the health system in terms of the changing determinants of health, the unfinished agenda of service delivery, the weak and fragmented health system and the greater need for governance and sustainable financing. These **strategic objectives** are to:

- (a) address risk factors to health by promoting an individual lifestyle and behavioural model for improving health and vitality, and strengthening inter-sector advocacy and actions;
- (b) rapidly scale up high impact health, reproduction and nutrition interventions and services targeting the poor, disadvantaged and vulnerable groups and bridge the gap between interventions that are known to be effective and the current relatively low level of effective population coverage;
- (c) strengthen the health system's capacity to expand access, manage and sustain high coverage of health services through investment; and
- (d) promote good governance, partnerships and sustainable financing.

2.3.3. GUIDING PRINCIPLES

The objectives of the 2008 POW 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 centered 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

3. KEY LESSONS AND CHALLENGES

The main challenges of the health sector in 2008 will revolve around financing the programme of work within a budget constraint whilst managing the expectation of rapidly scaling up the delivery of health interventions to meet the MDGs. In particular the sector will need to address the relatively high wage bill without concurrent increases in resources from the consolidated fund for services and investments. At the same time financing through the NHI system is going up. Given that NHIF disbursements are governed by law there is a limit to what NHIF can be used to fund within the sector. This notwithstanding the health sector has to depend increasingly on the NHIF to finance its service and investment budgets. However this has to be done in a manner that does not undermine the sustainability of the fund.

The NHI programme remains an important pro-poor strategy for the sector. Currently exemptions constitute about 57% of total projected expenditures under this programme. The benefit package under the NHIS includes children under 5, the elderly, pregnant women and indigents. The opportunities under the NHIS and the known difficulties in financing the exemptions under user fee system makes it imperative to transfer all exemptions to the NHI system. On account of the narrow definition of indigents it is expected that some poor people who can not afford the NHI premium may be deprived of services. Approaches for identifying and recruiting the poor under the NHIS need to be tested.

The NHIS continues to be confronted by a number of challenges. The desire to scale up registration including possibility of decoupling children from their parents and the persistent demands to expand the benefit package need to be reconciled with the threat of sustainability of the fund. Secondly there is an emerging threat to sustainability of health services from delays in reimbursement of claims. Thirdly, the management of reserves need to be strengthened to ensure the overall sustainability. In the long term the issue of provider and consumer moral hazards will need to be addressed to sustain the scheme.

The burden of diseases in the country has not changed significantly since independence and this would undermine the NHIF unless concurrent action is taken in the areas of health promotion and disease prevention. The pattern of diseases continues to be dominated by communicable diseases, persistent under-nutrition and poor reproductive health. The burden of non-communicable diseases such as cardiovascular disorders, diabetes and cancers has emerged as a major challenge to service delivery and a threat to health and national productivity. Similarly, mental health and neurological disorders are also on the increase whilst trauma and other injuries contribute significantly to the most commonly seen outpatient conditions. The two programmes introduced in 2007, the RHN and HIRD programmes present opportunities to reverse this trend and therefore need to be sustained and scaled up. It is however clear that extra effort and investments beyond what the budget can support will be required to scale up programmes for achieving MDG5.

An emerging threat in 2008 is a meningitis epidemic likely to coincide with the period of CAN 2008 and in the regions whose health infrastructure has been devastated by recent floods. Indeed the floods have eroded the health gains so far made in these areas in terms of the destruction of health infrastructure, disruption of health services and reversal of progress in the control of diseases such guinea worm, malnutrition and malaria all of which could undermine the achievement of the MDGs. These make re-establishing

services and surveillance systems in these regions a priority. It also calls for strengthening mechanisms for epidemic preparedness and response in the country.

The changes in Ghana's demographic profile have major implications for the health sector. Specifically the health sector needs to be positioned to respond to rapid urbanisation, ageing, changes in lifestyle and disruption of the family and traditional structures and support systems. In addition there is the need to integrate gender issues into the sector's programmes and priorities. This is primarily because men and women differ in terms of their healthcare needs and have different roles to play in their responses to health promotion and the reduction of barriers to accessing health services.

Today, the health sector is faced with an increasing demand for health services and rapidly expanding urban and peri-urban areas as well as deprived rural areas. At the same time existing health infrastructure are deteriorating and equipment are fast becoming obsolete thus undermining quality of care. In addition the sector is faced with numerous uncompleted projects with significant sunk costs. These issues will need to be addressed within the medium to long term within the frame work of the Capital Investment Plan III (CIPIII).

In 2007, the health sector abolished the additional duty hours allowance and introduced a new salary structure. This is already slowing down the brain drain. The expansion of training institutions with the initial assumption of a high brain drain already suggests that the health sector will have more nurses than required and the wage bill will continue to rise. Medium term programme for rationalising the human resource production needs to be instituted as part of the current HR strategy. At the same time efforts need to go into improving the productivity of health workers. These call for a reappraisal of the role of the public sector in health delivery and the introduction of fundamental changes in the way health workers are managed and motivated.

4. 2008 PRIORITIES

4.1. PROGRAMME PRIORITIES

The priorities for 2008 are based on the need to consolidate the gains made in 2007. Specifically the programme aims at scaling up the High Impact and Rapid Delivery (HIRD) and Regenerative Health and Nutrition (RHN) programmes. Efforts at refining the health worker incentive package and consolidating gains made in the implementation of the NHI programme will continue to receive significant attention. The following priorities will also be in focus:

- Promote the enforcement of regulations on food safety in collaboration with the MLGRD
- Improve quality of clinical care with a focus on essential obstetric care
- Expansion of middle level training and enhancing productivity
- Intensify intersectoral collaboration in the implementation of the RNH programme

Some new strategic initiatives will also be pursued. These include a Productivity Improvement programme to ensure that health worker performance is improved in response to the improvement in salaries. This will involve defining job descriptions and performance standards for different categories of health workers, guidelines for developing duty rosters and work scheduling in hospitals and linking job descriptions to performance appraisals and promotions.

The sector will seek new approaches to identifying the indigents under the National Health Insurance Scheme as a way of reaching the poor not covered under the narrow definition of indigents under the current provisions in the National Health Insurance Law.

A general screening programme will be introduced for the population. This will include screening for breast and prostate cancer in order to facilitate early detection and prompt treatment of diseases.

As in all other years, the poor will be exempted as much as possible from payment of user fees through NHIF either by subsidizing or payment of premium. The capital investment budget, on the other hand, will prioritize training institutions as well as provision of infrastructure and equipment that contribute to quality improvements and enhance revenue generation potential of health institutions such as laboratories, pharmacies, theatres and mortuaries. It is hoped such interventions will expand access of health services to the deprived as well as assist institutions to respond adequately to increased service load and challenges of urbanization.

4.2. EXPENDITURE PRIORITIES

Though the sector's resource envelope has increased in absolute terms from GH¢ 439.23 million in 2007 to GH¢763.02 million in 2008, the dwindling size of relative resources allocated to the sector from the government budget, in real terms, and the shift by donors to sector budget support have put resource allocation within the sector under severe pressure. Consequently, all Agencies and Budget Management Centres (BMCs) are to keep the nominal rolls updated throughout the fiscal year and ensure that the payroll is

reconciled with staff at post throughout the year. Additionally, all new recruitments are to be approved by the Ministry prior to engagement.

As part of the sector's expenditure programming policies to rein in the wage bill, trainee allowances will be phased out in the short to the medium term. Consequently, a programme is currently underway to phase out these allowances beginning with new intakes into our training institutions in September 2007. The deprived area incentive allowance will also not be implemented.

In line with our priority of reversing deteriorating health infrastructure and equipment, the policy of Planned Preventive Maintenance (PPM) will be implemented. In view of this, BMCs are required to prepare PPM plans and dedicate at least 10% of their internally generated funds to the implementation of these plans. In addition, it is envisaged Agencies and BMCs will implement efficiency savings programs targeted at minimising travels and running costs of offices (fuel, utilities, stationery, etc).

To take advantage of economies of scale, the budgeting and procurement of public health commodities such as vaccines, contraceptives and Insecticide Treated Nets (ITNs) will continue to be carried out centrally to achieve optimal efficiency in the use of scarce resources. All Agencies and BMCs have also been directed to budget for existing commitments; particularly, maintenance contracts and to operate within the budget as the Ministry will not pay off debts accumulated outside the budget

Finally, the item 4 budget will be centrally managed in consultation with heads of Agencies. The budget will give priority to the following capital investment programmes:

- Counterpart funded projects
- Expansion of training institutions
- Construction of CHPS compounds
- Provision of basic equipment for Reproductive and Child health services and management of pro-poor diseases such as Buruli Ulcer.
- Support to hospitals to expand portfolios that enhance quality and generate IGF e.g. Laboratories, dispensaries, mortuaries, theatres

All hospitals are to earmark at least 10% of internally generated funds for the replacement of equipment and machines and minor rehabilitation of infrastructure (minor civil works).

5. HUMAN RESOURCES FOR HEALTH

The Ministry's objective for Human Resources for Health is to ensure adequate numbers and mix of well motivated health professionals distributed equitably across the country to manage and provide health services to the population. A strategic plan which seeks to improve and sustain the health of the population by supporting appropriate human resource planning, management and training has been developed. This strategic plan will seek among others to address the imbalance of health workers in favour of highly trained professionals through scaling up the training of middle level health cadres, as well as address the mal-distribution of health professionals.

The productivity of the health work force varies considerably across the country and is generally perceived to be low. In 2007 the ADHA was replaced by the new Health Salary Scheme aimed at improving performance and arresting the brain drain. This new salary structure has had a considerable impact on the wage bill however this is not translating into increased productivity of the health workforce. There is therefore the need to evaluate these motivational packages to ascertain the impact on staff retention and performance. In addition there is the need to determine other factors which may influence health workforce productivity so as to find appropriate interventions to the issue.

The policy thrust for 2008 is to ensure an equitable distribution of the right numbers and mix of health staff and introduce staff productivity improvement programmes.

Key Activities

- Implement the planned Human Resource strategic plan
- Conduct impact assessment to ascertain the impact of the new salary scheme and other incentives introduced on staff productivity
- Review the expansion of the middle level training programme
- Deploy resources to the recently established Human Resource Observatory to ensure the HR governance issues are complied with.
- Collaborate with MLGRD, MOESS and GCPS to effectively train and distribute health personnel.

Expected Results

- Implementation of HR strategic plan
- Adequacy of staff mix
- Functional HR observatory

6. AGENCY SPECIFIC PROGRAMMES OF WORK

6.1. GOVERNANCE AND FINANCING

6.1.1. MINISTRY OF HEALTH HEADQUARTERS

The Ministry of Health is responsible for stewardship of the entire health sector and ensuring equity and efficiency in the sector activities. It exercises this function by providing overall policy directions, institutional development, coordinating the activities of agencies, partners and stakeholders involved in health and ensuring performance and accountability within the sector. In addition, MOH coordinates planning, resource mobilisation, budget execution, human resource development and the over all monitoring and evaluation of the health sector performance.

In the last few years the health sector has been going through a period of organisational reforms that has made coordination very challenging. In addition the financing environment has changed following the introduction of NHIS and movement of partners to budget support. Slow progress in improving outcomes requires stronger focus on performance monitoring, organisational incentives and accountability as well as greater harmonisation and alignment of activities of stakeholders.

The Thrust of the Ministry of Health in 2008 is to promote achievement of results through good governance the efficient, equitable and transparent mobilisation, allocation and utilisation of resources and better harmonisation and alignment of activities and investments by key stakeholders in health.

Priority Activities

- Oversee the execution of the 2008 POW and Budget and develop the 2009 POW and Budget.
- Review the Accounting treasury and Financial rules to bring them in line with the new Financial Administration Act, 2003 (Act 654)
- Coordinate the activities of agencies and donors, and promote partnerships with other MDAs, Private sector and NGOs/Civil society including the media.
- Define priorities and develop incentives and sanctions for aligning agency and partner activities to priorities.
- Mobilise, allocate, monitor and account for the use of resources within the sector.
- Develop, implement and undertake quarterly monitoring of annual Procurement Plans and the Capital Investment plan
- Explore options for aligning the procurement cycle to the budget and harmonise the systems for budget, procurement, financial, stores and asset management.
- Oversee the development of innovations within the sector including scaling up RHN, testing systems for identifying the poor under health insurance, introduction of screening programmes,
- Integrate traditional medicine into general health system and support the commercialisation of herbal medicines
- Strengthen internal audit systems, facilitate external financial and procurement audit and ensure timely responses and follow-on actions to the audits.

- Conduct needs assessment as the basis for improving Public Financial Management (PFM) in the health sector.
- Develop and execute an agenda for policy research and implement a participatory policy dialogue involving Agencies, Development Partners, NGOs Civil Society, the Private Sector, Media and other MDAs, through monthly partners meetings, quarterly business meetings, biannual summits and relevant interagency/inter stakeholder meetings.
- Review and reform existing systems for reducing wastage, enhancing quality and ensuring standard pricing for medicines and promote local production to ensure continued availability and affordability of essential medicines and logistics.
- Coordinate and harmonize data collection systems in the health sector and build central data repository to support assessment of performance based on the sector wide indicators.
- Continue efforts at rationalising the health sector wage bill and workforce numbers, mix and distribution in line with staffing norms and implement initiatives to improve workforce productivity within the health sector.
- Conduct annual sector-wide reviews and continuously monitor and report on performance of Agencies, policies and commitments of the sector. Work towards aligning the sector reviews to government wide reviews such as the MDBS and the APR.

Expected Results

- Approved 2009 POW and Budget
- Improved compliance to financial regulation (Reduction in audit queries)
- Effective execution of budget (Predictability and Variance)
- Reduced lead time in procurement
- Broad and inclusive policy dialogue (Representation at partners meetings)
- Stronger evidence for policy and accountability (Timeliness of reporting)
- Medicines and Logistics supply security

Collaborators

Agencies of the Ministry of Health, MDAs, Development Partners, Private Sector, NGOs/Civil society, Media, Public, Ghana AIDS Commission, Population Council, Ghana Statistical Services, National Development Planning Commission, NHIC

6.1.2. NATIONAL HEALTH INSURANCE

The National Health Insurance Council (NHIC) was established by the National Health Insurance Act, 2003 (Act 650) to ensure universal access to basic healthcare services to all residents of Ghana. The Council's mandate includes among others the regulation of practice of DMHIS, accreditation of health care providers and the management of the NHIF including providing subsidies for the healthcare of indigents and other exempt groups.

As at September 2007 the Council had met the target of 55% coverage set for the year 2007 and one hundred, forty-three (143) schemes were fully operational and provisional accreditation granted to all government facilities. An amount of ₵120,000 (GH¢12.00) was paid as subsidy per head to the exempt group members and SSNIT contributors in the year

2007. However, given the rising cost of medical bills evident from bills submitted by service providers and the Review of the Medicines List and Tariff Structure, it has been proposed to increase the subsidy from GH¢12.00 to GH¢14.00 per person for 2008.

The delays in reimbursement of claims could potentially undermine service delivery. The scheme also faced double counting of indigents because some population groups are already covered under DHMIS. Chronic patients also do not adhere to referral requirements of the scheme. These challenges have been compounded by delays setting up zonal offices of the council and inadequacy of staff.

The thrust for the year is to consolidate gains made in the registration of clients, strengthen the accreditation of providers and streamline claims management.

Priority Activities

- Complete and disseminate findings of financial sustainability analysis of the scheme.
- Mount a programme for accrediting all health facilities, both public and private.
- Extend coverage to cover five (5) more schemes whose establishment began in 2007.
- Assist schemes to build their administrative and logistical capacity.
- Streamline the process for the identification of indigents to minimize double counting.
- Continue the subsidization of schemes to cover exempt groups.
- Provide technical and financial support to distressed schemes.
- Install Integrated MIS and ICT infrastructure to aid communication and data analysis.
- Recruit personnel for key positions and supporting roles.
- Support the Ministry of Health to expand health services in the country in the training of Health Assistants and KATH's rehabilitation

Expected Results

- One hundred and forty-six (146) operational schemes
- Increased coverage of total population
- Increased coverage of indigents, aged and under 18s
- Reduction in fraudulent registration
- Reduction in number of distress schemes
- Increased compliance with conditions for referrals

Collaborators

Ministry of Health, Ghana Health Service, Ministry of Finance and Economic Planning, Private Hospitals and Maternity Homes Board, Ghana Registered Midwives Association, Teaching Hospitals, Society of Private Medical and Dental Practitioners,

6.2. SERVICE DELIVERY

6.2.1. GHANA HEALTH SERVICE

The Ghana Health Service (GHS) has been established under Act 525 to ensure access to health services at the community, sub-district, district and regional levels. Indicators on specific programmes, such as EPI, TB control, malaria, HIV/AIDS and nutrition, showed positive trends. However the burden of other communicable diseases including ‘neglected’ diseases and non-communicable diseases such as hypertension and diabetes continue to increase due to unhealthy lifestyle choices. High maternal mortality, still birth rates and infant mortality rates continue to persist due to the fact that uptake of health interventions are not at their optimal levels. The rollout of CHPS as a strategy to extend health interventions to the doorstep of the community has been extremely slow. In addition, the quality of clinical care services especially for maternal and neonatal health is below approved standards in most facilities.

Other more systems challenges facing the GHS include inadequate coverage of some priority interventions; inadequate financing and delays in the disbursement of funds, poor staff attitude and low productivity due to insufficient monitoring and supervision across all levels of the GHS. There is also general lack of commitment and little accountability for performance. NHI claims as a major source of funds remain poorly managed resulting in delays in payment claims

The GHS will continue to use the HIRD strategy as basis for scaling up interventions as well as ‘modernize’ clinical care services with special emphasis on maternal and child health outcomes.

Priority Activities

- GHS will continue to scale up the implementation of interventions based on the HIRD strategy.
- GHS will continuously mount surveillance and timely report on epidemic prone diseases with a view to ensuring rapid response to and effectively manage and control epidemics
- Place special emphasis on efforts to eradicate guinea worm by strengthening collaboration with the Ministries of Water Resources Works and Housing, Local Government, Rural Development and Environment, and relevant stakeholders in the provision of water whilst improving other mechanism for prevention and containment of guinea worm disease.
- All GHS health facilities will be prepared to meet accreditation standards as defined by NHI law including strengthening referral systems, instituting quality assurance programmes and providing 24 hour essential services.
- Training in financial management including auditing will be done at all levels and monitoring and supervision will be improved to ensure compliance to available financial rules and regulations.
- The peer review mechanism and district league performance table will be extended as mechanism to motivate lower level managers to perform.
- Introduce systems to improve management and access to health information at the district level.
- Ensure compliance to planned preventive maintenance plans at all levels
- Refine and clarify strategies and programmes for promoting gender equity

- As part of the modernization agenda the GHS will introduce ICT extensively into clinical care and as basis for improving claims management.
- Quality of midwifery care will receive greater attention and negative staff attitude will be addressed.

Expected Results

- Coverage of key health interventions
- Proportion of health institutions meeting accreditation criteria
- Timeliness and completeness of surveillance reports
- Quality of midwifery care

Collaborators

Ministry of Health, Ghana Statistical Service, Ministry of Education Science and Sports (MESS), Ministry of Local Government, Rural Development and Environment (MLGRDE), Christian Health Association of Ghana (CHAG), Quasi-government institutions, Teaching hospitals, Private Sector including NGOs, Research Institutions, Professional and Civil Society Organizations, Regulatory Bodies, St John Ambulance, Ghana Red Cross, Centre for Scientific Research into Plant Medicine (CSRPM), Ministry of Private Sector Development, Ministry of Water Resources, Works and Housing, Development Partners, National Health Insurance Council, Media and Public, Ghana AIDS Commission

6.2.2. CHRISTIAN HEALTH ASSOCIATION OF GHANA

Institutions under CHAG exist to contribute to the efforts of the health sector to improve the Health status of the people living in Ghana. CHAG member Institutions are predominantly located in the hard to reach areas with a few in urban slums and are therefore positioned to provide services to the poor and marginalized in fulfilment of Christ's Healing Ministry. In this context CHAG institutions see the regenerative health programme as a central strategy to the overall efforts to improve the health of people living in these catchment areas.

In fulfilling this mandate, CHAG member institutions are faced with the problem of inadequate human resource and weak management capacities and systems. In particular the health information systems at both the secretariat and institutions are not properly developed and this affects their ability to manage and provide services effectively. Finally, CHAG secretariat does not have the requisite personnel, skills and experience to effectively manage and report on its financial activities.

The Thrust of the Christian Health Association of Ghana is to draw on its comparative advantage to innovate, fill service gaps and improve quality of health services.

Priority Activities

- Set up a Health Management Information system at the secretariat and institutions for data capture and reporting including financial reporting.
- Re-orient and train health workers in the regenerative health and nutrition and other HIRD programmes including a healthy schools programme with emphasis on hygiene, physical exercise and school feeding.

- Collaborate with District Assemblies and other stakeholders to support the scaling up of Community based Planning and Services (CHPS) especially in deprived districts and communities, with focus on increasing package of public health services delivered
- Establish screening and management programmes for diabetes, hypertension, cancers, sickle cell, and asthma in all designated CHAG district hospitals
- Initiate a programme to engage the services of specialised health care providers through a volunteer/part time/exchange schemes.

Expected Results

- Professional staff recruited.
- An operational HMIS
- Timely and accurate monthly, quarterly and yearly financial reports.

Collaborators

Ministry of Health (MoH), Ghana Health Service (GHS), Development Partners, District Assemblies, Communities

6.2.3. TEACHING HOSPITALS

6.2.3.1. KORLE BU TEACHING HOSPITAL

Korle Bu Teaching Hospital (KBTH) was established to provide tertiary health care for all Ghanaians. It also provides facilities to educate and train health professionals, conduct research and provide specialist outreach services to all Ghanaians. Currently KBTH has 17 clinical and diagnostic departments and units and has an average daily out-patients attendance of 1,200 with an admission rate of about 150 patients per day.

The hospital faces on daily basis, challenges such as overcrowding and congestion of departments and wards by patients. In addition to this there are obsolete medical equipment and deteriorating physical structures. These challenges pose a threat to effective and efficient health care delivery at the hospital.

The thrust for 2008 is to ensure that resources are directed towards improving the provision of quality tertiary health care through the upgrading of the infrastructure and review of standards of operation at all clinical and management levels.

Priorities Activities

- Reorganise services to focus on referral and tertiary services and improve the quality of patient care
- Introduce programmes to promote regenerative health and behaviour change among client.
- Put in place programmes aimed at attracting and retaining the required number of staff to ensure quality of care.
- Expand, modernise and rehabilitate physical structures and facilities, equipment and tools;

- Review financial management systems and improve on internal controls as part of the revenue mobilization efforts.
- Upgrade connectivity and ICT infrastructure to improve information management
- Develop operational research capacity at all levels

Expected Results

- Increase in number of referred cases as against OPD cases
- Physical structures modernized and rehabilitated
- Financial management practices and internal controls improved
- Staffing levels improved
- New equipment provided to replace obsolete ones

Collaborators

Ministry of Health, GHS, KATH, Tamale Teaching Hospital, Medical & Dental Council, Nurses and midwives Council, University of Ghana Medical School, School of Public Health, Pharmacy Council, CHAG, Mutual Health Insurance Organization and National Health Insurance Council

6.2.3.2. KOMFO ANOKYE TEACHING HOSPITAL

Komfo Anokye Teaching Hospital is mandated to provide specialist clinical care services, train under graduate and post graduate medical students and undertake research into emerging health issues in Ghana. However due to funding difficulties the hospital has not been able to fulfil this mandate as expected.

Emergency cases recorded over the past 3 years have increased and it is expected that this will increase further in 2008 due to hosting of CAN 2008 in Ghana. Maternal and child deaths are still unacceptably high. The situation is compounded by the congestions at both the Paediatric and Obstetrics and Gynaecology wards. Management systems are also weak resulting in inadequate number of human resources especially specialized nursing cadres, inadequate equipment and inadequate physical infrastructure.

The thrust for 2008 is to improve quality of services for better care outcomes by improving the human resource base and health infrastructure of the hospital.

Priority Activities

- Scale up specific specialised services such as Urology, Neurology, Dialysis and Accident and Emergency.
- Introduce the provision of Paediatric Cardio thoracic, Orthodontic and Advanced Restorative and MRI services
- Reconstitute and strengthen mortality audit and quality assurance committees
- Expand library facilities for students and Practitioners
- Set up faculty for the training of critical care Physicians and Nurses
- Conduct operational research, including patient satisfaction surveys
- Conduct research into emerging diseases like HIV/AIDS, Diabetes and Hypertension
- Intensify performance monitoring, quality assurance and promote financial accountability and controls.

Expected Results

- Improved care outcomes (reduced institutional deaths)
- Increased efficiency in use of resources (optimal use of hospital beds and other resources)
- Improved critical care services (human resource for critical care developed)
- Operational research activities increased

Collaborators

Ministry of Health, Korle Bu Teaching Hospital, Tamale Teaching Hospital, Ghana Health Service, Medical and Dental Council, Nurses and Midwives Council, Pharmacy Council and Kwame Nkrumah University of Science and Technology.

6.2.3.3. TAMALE TEACHING HOSPITAL

The Tamale Teaching hospital is currently in the process of being upgraded into a teaching facility for the University of Development Studies. Consequently the focus of its activities is related to building the requisite capacity for tertiary and teaching services. In addition the hospital aims at improving quality and affordable referral services by well-trained, highly motivated and customer-friendly professional health staff.

The major challenges facing the hospital are the weaknesses in management and support systems particularly with respect to information and records management, equipment management and the inadequate human resource base. In addition to these challenges there are general weaknesses in financial management leading to poor revenue mobilization. There are also significant weaknesses in procurement practices and planned preventive maintenance.

To address these challenges, the 2008 programme will focus on building overall management capacity, initiate moves to improve the human resource base and putting in place mechanisms to improve revenue generation.

The thrust for 2008 will be on building strong, effective and efficient management and support systems and structures to enhance service delivery and to build capacity towards effective tertiary Health Care and Medical Education

Priority Activities

- Decentralise management structures through the creation of sub-BMCs
- Develop strategic plan to attract and retain the requisite staff numbers and staff mix
- Set up a functional emergency service including emergency preparedness plan.
- Initiate activities to improve internal revenue generation and to control expenditure and minimise waste
- Implement a planned preventive maintenance programme for buildings, equipment and transport
- Review and improve records and information management in all departments
- Reorganise the procurement and stores management system in accordance with the procurement law and manual
- Reconstitute and strengthen mortality audit committees

Expected Results

- Management practices improved (New management structure with designated sub-BMCs created)
- Staff numbers increased
- Revenue generation improved
- Emergency services functional

Collaborators

Ministry of Health, Korle Bu Teaching Hospital, Tamale Teaching Hospital, Ghana Health Service, Medical and Dental Council, Nurses and Midwives Council, Pharmacy Council, DMHIS

6.2.4. PSYCHIATRIC HOSPITALS

The Mental Health Unit seeks to promote mental health, prevent mental illness, provide quality mental health care to persons with mental illness and ensure a sustainable, equitably distributed quality and efficient client-centered community based mental health service to all people in Ghana. The Mental Health Unit has two components: the institutional component comprising the three psychiatric hospitals at Accra, Pantang and Ankaful, and the community component comprising the psychiatric wings of some regional and district hospitals, and community psychiatric nursing.

Stigma at all strata of the society remains the core and bane of mental health care. Stigma prevents patients from seeking early treatment and leads to relatives abandoning their wards at the hospitals and in the communities. Through stigma, mental health is often considered as an afterthought in decision making. Human resource remains a major problem in mental health care. There is general shortage of health workers but this is even much more acute in mental health sector. Currently there are about 500 psychiatric nurses for 22 million people in Ghana, giving a ratio of 1 nurse to 44,000 people. The ratio for consultant psychiatrists is 1:2 million people. This poses a great challenge to accessibility and quality of care. Mental health services are skewed to the southern sector as there is no psychiatric hospital north of Accra.

Non-availability of psychotropic drugs is another major issue. The old generation drugs are still being prescribed and these are often in short supply. Even though these drugs are purchased at a heavy cost, the current procurement system sometimes leads to expiry of the drugs bought. In addition inadequate financing is an obstacle to mental health care. By policy, mental health care is free and the government is the sole financier yet the release of funds has been inadequate and irregular. This leads to a handicap in our ability to deliver quality care. The National Health Insurance Scheme also does not adequately address mental health. The 2008 POW of mental health combines the three psychiatric hospitals and the activities of the national coordinator of community psychiatric nursing.

The thrust for 2008 is to improve the human resource capacity for Mental Health and ensure that all individuals especially the poor and the vulnerable groups have access to quality mental health care.

Priority Activities

- Advocate for the passage of the mental health law.
- Implement programmes to train and recruit additional psychiatric nurses and psychiatrists
- Conduct Research into mental health issues
- Re-equip laboratories for the 3 facilities
- **Ankaful**
 - a. Increase revenue generation by expansion and improvement of mortuary services
 - b. Re-equip the operating theatre and rehabilitation centre
- **Accra**
 - a. Provide 24-hour service for dispensary
 - b. Decongest the wards,
- **Pantang**
 - a. Establish infirmary wing for physically ill patients
 - b. Establish detoxification unit for alcohol and substance abuse
 - c. Establish VCT and prevention of mother to child transmission services for HIV prevention
 - d. intensify outreach services and mental health education
 - e. Institute private partnership programmes to improve mental health services in the communities.

Expected Results

- Coverage of outreach services
- Number of psychiatric nurses and psychiatrists trained/recruited
- Functional Detoxification unit established for Pantang
- Functional laboratories for all facilities
- Increase in IGF

Collaborators

Ministry of Health, the 3 Teaching Hospitals, CHAG, Ghana Health Service, NGOs/CSOs

6.3. NATIONAL AMBULANCE SERVICE

The mandate of NAS is to provide pre-hospital care to the sick and the injured and transport them to health facilities. It aims to improve the outcome of accidents and emergencies through efficient and timely pre hospital care. However, the coverage of ambulance services is limited to regional capitals and a few districts. NAS also lacks the right calibre of personnel and services are limited to provision of only basic care. Again, health institutions also have inadequate infrastructure to respond appropriately to accidents and emergencies.

The thrust for 2008 is to increase access to emergency care through the establishment and operation of an efficient nationwide ambulance service.

Priority Activities

- Establish 6 additional ambulance stations

- Recruit and train 100 emergency medical technicians (EMT)- Basics and upgrade the skills of 45 EMT- Basics to EMT- Advance.
- Introduce a program to ensure timely and efficient management of emergencies
- Screen and immunize EMTs against hepatitis B
- Strengthen the functional and communication linkages between NAS, facility based ambulance and health facilities
- Finalise the NAS bill for approval by cabinet and passage by parliament

Expected Results

- Six new ambulance stations established/number of districts with functional ambulance services.
- One hundred EMT-Bs trained and 45 EMT- Bs upgraded
- Immunisation of 100% EMTs against hepatitis B

Collaborators

Ghana Health Service, Ghana national Fire Service, District Assemblies, NADMO, Quasi-Government Hospitals, Teaching Hospitals, CHAG Facilities.

6.4. REGULATION

6.4.1. FOOD AND DRUGS BOARD

The Food and Drugs Board was set up by the PNDCL 305B (1992) to regulate the manufacture, importation, exportation and distribution of food, drugs, cosmetics, medical devices and household chemicals in the country. In Pursuance of Sections of this law, and in order to ensure the safety and quality of regulated products, the Board prepares guidelines to provide players and stakeholders in the food and drug industry with the requirements of the Food and Drugs Board (FDB) and also provide a comprehensive procedure for bringing their activities into compliance with the law. In line with these provisions the Board has made a strong presence at the ports of entry to inspect, collect data and store information for appropriate regulatory decision-making.

Despite these achievements, the capacity of the board to protect consumers from locally manufactured goods is limited due to inadequate personnel. This calls for a concerted effort to extend regulatory activities to the district through increased involvement of the district assemblies.

The FDB Policy Thrust for 2008 is to improve surveillance on locally produced food and medicinal products and to protect the consumer by ensuring the safety and efficacy of food and drug products on the local market as well as food and drug products processed for export.

Priority Activities

- Develop relevant regulations and guidelines to ensure food and drug safety
- Mount a comprehensive Public Awareness campaign on Food and Drug Safety
- Train identified food processors with special emphasis on schools feeding programmes, major street-food joints and selected local restaurants.

- Plan and execute regulatory enforcement programmes in collaboration with the Metropolitan, Municipal and District Assemblies.
- Review and improve systems for continuous monitoring and assurance of quality, safety of food and medicines including traditional medicines
- Finalize the framework and manual for pharmaco-vigilance

Expected Results

- Guidelines on food and drug safety developed
- Improved knowledge in basic food safety among food processors and handlers
- Increased surveillance activities on safety of food and medicinal products

Collaborators

Ministry of Health, Ghana Health Service, The Ghana Standards Board (GSB), Environmental Protection Agency (EPA), Ghana Tourist Board (GTB), Pharmacy Council, Veterinary Council

6.4.2. NURSES AND MIDWIVES COUNCIL

The Nurses and Midwives Council of Ghana is mandated to regulate nursing and midwifery education and practice. With the current rise in the numbers of trainee nurses, the responsibility of the Council has increased. This situation is compounded by the dwindling staff numbers leading to increased workload and reduction in staff morale within the council.

Due to ineffective collaboration between the Council and health care facilities in the country, there are difficulties in regulating standards of nursing and midwifery practice. The effect is that most cases of professional misconduct are not reported to the Council.

The thrust of the council for 2008 is to ensure increased adherence to standards of nursing and midwifery practice within health facilities with emphasis on the public sector.

Priority Activities

- Recruit more staff to augment the existing staff numbers in the Council.
- Update the knowledge of nursing and midwifery educators and practitioners on current trends in the profession
- Conduct support supervisory visits with the view to enforcing standards of professional practice at all health institutions and facilities throughout the country
- Prepare curricula for new post basic nursing programmes like paediatrics, accident and emergency, community Psychiatry.
- Decentralize activities of the Council by establishing two more zonal offices in Ashanti and western regions
- Conduct operational research on topical nursing issues e.g. Attitude of nurses

Expected Results

- Staff numbers of the Council is improved
- Supervision strengthened through increased visits to training schools and sites

- New curricula for post basic nursing programmes developed.
- Two zonal offices of council established.

Collaborators

Ghana Health Service(GHS), Teaching Hospitals, National Accreditation Board (NAB), all nursing and midwifery training institutions , International Nursing and Midwifery Regulatory Bodies and Associations, Health Partners (WHO, USAID, CHPS-TA, QHP, DANIDA, GSCP), Christian Health Association of Ghana (CHAG), and the Universities.

6.4.3. MEDICAL AND DENTAL COUNCIL

The Medical and Dental Council is a statutory governmental agency that regulates the standards of training and practice of medicine and dentistry in Ghana. It operates by prescribing, developing and enforcing high standards of medical and dental practice that will ensure the safety of the public. It also works through empowering the public to become active participants in their medical and dental treatments.

The Council has inadequate requisite staff to manage the secretariat and this affects its operations and the regular update of the register. The council is also faced with inadequate numbers of accredited facilities for training housemen in specific disciplines leading to congestion at the two teaching hospitals in the country. The existing standards and guidelines also need to be reviewed in the context of new developments and policy shifts in the health sector.

The thrust of the council for 2008 is to strengthen human resource capacity to improve on regulatory activities of the council.

Priority Activities

- Recruit staff to augment the current workforce of the Council
- Develop A Comprehensive Registration Information Documentation System
- Accredite 2 regional hospitals and 10 district hospitals for housemanship training in Internal Medicine, Obstetrics and Gynaecology, Paediatrics, and Surgery
- Develop policy and guidelines on Continuing Professional Development (CPD)
- Develop standards and guidelines for facilities and practitioners to ensure 'fitness to practice' medicine and dentistry.
- Review curricula of training institutions to respond to current trends and developments.

Expected Results

- The capacity of the council to pursue its mandate is improved (update of register to reflect actual numbers of doctors and dentists practicing in the country)
- Training Institutions' curricula reviewed
- 10 district and 2 regional hospitals accredited for housemanship training
- Standards and guidelines of professional practice updated.

Collaborators

Training Institutions (Kwame Nkrumah University of Science and Technology School of Medical Sciences, University of Ghana Medical School), Teaching Hospitals, Ghana

Health Service, Private Hospitals and Maternity Homes Board, Ghana Medical Association, Society of Private Medical and Dental Practitioners

6.4.4. PHARMACY COUNCIL

The Pharmacy council seeks to guarantee the highest level of pharmaceutical care to Ghanaians. In addition, the Council collaborates with related local agencies and international pharmaceutical organizations to enhance the effectiveness of pharmaceutical services and rational medicines use in the country.

Though progress has been made to extend pharmaceutical services to all parts of the country, problems with regard to equitable distribution of these services still remain. There is also the need to protect the rights of the consumer by ensuring that medicines are used rationally.

The thrust of the pharmacy council for 2008 will be to work towards improving access of Pharmaceutical facilities to deprived areas and to empower consumers to use medicines rationally.

Priority Activities

- Develop and implement policies and programmes to enhance access to deprived areas
- Institute public education activities on rational medicines use (RUM) and danger of drug abuse
- Work with collaborators in the pharmaceutical industry to assure quality of medicines available to the population.
- Expand pharmaceutical services to increasingly cover the deprived areas.

Expected Results

- Increase number of licenses issued to pharmacies and chemical sellers in deprived areas.
- Percentage population knowledgeable in RUM increased

Collaborators

Pharmaceutical Society of Ghana, Food and Drugs Board, Ghana Standards Board, Ghana Police Service, Media, NGOs, District Assemblies

6.4.5. TRADITIONAL MEDICINE PRACTICE COUNCIL

The Traditional Medicine Practice Council has the mandate to regulate the practice of traditional medicine in Ghana. Presently the legal instruments to guide its functions and operations exists however the Council is still not in place even though the secretariat has been established.

Currently, the key challenges of the Secretariat of the Council include inadequate resources to pursue its mandate effectively. There is inadequate staff capacity and efforts at building these have progressed slowly. These have greatly affected the secretariat's

ability to enforce regulatory provisions on Traditional Medicines Practitioners of which the majority have not received formal education.

The thrust for 2008 is to continue to build structures to enable the secretariat enforce the provisions of the law on Traditional Medicine Practice in Ghana

Priority Activities

- Advocate for the establishment of the Traditional Medicine Practice Board
- Recruit staff to augment the existing numbers in the secretariat
- Organise awareness creation/ public education activities and sensitization on the registration and licensing of Traditional Medicine Practitioners.
- Certify Traditional Medicine Practitioners and licence Practice Premises.
- Develop standard Operating Procedures Manuals for quality assurance in traditional medicines practice.

Expected Results

- Effective structures for the regulation and practice of Traditional Medicine in Ghana
- At least **500**TMPs registered and certified and **300** licensed practice premises.

Collaborators

Ministry of Health, College of Health Sciences- Kwame Nkrumah University of Science and Technology, World Health Organization, Pharmacy Council, Food and Drugs Board ,Centre for Scientific Research into Plant Medicine, Ghana Federation of Traditional Medicine Practitioners Association and Ghana Association of Medical Herbalists (GAHM).

6.4.6. PRIVATE HOSPITALS AND MATERNITY HOMES BOARD

The Private Hospitals and Maternity Homes Board was established to assist in the provision of appropriate regulations relating to private health care practice and the delivery of appropriate services by approved private hospitals and maternity homes.

The laws and statutes governing health service provision and public health protection are fragmented and inadequate in ensuring quality and efficiency in the private sector. There are different standards for regulating private sector and public sector services. The institutional framework for regulating the sector relies on sanctions for enforcement, with very limited emphasis on providing incentive support and monitoring and evaluation. Non-enforcement and malfunctioning of regulation has also led to the non-recognition of the capabilities and contributions of the Board to the sector's outcome. In addition the activities of the board have been affected by inadequate management systems and resource flow.

The thrust for 2008 is to reorganize and equip the board to improve on its regulatory function.

Priority Activities

- Update database on private health care sector

- Review and amend existing legal instruments to ensure that same standards are used in regulating both public and private health sectors.
- Advocate for the establishment of a council for the board.
- Assist in the identification of underserved areas for locating facilities to ensure equitable distribution of private facilities across the country

Expected Results

- Private healthcare facilities database updated
- Revised and Amendment legal instruments
- Functional council established

Collaborators

Ministry of Health, Private Medical and Dental Practitioners association, Ghana registered Midwives Association, Medical and Dental Council, Nurses and Midwives Council, Pharmacy Council,

6.5. RESEARCH AND TRAINING

6.5.1. CENTRE FOR SCIENTIFIC RESEARCH INTO PLANT MEDICINE

The Centre for Scientific Research into Plant Medicine has the mandate to undertake research and development of plant medicine and to liaise with Traditional Medicine Practitioners in plant medicine development and dissemination of research findings.

The Centre currently works on developing herbal medicines from local herbs, some of which have been cultivated by the Centre as part of its medicinal plant conservation programme. The Centre also has a clinic which provides services to patients who come to the Centre for herbal treatment, using herbal products developed by the Center. As part of its research activities the Centre carries out clinical monitoring of patients to evaluate the efficacy and safety of new products. The Centre also assists the FDB in the analysis of herbal products developed by herbalists and intended for registration by the Board.

The key challenge is inadequate budgetary allocation to expand services to meet the ever growing demand for herbal products and information on herbal medicines in use in Ghana. The other challenge is the retention of the core technical and research officers due to high attrition as a result of poor remuneration.

The thrust for 2008 is to reposition the Centre to respond to the changing needs for herbal medicines in health care delivery in Ghana.

Priority activities:

- Reprioritise research on herbal medicines to focus on priority diseases of public health importance.
- Initiate a recruitment exercise to improve staffing situation at the centre.
- Improve the provision of technical support services to Traditional Health Practitioners.
- Undertake training of students/interns in herbal medicine development and provide research information on efficacy and safety of herbal medicines.

- Research and develop Herbal Medicines into modern dosage forms.
- Establish two (2) satellite Centres for clinical services

Expected Results

- Increased use of herbal medicinal products developed at the center in health facilities including public health institutions
- Internship programme for Medical Herbalist streamlined.
- Two satellite centers for clinical services established

Collaborators

CSIR (Health and Environment), Food and Drugs Board, Noguchi Memorial Institute for Medical Research, University of Ghana, KNUST, Traditional Medicine Practice Council, WHO, Other Development Partners, Health training Institutions, Aberdeen University, Scotland, University of Michigan, USA.

6.5.2. TRAINING INSTITUTIONS

Training of Health Professionals in Ghana is a shared responsibility between Ministry of Education, Ministry of Health, the private sector and quasi government organizations. However, there has not been much collaboration and consultations between the stakeholders in the production of health professionals. This has created a gap between planning, production and placement of certain categories of health professionals like herbal medicine practitioners and nurse practitioners. There is therefore the need to ensure effective collaboration between the Training Institutions in the public sector and the other sectors to create synergies and harmonization in training.

In the last five years, the Ministry has made significant gains in the production of Health professionals following the establishment of new schools and restructuring of programmes as well as expansion of existing schools. These measures have resulted in the establishment of Ghana College of Physicians, Direct Midwifery Training, Direct Medical Assistants Training, Diploma in Community Health and the Middle level cadre Training.

Production of certain categories of health professionals has been scaled up resulting in an average of 20% increase in admission into the Health Training Institutions. However, production of health professionals has seen implementation difficulties in the areas of infrastructure, equipment and capacity of tutors. The need to strengthen capacities of Training Institutions is therefore paramount.

The policy thrust of the Ministry is to provide adequate resources to support training of appropriate cadres of the health workforce.

Priority Activities

- Scale up middle level cadre training with emphasis on midwifery and medical assistants.
- Increase the number of trainees admitted into the training schools.
- Increase resource allocation to the training institutions
- Organise Continuing professional education for tutors

- Work with District Assemblies and other agencies to identify and sponsor students within deprived areas for middle level training

Expected Results

- 20% increase in enrolment of midwives and medical assistants
- 35 existing libraries supplied with books
- 20 existing demonstration rooms equipped
- 10 additional practical sites accredited and 15 new preceptors identified and trained.
- 120 tutors upgraded
- 20% of students admitted sponsored by District Assemblies and other agencies

6.5.3. GHANA COLLEGE OF PHYSICIANS AND SURGEONS

The Ghana College of Physicians and Surgeons was mandated to train specialists in medicine, surgery and allied specialties to meet the needs of the country. The college has made a lot of progress since its inception although problems such as inadequate physical facilities, poor revenue mobilisation and poor financial management practices remain. The managerial capacities of administrative staff also need upgrading to bring the performance of the college to acceptable standards. Also, the college is finding it difficult to accredit adequate health facilities to support the training of its students because most facilities are less endowed with the requisite resources.

The thrust of the college's policy is to expand the continuous professional development programme, improve training outcomes and build general capacities to enable the college operate more efficiently.

Priority Activities

- Formulate guidelines for the smooth running of the continuous professional development programme
- Generate revenue by offering the college's facilities to the general public for seminars, workshops and conferences
- Arrange for short training courses, seminars and workshops for the accounting and audit staff of the college to upgrade their knowledge and competencies.
- Provide specialist education in medicine, surgery and related disciplines,
- Conduct research in medicine, surgery and related disciplines.
- Collaborate with stakeholders to improve the facilities and human resource base of accredited health facilities
- Prepare and publish journals

Expected Results

- Number of articles published
- Number of specialists produced
- Number of professionals benefitting from continuous professional development
- Formulation of guidelines for the professional development programme.
- Increased revenue generation to support the college's activities

Collaborators

7. CAPITAL INVESTMENT

The Capital Investment Programme outlines investments in health infrastructure, equipment, Information and Communications Technology (ICT) and transport (including ambulance), for sustaining and expanding the delivery of health services.

A review of the capital investment environment shows some key challenges that need to be addressed in 2008. These include:

- The increasing demand for health services in response to the National Health Insurance Scheme and the need to scale up achievement of health related MDGs.
- The increasing demand to expand the national Ambulance Service to all regions and districts
- Threats to quality of care arising out of deteriorating health infrastructure and obsolete equipment
- Disruption of the health services due to the devastating effects of the recent floods in the affected regions of the country.
- Poor implementation of capital plans contributing to the several uncompleted capital projects as well as outstanding payments owed to contractors, suppliers and consultants for work done on various projects;
- Ageing of vehicles and relatively slow deployment of ICT affecting service delivery and management.
- Understanding the health service capacity needs of the newly created districts
- Rapid urbanisation with its attendant pressures on limited health facilities particularly in the peri-urban areas.
- Inadequate emergency and epidemic preparedness of health facilities

The Thrust of the 2008 Capital Investment POW will focus on the completion of ongoing projects with priority to projects with significant contribution to enhancing quality and equitable access to health care.

Priority Activities

- Define priorities for 2008 Capital Expenditure by using the following criteria:
 - Commitments such as Matching Funds required for projects funded under mixed credits/grants and payment of accumulated debts from 2007;
 - Projects with 100% secured/earmarked funding;
 - Ongoing projects procured under international competitive tendering with legal implications for GOG arising from delays in payments;
 - Ongoing projects with high level of completion and substantial sunk cost that can be completed in 2008;
 - Investments that respond to priorities of the MOH POW III (2007–2011) and the MOH Health Policy with emphasis on investments that could propel the achievement of the MDGs by 2015;
 - Basic emergency and essential obstetric care equipment, transport and ambulance requirements;

- MIS/ICT requirements for full integration of the NHIS and its DMHIS
- Finalize the 2007-2011 Capital Investment Plan
- Execute the 2008 Capital Investment plan with emphasis on projects that promote equity and improve quality of care.
- Deploy the Capital Investment Planning Model in the development of the 2009 Capital Investment Plan
- Design a framework for routine progress and expenditure tracking system for capital investment in collaboration with Development Partners;
- Commence the following major projects with secured funding and completed preparatory activities:
 - Major rehabilitation and upgrading of Tamale Teaching Hospital (ORET funding)
 - Construction of Bekwai and Tarkwa District Hospitals (ADB III)
 - Construction District Hospital at Nkawie (ORET funding)
 - Sunyani Regional Hospital staff accommodation project

Expected Results

The following projects will be completed and commissioned:

- Ghana College of Physicians and Surgeons office complex at Ridge. Currently the facility is only at the stage of practical completion.
- Offices and Laboratories for Food and Drugs Board
- Offices for the Nurses and Midwives Council
- Office Complex and Training Centre for NAS/ST. John's Ambulance, Accra
- KBTH Medical Block
- Doctors' Flats at KBTH
- KATH Maternity and Children's Hospital
- National Accident and Emergency Centre at KATH
- Doctors' and Nurses' Flats at KATH
- Office blocks for Ghana Health Service at LFC
- Gushegu District Hospital
- Dental facilities in 22 hospitals nationwide under ORET sponsorship. Final completion envisaged in 2008
- 35 District hospital projects including 3 under OPEC sponsorship
- 43 Health Centres nationwide including 21 under OPEC sponsorship
- 2nd Phase of the Bolgatanga Regional Hospital project with BADEA funding
- 6 no. DHMT & RHMT office facilities
- 34 no. staff accommodation projects in selected districts
- 50 new CHPS Compounds
- Reconstruction/rehabilitation of about 50 district health facilities destroyed by floods in the 3 northern regions comprising mainly CHPS, nutrition and health centers
- Equipment procured under the Spanish Protocol installed and commissioned to replacement obsolete equipment in selected hospitals and health centres.
- Procurement of basic essential obstetric and emergency equipment
- Procurement of transport for various levels of the sector with emphasis on the districts
- Integrated MIS solution and ICT infrastructure for NHIS deployed nationwide.
- Classroom and/or hostel blocks in 10 selected nursing training institutions.

8. 2008 HEALTH SECTOR BUDGET

The year 2008 which marks the second year of the third Five Year Program of Work of the sector is a year of uncertainty as far as funding of the sector is concerned. This suggests that an end to the initial SWAp arrangement is in sight. The health sector 2008 budget derives from the third health sector Medium Term Expenditure framework.

The sector is going through a budgetary transition. From the previous common fund arrangements of having most of our donor funding passed through the Health Fund (or pooled donor funds) most of the funding from our health partners will now be channelled through the sector budget support (SBS) and the earmarked funds. On the other side, the NHIS is beginning to play a major role in the funding of the sector.

It is not clear how the SBS will operate. It is also not certain how inflows from the NHIS would be. The only traditional source of funding which remains the same is the Government of Ghana (GOG) source but even there, sharp variation in proportion of funding to the item levels do exist with the implementation of the new salary regime which proves to leave little for the service provision, support and investment services.

Macro level analysis of 2008 allocation to the MOH

Of total GOG vote of GH¢2.805 billion, the MOH has been allocated GH¢ 0.268 billion constituting 9.6% compared with the 2007 provision of 13.8% of GOG to the ministry. This is a 4 percentage fall from the 2007 provision. In nominal terms there is an increase. This drop in 2008 provision may be ascribed to larger inflows in 2008 but with more provision being given to other priority areas as energy. The item two provision indicates a drop to less than 50% of the previous year's provision. The likelihood that the total GOG provision to the health sector would be revised upwards exists because of the head count which has not been concluded. What ever the increase may be, the P.E. would take a near 90% of the total. As in previous years, not much would be available for service delivery and service delivery will suffer if no buffers are found.

MOH's share of the total of Donor, IGF and HIPC is 12.7%, 38.5%, and 2% respectively. Overall, 12.1 % of MOFEP ceilings have been allocated to the MOH. This level is yet below the 15% Abuja pledge. Table 1 presents these details.

Table1: Macro level analysis of 2008 allocation as presented by MOFEP¹ ('000)

	GOG	Donor	User fee	HIPC	Total
MOH	268,517.10	126,731.00	115,070.00	6,485.00	516,803.00
Total country	2,805,928.00	1,000,166.00	299,184.00	127,550.00	4,232,828.00
MOH share of total (%)	9.6	12.7	38.5	5.1	12.2

¹ The expected NHIF inflows are not included.

Total 2008 Resource Envelope

A total resource envelope of GH¢ 752.233 million is expected to finance the health sector in 2008. GoG provides the largest with 35.70%² followed by NHIS, User fee, Budget support, and HIPC inflows with 31.30%, 16.85%, 15.30% , and 0.86% respectively –see Table 2 a

Table 2a : Total 2008 resource envelope as approved in the 2008 National Budget excluding Earmarked funding ('000 GH cedi)

Source	GOG	NHIS	User Fee	HIPC	Budget Support	Total
level	268,517.00	235,430.00	115,070.00	6,485.00	126,731.00	752,233.00
% of total	35.70	31.30	15.30	0.86	16.85	100.00

Earmarked funding continues to pose a challenge to the health sector budget. Partners present large estimates as earmarked funds but the reality is that much of this does not support the sector's direct programmes. Neither does the ministry have direct control over them. The situation creates the misleading impression that much funding is available to support the health sector's programme of work.

Table 2b : Total 2008 resource envelope in the 2008 MoH Programme of Work including aligned earmarked funding ('000 GH cedi)

Source	GOG	NHIS	User Fee	HIPC	Budget Support	Earmarked	Total
level	268,517.00	235,430.00	115,071.00	6,485.00	126,731.00	92,191.00	845,142.00
% of total	31.77	27.86	13.62	0.77	15.00	10.99	100.00

The trends of the health budget from 2005-2008 indicate nominal increases in successive years. The budget increased by 33.34% in 2006 from 2005 and in 2007 increased by 18.68% over the 2006 level, while in 2008 the increase has been 31.49% over the 2007 level. See table 2c. These do not include the NHIF. With the NHIF added the increase of 2006 over 2005 was 95% (The operation of the NHIF began in 2006 which accounts for the big jump.) The increase in 2007 over 2006 was 22% whilst the increase in 2008 over 2007 with the NHIF inclusive is 28%. Considering the level of inflation of about 10%, these can be said to be increases in real terms. It should however be noted again that the PE component over shadows much of these increments.

² A head count is underway of all health staff and the exact amount to be provided for personal emoluments is yet to be determined. This count may result in increase or decrease in the P.E.

Table 2c: Trend of MOH budget allocation (GH¢ '000) (Total Budget excluding NHIF)

ITEM/YEAR	2005	2006	2007	2008
1	132,896.00	172,938.00	221,437.00	239,311.00
2	20,283.00	24,350.00	25,101.00	11,879.00
3	32,136.00	79,804.00	96,754.00	163,247.00
4	59,961.00	49,962.00	44,845.00	95,881.00
Total	245,276.00	327,054.00	388,137.00	510,318.00
% Increase over previous year		33.34	18.68	31.49
National total Budget including NHIF	245,276.00	478,419.00	583,737.00	748,234.00
% Increase over previous year		95.00	22.00	28.00

Item-wise distribution of 2008 budget

The share of resource by item indicates that item 1 constitutes 29.36% Item two constitutes 3.38% while items 3 and 4 constitute 46.46% and 20.80% respectively (see table 2d). The table also indicates the source of funding the items. The health sector Item one is hundred percent financed by GOG while the vote under NHIS also caters entirely for staff of the NHIS. The main financier of the Ministry's Item 2 is GOG. Again the NHIS vote is exclusively for its activities. The biggest source of funding for item three is the NHIS and User fees while item four funding source is earmarked funds and the NHIS. Table 2d provides the details.

Table 2d : Total 2008 resource envelope allocated by sources and line items including Earmarked funding ('000 GH cedi)

Source	GoG	NHIS	User Fees	HIPC	Budget Support	*Earmarked	Total	%
Resource Envelope	268,517	235,420	115,070	6,485	126,731	95,485	847,708	
Item 1	239,311	8,820					248,131	29.36
Item 2	10,904	16,690	475		500		28,569	3.38
Item 3	10,039	174,960	113,049	3,243	40,159	51,217	392,667	46.46
Item 4	8,263	34,950	1,546	3,242	86,072	41,702	175,775	20.80
Total	268,517	235,420	115,070	6,485	126,731	92,919	845,142	100.00
	31.77	27.86	13.62	0.77	15.00	10.99	100.00	

* Level of Earmarked as provided includes only those components identified to be directly controlled and implemented by the health sector and its partners.

Detailed analysis of 2008 by item

The 2008 health sector budget is guided by the principle of maximizing efficiency in the use of resources and therefore prudent allocation of resources. The budget thus tries to protect essential commodities, pro-poor activities and programs of public health importance. Most of this is done through ring fencing. As part of this measure, there is a

gradual shift of resources from IGF generating institutions to non IGF generating institutions. The table 3 below shows the total health budget by source of funding and allocation to budget sub-items.

Table 3: Allocation of 2008 budget by source of funding and item/sub item (and project

	GOG	HIPC	Budget Support	NHIS	IGF	Earmarked	Total
ITEM 1							
Established post	217,018			8,820			225,838
Trainees on Payroll	6,007						6,007
Regulatory Bodies	1,151						1,151
Ambulance Services	1,080						1,080
Attrition							0
Training Allowance							0
Contract Appointments							0
Promotion							0
Waiting for financial clearance	10,284						10,284
Waiting for processing onto pay roll	3,771						3,771
Recruitments							0
Consultancy							0
Intake into training institutions							0
Subtotal	239,311	0	0	8,820		0	248,131
							0
ITEM 2							0
Operational costs for MOH & agencies excl NHIS	8,684				475		9,159
Cuban Doctors	1,000						1,000
Procurement							0
Reviews, health summits and Audits	500		500				1,000
Blood Transfusion	120						120
ICT Maintenance	100						100
Audit/ Financial Management Strengthen	500						500
NHIS Administration / Logistics				16,690			16,690
Subtotal	10,904	0	500	16,690	475	0	28,569
							0
ITEM 3							0
Operational costs for MOH & agencies excl NHIS	7,128			1,680	54,699		63,507
Sub total	7,128				54,699		61,827

Procurement							0
Pharmaceutical					46,660		46,660
Vaccines			1,900	2,000		12,358	16,258
Contraceptives	300		1,400			600	2,300
TB drugs			450			335	785
Procurement of psychiatric drugs			450				450
Printing & Publication			500		1,440		1,940
HIV/AIDS			1,200			9,211	10,411
Malaria/ACT			500			6,375	6,875
ITNs			2,000	2,000		9,400	13,400
Basic health equip / Cold Chain			500				500
Anti Snake & Rabies			1,500				1,500
Subtotal	300	0	10,400	4,000	48,100	38,279	101,079
Programme							0
Nutrition and malaria project	100					6,757	6,857
Guinea worm eradication activities	203		1,000			207	1,410
Communicable diseases (pro-poor)			1,000				1,000
Screening Program (general prostate and breast mammogram)			1,000				1,000
Specialist outreach Services			500				500
Counterpart for WFP	200						200
MCH Campaigns			5,000			334	5,334
HIRD implementation	1000		11,000			3,572	15,572
Regenerative Health & Nutrition			2,000			132	2,132
Labiofarm			1,000				1,000
Equipment maintenance and reagents			2,500		10,250		12,750
Productivity Improvement Initiatives			200				200
Capacity building				1,000			1,000
Advertisement / Publication				1,660			1,660

Health Assistants program				23,500			23,500
Non Communicable diseases						1,109	1,109
Traditional & Alternative Medicine						86	86
Strategic Initiative Fund							0
Emergency preparedness	300		800			741	1,841
Sub total	1,803	0	26,000	26,160	10,250	12,938	77,151
							0
Exemption		3243					3,243
Buruli Ulcer			500				500
Refund of Medical exemptions			500				500
Piloting NHIS subsidies			500				500
Support to Financially Distressed Schemes				8,550			8,550
Subsidy for Exempt Group				134,570			134,570
Sub total	0	3,243	1,500	143,120	-	-	147,863
Overseas conferences	400						400
Fellowship	300		1,500				1,800
Budget and Programme of Work	108		259				367
Health Research			500				500
Sub total	808	0	2,259	-	-	-	3,067
Grand Total Item 3	10,039	3,243	40,159	174,960	113,049	51,217	392,667
Item 4							0
Emergency and Essential Obstetric Care Equipment			4,000	2,500	1,546	4,566	12,612
Infrastructure	8,263	3,242	78,072	17,207		37,136	143,920
Transport and Ambulances			4,000				4,000
MIS & ICT				11,513			11,513
NHIS Reserve Fund				3,730			3,730
Total	8,263	3,242	86,072	34,950	1,546	41,702	175,775
Grand Total	268,517	6,485	126,731	235,420	115,070	92,919	845,142

Personnel Emoluments – Item 1

Personal emoluments are costs pertaining to manpower employed by the Ministry of Health to carry out its functions. The item one budget prioritizes payment of salaries of staff at post and other related expenditure as summarised in Table 3. The main source funding of Item 1 expenditure is GOG and it constitutes 89% of the total GOG vote. The NHIF vote for Item 1 covers the emoluments of the Council and District Secretariats of the

District Mutual Health Insurance Secretariats. It should be mentioned that the Item 1 budget has been approved by Parliament although there remain some issues to be resolved based on the results of the on going head count exercise. Should there be the need to increase the item one vote, Parliament will debate this and appropriately recommend extra-budgetary appropriation as supplementary budget.

Administrative Services - Item 2

These are the overhead costs and include provision for sub-items such as utilities, maintenance of vehicles & equipment printing and publication, office consumables, allowances, etc. The main funding sources of Administrative cost of the Ministry of Health are GOG and user fees/NHIF. It must be said that the NHIF funding is exclusively earmarked to support the NHI Council and the DMHIS. Table 3 provides details on the share out of item two.

Service Vote - Item 3

Service vote covers the cost of service delivery incurred by agencies and BMCs in their operations and covers a wide range of activities that underpin the core functions of the Ministry and its agencies. These include essential commodities expenditure, public health goods, special programmes, and pro poor activities. The Table 3 shows how the Service budget for 2008 has been allocated. Apart from the operational cost of agencies which are decentralised, most of the Item 3 vote has been ring fenced to ensure that the essential inputs required for service delivery are protected. Ring fenced items are centrally located at MOH headquarters and this explains the relatively high percentage of the headquarters budget found in the summary table.

Investment- Item 4

The investment budget covers the procurement of items such as new constructions (civil work), major rehabilitation, major equipment, vehicles, furniture and ICT. In 2008 a total of GH¢175.775 million has been allocated to health investment under the various sources and has been allocated to the various items as shown in Table 3. Refer to Annex 1 for details of the Investment Budget

Allocation to Agencies

Table 4a, presents allocation of the 2008 budget to the agency level. In table 4a, some ring-fenced items have been lodged in Health Hq but to be benefited especially by the district level³. Sending the ring-fenced items to the beneficiary levels, as in table 4b the allocations become clearer. As much as 86% of the MOH Headquarters vote in table 4b is made up of earmarked item 4 funds which is for the whole sector.

The District Health Service share of the total Item 3 vote is 75.07% as shown in Table 4c. This total share does not include the statutory funds.

³ Ring fenced items includes procurement of vaccines and pharmaceuticals, fellowship, Cuban Doctors , Audit ,Health Summits & reviews, Counterpart funding , labiofam and regenerative health and nution and intangible investment funds

Table 4 a Allocations by source and levels as in the 2008 MTEF Budget Estimates

<i>FUNCTION</i>	<i>Total GoG</i>	<i>Total IGF</i>	<i>HIPC</i>	<i>OTHERS</i>	<i>Total Donor</i>	<i>Grand Total</i>
Ministry of Health	268,517,035	115,070,600	6,485,000	235,429,513	126,731,219	752,233,367
Health Headquarters	32,674,581	0	0	0	117,465,219	150,139,800
						0
Subvented Organisations	8,463,740	5,805,333	0		800,000	15,069,073
						0
Teaching Hospitals (Tertiary Health Services)	59,763,734	18,666,155	0	0	0	78,429,889
						0
Ghana Health Service Headquarters	11,875,316	314,899	0	0	5,926,200	18,116,415
						0
Psychiatry Hospitals (Tertiary Health Services)	16,607,624	0	0	0	0	16,607,624
						0
Regional Health Services	18,572,498	25,742,583	0	0	0	44,315,081
						0
District Health Services	72,027,880	31,453,085	6,485,000	0	0	109,965,965
						0
Christian Health Association of Ghana (CHAG)	33,497,553	31,529,433	0	0	0	65,026,986
						0
Training Institutions	15,034,106	1,559,113	0	0	2,539,800	19,133,019
NHIS				235,429,513		235,429,513

Table 4 b Allocations by Levels and sources with ring fenced decentralized (excluding NHIS)

<i>FUNCTION</i>	<i>Total GoG</i>	<i>Total IGF</i>	<i>HIPC</i>	<i>OTHERS</i>	<i>Total Donor</i>	<i>Grand Total</i>
Ministry of Health	268,517,035	115,070,600	6,485,000	235,429,513	126,731,219	752,233,367
Health Headquarters	32,674,581	0	0	0	73,558,000	106,232,581
						0
Subvented Organisations	8,463,740	5,805,333	0		800,000	15,069,073
						0
Teaching Hospitals (Tertiary Health Services)	59,763,734	18,666,155	0	0	0	78,429,889
						0
Ghana Health Service Headquarters	11,875,316	314,899	0	0	5,926,200	18,116,415
						0
Psychiatry Hospitals (Tertiary Health Services)	16,607,624	0	0	0	0	16,607,624
						0
Regional Health Services	18,572,498	25,742,583	0	0	0	44,315,081
						0
District Health Services	72,027,880	31,453,085	6,485,000	0	43,907,219	153,873,184
						0
Christian Health Association of Ghana	33,497,553	31,529,433	0	0	0	65,026,986
						0
Training Institutions	15,034,106	1,559,113	0	0	2,539,800	19,133,019
NHIS				235,429,513		235,429,513