

INTERSECTORAL COLLABORTION

FOR

*A***CCCELERATED** *H***EALTH**

*I***MPROVEMENT** *I***N**

*G***HANA**

A DISCUSSION PAPER PRESENTED AT THE HEALTH

SUMMIT

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EXECUTIVE SUMMARY

Good Health is not only a human welfare issue but is a fundamental objective of socio-economic development. No single Ministry, Department or Agency can ensure the health of the nation; it requires the concerted effort of the public and private sectors, civil society, religious bodies and virtually all segments of the society. This realization has motivated past and present policy makers and development partners of the Health sector to pursue Inter-Sectoral Collaboration (ISC) aimed at approaching health from a more holistic manner.

The President's Vision of Ghana reaching a middle-income status, achieving the aims of the Ghana Poverty Reduction Strategy (GPRS) and the Millennium Development Goals (MDGS) can be realized if health is tackled as a developmental issue. It is against this background that, the Minister of Health, Major Courage Quashigah (Rtd.) is championing a holistic approach to health by making food security, nutrition, potable water, environmental health, personal hygiene regular exercise among others as key pillars of the Programme of Work of his Ministry (2007-2011). The vehicle for achieving this goal is via Inter-Sectoral Collaboration.

Information gathered from key people in some MDAs whose work have direct bearing on health indicate the need to strengthen ISC in order to accelerate socio-economic development of Ghana. In order to strengthen ISC, there is the need to assess the past efforts and why it did not achieve much progress. The reasons for the poor performance at ISC are several and key ones include the fact that, health has not been regarded as a developmental issue. Additionally, there has not been effective structures and mechanisms for ISC.

For future attempt at ISC for health to be successful, the following recommendations are made:

- The Ministry of Health should set the tone or lead the ISC for Health. It should invest more in Advocacy.
- Bring on Board MDAs like the Ministries of Food and Agriculture, Local Government Rural Development & Environment, Water Resources, Works and Housing, Education/Ghana Education Service, Standards Board and Food & Drugs Board.
- Re-define ISC to include other stakeholders in health like the Development Partners, Private Sector, Civil Society, Religious Bodies, NGOs, CBOs and the Mass Media. These bodies should be used for policy making and the implementation of ISC-related programmes and activities. They should also be used as channels of behavioural change activities.
- The Ministry of Health should invest in changing the mind-set of health personnel and policy makers of collaborating MDAs and other stakeholders of health to accept health as a developmental issue and therefore, work collaboratively to ensure the socio-economic development of the Nation.

- The Ministry of Health should organize consensus building workshops at all levels (National, Regional and District) of stakeholders of health to agree on a common platform for the take-off of ISC nationwide.
- Government should build the capacity of the National Development Planning Commission (NDPC) to effectively perform its statutory function of coordinating the ISC at the National Level. More qualified professionals should be attracted to accept positions in the organization.
- Form Inter-Ministerial Committee on Health & Development (IMCHD) to support the work of NDPC. If the NDPC fails to perform its duties satisfactorily, the IMCHD should perform the National Coordinating role of ISC.
- The existing structures and mechanisms at the Regional and District Levels (eg. Regional Coordinating Council, Regional and District Coordinating Planning Committees, Regional and District Health Committees) should be revitalized to champion ISC for Health.
- The Ghana Health Service should lobby the District Assemblies to form District Health & Development Planning Committees to engender ISC at the district level.

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Chapter 1 Introduction

1.0 Background

Good Health is basic to human welfare and a fundamental objective of social and economic development. To echo the Alma-Ata Declaration of 12 September, 1978 which brought into being the concept of Primary Health Care, Health was defined as;

“A state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector”.

About three decades after the WHO and UNICEF had come out with the definition of Health, it is still as relevant today as it was in 1978. Many countries, especially in the developing world embraced the concept and started to redirect efforts from the purely curative and institution-based health service provision to collaborating with Ministries, Departments, Agencies, the Private sector and Civil Society to achieve this noble goal. Some essential elements of Primary Health Care were:

- The promotion of Food Supply and Proper Nutrition particularly of children and mothers.
- Adequate Supply of Safe Water and Basic Sanitation.
- Maternal and Child Health Care including Family Planning.
- Immunization against the major Infectious Diseases.
- Prevention and Control of Locally Endemic Diseases.
- Appropriate Treatment of Common Diseases and Injuries; and
- Provision of Essential Drugs.

The Alma-Ata Conference considered the *close relationship* and *interdependence* of health and socio-economic development, with health leading to and at the same time depending on a progressive improvement in the conditions and quality of life (WHO, UNICEF 1978). In the light of the foregoing, activities of the health sector must be coordinated at the national, regional, district and local levels with those of other social and economic sectors, including, education, water, food and sanitation.

In Ghana, various Governments since 1978 when the country adopted the Primary Health Care concept have endeavored to collaborate with other sectors whose programmes and activities have direct or indirect bearing on health. This Inter-Sectoral Collaboration (ISC) in Health has unfortunately, not been active enough to reap the desired benefits. The result of this, is the fact that, in spite of investments

made by government, its development partners and other stakeholders, there is a slow pace of health improvement using such indicators of infant mortality, maternal mortality, and access to safe water and proper sanitation. Selected indicators discussed below are the under five mortality, food and nutrition, water and sanitation and reported guinea worm cases

Under Five Mortality

“Progress in the reduction of under-five mortality has been very slow with reduction rate of 119 per 1.000 births in 1993 to 111 per 1.000 in 2006 NDPC, 2006). Given the current trends, it is unlikely that the Millennium Development Goal (MDG) target of reducing under-five mortality by two-thirds can be met without significant efforts to strengthen the supportive environment” (NDPC, 2007).

Food and Nutrition

Nutrition is one of the most important components that determine health, wellbeing and longevity. Food and Nutrition have over the years not witnessed any appreciable progress in spite of a number of initiatives that have been put in place to promote exclusive breast feeding, salt iodization and vitamin A supplementation. The result has been high levels of malnutrition especially under-nutrition in children, micro-nutrient deficiency in pregnant women and obesity (MoH, 2007).

Available data indicate that the proportion of underweight children as well as the incidence of wasting and stunting among children has generally improved, but slow. The proportion of malnourished children under five years old reduced from 25% in 1998 to about 18% in 2006. This represents about 2% decline over the target set for 2006 (NDPC, 2007).

Water & Sanitation

The level of access to safe water continued to improve in both rural and urban communities at 2006. The percentage of rural population with access to safe drinking water increased, marginally from 52.0% in 2005 to 53.18 in 2006. Access was much better for the urban population than for the rural population, and increased from 55% to 56.0% during the same period (NDPC, 2006).

An assessment of progress made towards improving sanitation is seriously hampered by the absence of adequate data. According to the NDPC, the most reliable data sourced from the result of the 2003 Core Welfare Indicator Questionnaire (CWIQ) indicates that, only 55% of the population had access to adequate sanitation with marked regional variations. Data available on solid waste disposal however, indicate that, three-out of four largest cities in Ghana namely Accra, Kumasi and Takoradi, exceeded targets set for 2006.

Guinea Worm Cases

In 2001 (baseline) the number of reported guinea worm cases was 4.739. It increased to 5.611 in 2002 and to 8.290 in 2003. In 2004, the number of cases reduced marginally by 4% from 6.582 in October 2003 to 6.317 in October, 2004. The number

of districts affected by the diseases had reduced from 69 in 2001 to 62 in 2003 and 56 as at October, 2004, Only 20 districts were accounting for 98% of guinea worm cases in 2003 and 2004: 11 districts in the Northern Region were responsible for 70% of all cases ; 2 districts in the Volta Region were responsible for 24% of all cases; 3 districts in the Brong-Ahafo Region for 3%. One district in the Upper West Region and 3 districts in the Ashanti Region for 1% of all cases (MOH, 2005).

According to the NDPC 2006 Annual Progress Report, there was a cumulative total of 4.136 guinea worm cases recorded in 2006. This represents about 6% increase of the 2005 cases of 3.981. This trend poses a great challenge to policy makers and development practitioners.

FIGURE 1. DETERMINANTS OF HEALTH

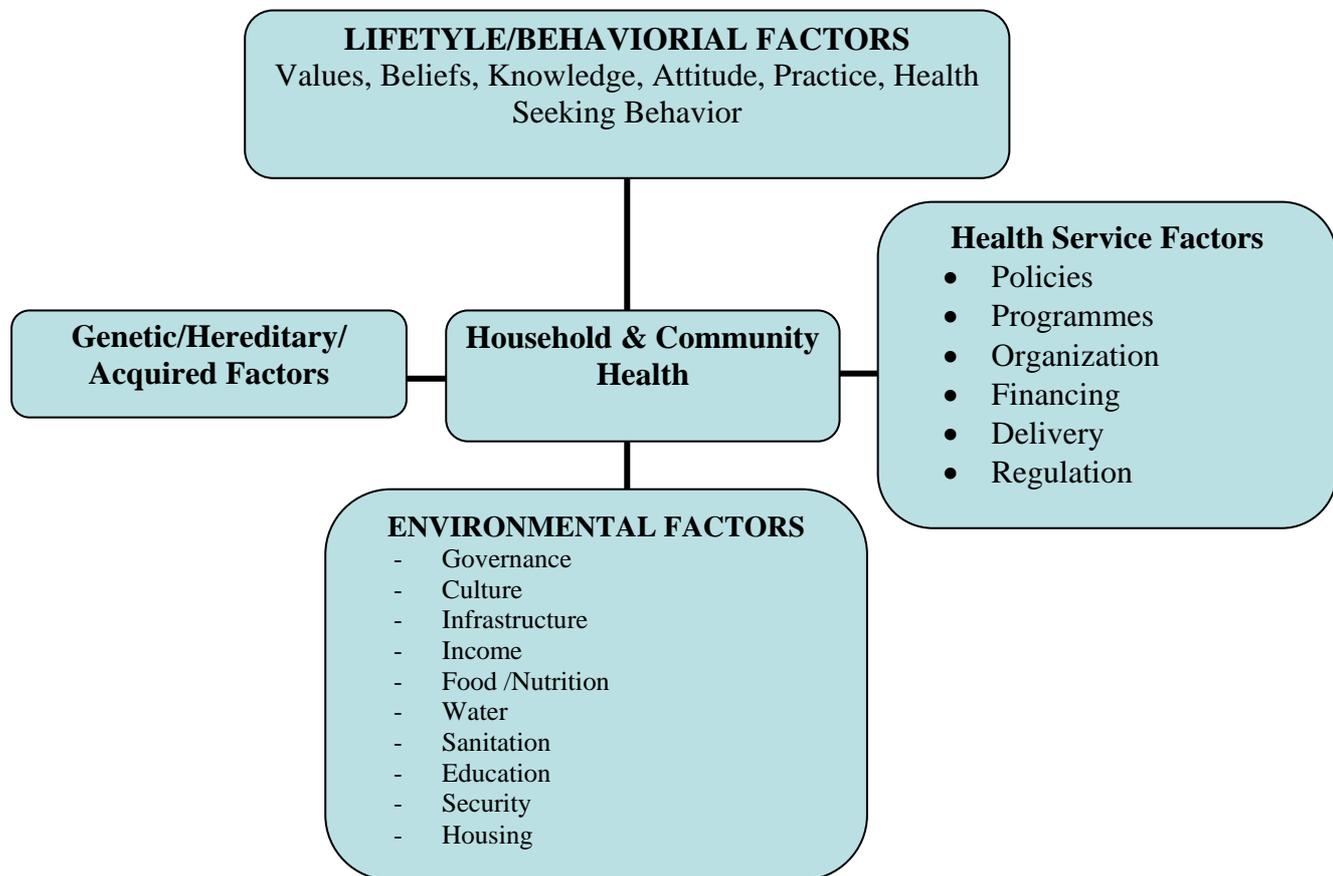


Figure 1 above, demonstrates the comprehensive and complex nature of health determinants. To ensure good health for the individuals, communities and the nation at large, almost all sectors of the economy including the private sector, civil society, religious bodies and the mass media need to play a part in a concerted effort for a common goal.

1.2 Objective of the Report

The main objective of the report is to prepare a discussion paper on Inter-Sectoral Collaboration (ISC) in the context of Health at the 19-23 November, 2007 Health Summit at GIMPA, Accra. Based upon the discussions at the summit and relevant Aide Memoire Recommendations, a Road Map for improving ISC for Health shall be prepared to guide all stakeholders in implementing an effective and sustainable ISC in Ghana.

1.3 Methodology

The methodology used in preparing this report was the following:

- Extensive review of relevant literature on the subject matter. Key documents reviewed are listed in Annex 3 of the report.
- In-depth Key Informants Interviews at the National, Regional and District levels. Ministries, Departments and Agencies (MDAs) were with the following:
 - Ministry of Food & Agriculture.
 - Ministry of Water Resources, Works & Housing.
 - Ministry of Local Government, Rural Development & Environment.
 - Ghana Education Service.
 - National Development Planning Commission (NDPC).
 - Christian Health Association of Ghana (CHAG)
 - Ministry of Health – National Level.
 - Ghana Health Service National, Regional and District Directorates: Brong-Ahafo Regional Health Directorate, Berekum and Dormaa District Health Directorates and Tema Municipal Health Directorate.

1.4 Limitations

The timing of the report preparation (October-November) did not favour key personalities in the MDAs. It was the period these MDAs were busily preparing their 2008 Plans and Budgets for Government. Getting access to Ministers or their Chief Directors responsible for the Ministries was virtually not possible. Their ideas or opinions on the ISC would have enriched the quality of the report. Nevertheless, officers the author was referred to for the interviews were capable and resourceful enough not to significantly compromise the quality of the information given from the standpoint of those MDAs.

2.0 Past and Present Efforts of the Ministry of Health at ISC.

2.1 Operational Definition of Inter-Sectoral Collaboration for Health

In the context of this report, Inter-Sectoral Collaboration is defined as follows:

Collaboration:

Collaboration is a slippery concept that may mean different things to different people in different contexts. It is used in organisations to mean different kinds of operations. Collaboration is expected to be:

- An invitation to participate.
- Consensus building.
- Promoting the building of strategies.
- Facilitating coordinated actions.
- Bringing resources for mutual benefit.
- Inter-dependence – relying on each other to achieve a goal which on your own, might not be possible or will be too costly.

Inter-Sectoral

Inter-Sectoral covers more than Ministries, Departments and Agencies in the Public and Civil Service. It includes all stakeholders of health. These stakeholders include but not restricted to the Private Sector, Civil Society, Faith-Based Organisations, Non-Governmental Organisations, Community-Based Organisations and the Mass Media.

Inter-Sectoral Collaboration for Health

In the context of this report, *Inter-Sectoral Collaboration* is defined as voluntary alliance or cooperative working relationship of parties who are committed to share responsibilities, resources, risks and benefits based on transparency and mutual trust in a mutually interdependent fashion to improve the health status of a defined population.

2.2 Past and Present Efforts of the Ministry of Health at ISC for Health

The Ministry of Health in the past and present has demonstrated that, to effectively carry out its mandate of ensuring good health of the people of Ghana, it needs to work closely with other sectors whose operations have impact on health. The statement below amply demonstrates the Ministry's intention for collaboration for the 1997-2001 Programme of Work:

“The MoH needs to redefine its role in providing health interventions and to re-examine many of the health related issues that impact on health. Such issues include conducting health impact assessments, providing potable water, wearing seat belts, and many others. Many of these issues lie outside the MoH domain. The MoH should consider how its resource allocation can be re-

organised to work in partnership towards the achievement of the goal of improving health”.(MoH, 2001).

If Ghana is to achieve the President’s Vision of reaching a middle-income status, achieve the aims of the Ghana Poverty Reduction Strategy (GPRS) and the Millennium Development Goals (MDGs), then a more holistic and vigorous approach to Inter-Sectoral Collaboration needs to be adopted. The message of the Hon. Minister of Health, Major Courage Quashigah (Rtd.) for the 2005 Programme of Work of the Ministry of Health therefore, states in part:

Health is one of the central pillars in Government’s human development agenda

and indeed an underlying condition for Government’s overall strategy for accelerated growth in the country. Government is therefore, committed to improving the health status of all Ghanaians. Progress in health status and health service indicators has been mixed. Infant and Under Five Mortality rates have stagnated after a period of sustained improvements since independence in 1957. Guinea worm eradication stalled and access to clinical care has stagnated. If these trends continue, Ghana will neither achieve the targets set in the 5-Year Programme of Work by 2006 nor the Millennium Development Goals by 2015”.

The 2005 Programme of Work of the Ministry of Health had seven (7) priorities among which was “*pursuing intersectoral collaboration in order to address the broader determinants of health*’.

Again, in its 2007-2011 Programme of Work of the Ministry of Health with the theme – “Creating Wealth through Health”, it places Inter-Sectoral Collaboration on its priority list. Programmes to be pursued through ISC include:

- Promoting **good nutrition** across the life span, **food security** and **food safety**.
- Effectively collaborating with relevant MDAs and stakeholders to improve **housing, personal hygiene, environmental sanitation** and access to **potable water**.
- Reducing **risk factors associated with non communicable diseases** such as tobacco and alcohol use, lack of exercise, poor eating habits, unsafe driving and stress.

2.3 Structures and Mechanisms of ISC for Health

Structures are in place at the National, Regional and District Levels for ISC for Health. Mechanisms however, appear inadequate or inappropriate to engender effective ISC especially at the National Level. Additionally, health has not been considered as an integral part of development, policy makers have therefore, not made serious efforts at committing resources to bringing health-related MDAs and other stakeholders together in a collaborative manner to promote health and development.

National Level: The National Development Planning Commission (NDPC)

At the national level, the National Development Planning Commission (NDPC) is the statutory body mandated by Act 480 to ensure among other functions, ISC for Health. The NDPC is responsible for the coordination of all planning systems at the District and Regional levels in Ghana. Almost all the key informants the author talked to stated that, the NDPC is strategically placed to lead the ISC for health. They were however, concerned that, the NDPC has not got the required capacity to function as such. The key constraint which is making the NDPC incapable of leading or coordination the ISC for health is manpower. It has not got the right number of professionals due mainly to the unattractive conditions of service. It is unable to compete with the emerging private Universities and other Research Institutions in the country for qualified and experienced professionals.

The 16-member Commission is composed of the following:

- 3 Key Government Appointees, two of whom are the Chairman and Vice Chairman.
- 1 Representative each of the 10 Regional Coordinating Councils.
- The Minister of Finance.
- The Governor of Bank of Ghana, and
- Government Statistician.

Regional Level: The Regional Coordinating Council (RCC).

By its name, the Regional Coordinating Council is by Law, responsible for coordinating all Plans of the Districts in the Region. Heads of the various Ministries (including the Health Sector), Departments and Agencies serve as ex-officio members of the RCC. Besides the RCC, there is also the Regional Coordinating Planning Unit (RCPU), which is mandated to comprehensively coordinate Sector and District Plans for onward transmission to the National Development Planning Commission. The RCPU is supposed to meet weekly. Information from a few informants however, indicate that, both the RCC and the RCPU in many of the Regions are not active enough to ensure effective Inter-Sectoral Collaboration. There was not enough time for the author to do thorough investigation into the operations of these structures to ascertain the reasons for their inactiveness.

District Level : The District Assembly

The District serves as the converging and unifying point where national policies and priorities are translated into action. It is at this level that, real Inter-Sectoral Collaboration should manifest itself in terms of services to the people through the operations of the 22 Decentralised Departments including key health related ones Education, Agriculture and Water and Sanitation. The Social Services Sub-Committee (SSS-C) of the District Assembly, the District Health Committee and the District Coordinating Planning Unit (DCPU) are structures which can be used for Inter-Sectoral Collaboration.

The District Health Committee is made up of 11 members as specified in Act 525 Section 23 (1):

- a. A Chairman
- b. The District Director of Health Services.
- c. 2 Representatives of the District Assembly.
- d. 1 Representative each of the Christian and Muslim religious groups in the District.
- e. 2 Health Care personnel in the District, one of whom shall be from the Private Sector.
- f. 1 Representative from the Traditional Councils in the District, and
- g. 2 other persons at least one of whom shall be a woman.

Information from key informants and the author's own 22 years experience of Ghana's health system indicate that some District Health Directors are taking opportunity of the structures and mechanisms at the district level to champion ISC. In both Dormaa and Berekum in the Brong-Ahafo Region where the author visited as part of the field interview for this report, the District Health Directorates work closely with personnel of the Environmental Health. The Environmental Health Department is part of the District Assembly however, their services are not fully utilized for lack of logistics especially transport. Arrangements have been made by the District Health Directorates for these personnel to join the routine trips to communities. By this arrangement, education on environmental health is promoted.

The District Health Directorates of Dormaa and Berekum also work closely with the Ghana Education Service in the School Health Education Programme (SHEP). Teachers are offered training by the health personnel. In collaboration with the personnel of the Environmental Health, food vendors in the schools are periodically screened medically to prevent the spread of any diseases any of them may have to the school children and the staff.

In other Districts in Ghana, the wholistic approach to health which calls for ISC is not visible. The District Directors of Health in those Districts are not innovative enough to take advantage of the numerous opportunities available. Experienced and committed professionals from the District Assemblies, the Private Sector, Traditional Authority and Decentralised Departments like Education and Agriculture serving on the District Health Committees are used mainly for the promotion of health services rather than health. Such lost opportunity may be due to the ignorance of some of the District Directors of Health on the need for ISC or they may be handicapped on the mechanisms to be used for ISC. Some District Directors also perceive the District Assembly as an institution with mainly unqualified personnel whose professional expertise cannot significantly impact on health. In such situations, respect is not given to the District Assembly and collaboration is also minimal. The District Coordinating Director in one District in the Brong-Ahafo Region had this to say during a research into Public-Private Partnerships in Health Service Planning and Provision in Ghana (Yeboah, 2003):

“Health is a priority of the District Assembly, and we do appreciate the good work of all the institutions both public and private are doing. We have cordial

relationship with all of them. The past District Directors of Health were more active on our Committees so we were well informed of the needs of the health sector. We were therefore, in a better position to support the health work. The current Director is different. He neither attends the Social Services Committee's meetings nor sends health budget and quarterly reports to us. In the absence of his budget, we have to decide what to put in for the health sector which might not necessarily be their top priorities".

One other possible reason for the situation described above where the District Director did not seem to have anything to do with the District Assembly may be due to the Acts which established the District Assemblies (Act 462) and the Ghana Health Service (Act 525). There are at times lack of understanding of the provisions of the two Acts. There is the tendency of the Health personnel not to feel responsible to the District Assembly and for that matter the District Chief Executive. On one hand, the District Director is expected to report on health matters of the District (like all Government Departments) to the District Chief Executive whilst on the other hand he/she is responsible to the Regional Director of Health. This system does not in any way engender ISC at the District level.

2.4 Reasons why ISC for Health has not been successful in the Past.

In order to embark upon yet another step towards Inter-Sectoral Collaboration, it is necessary to identify possible reasons why efforts in the past did not succeed. Literature Review, Interviews with key informants and the author's own experience in health matters over the past 22 years, have the following as some of the reasons:

- Health has not been considered as a developmental issue. Good health is basic to human welfare and a fundamental objective of socio-economic development. Productivity in some countries in Africa could increase by up to 15% were illness and disability attacked more seriously (World Bank, 1994). Governments and policy makers have not made the integration of health in socio-economic planning a serious matter.
- The feeling of some health personnel (from policy makers to implementers) that, the health sector alone can ensure the health of the people.
- The verticalization of some health programmes (made worse by funding mechanism) does not promote wholistic approach to health and thus work against ISC.
- Some MDAs which are approached for ISC for Health perceive the Health Sector as a wealthy organization and therefore, expect it to single-handedly shoulder all financial responsibilities of ISC. Where the Health Sector is unable to meet such high expectation, the programmes of ISC becomes ineffective or remain on the drawing board.
- The National Development Planning Commission (NDPC) which is mandated to coordinate all development plans of the nation and to ensure ISC appear ineffective. Almost all the key informants for this report accepted the fact, the

NDPC is the right organisation well placed to ensure Inter-Sectoral Collaboration. It is not however, well resourced to perform its functions effectively.

- There are no incentives for ISC. Organisations which play active role in ISC for instance, should be rewarded (this should not necessarily be money). It may take the form of high profile recognition. In the same manner, organizations which do not show interest or cooperate in ISC should be sanctioned.
- It is at the District Level, that the policies and programmes of ISC are translated into action. The District Assembly and the Ghana Health Service operate under different statutes (ACT 462 and 525 respectively). The two ACTs as they stand now do not promote effective ISC. Unlike the other 22 decentralized Departments, the Health Department owes allegiance more to its Regional and National Offices. There are different command structures, systems and channels of reporting. How much the Health Department benefits from the District Assembly depends very much on the Leadership style of the District Director of Health rather than on laws, policies, structures and systems.
- District Assemblies are not adequately oriented about their responsibilities towards health. Most Assemblies also lack the requisite capacity to effectively coordinate the activities of the decentralized departments. Some Assemblies do not have professionally trained planning officers to facilitate ISC at the Assembly level.

3.0 Inter-Sectoral Collaboration for Health – The Way Forward

3.1 Main Priorities for ISC in relation to Health.

The determinants of Health are many as Fig.1 above shows. The policies, programmes and activities of almost every sector of the economy have direct or indirect bearing on Health. This presupposes that, the Health sector needs to collaborate with virtually all the sectors of the economy; such an act will however, be too unwieldy to manage and may make the Health sector lose focus. Priorities therefore, need to be set at least for the short and medium term. Putting emphasis on the priorities does not mean the Health sector shall not collaborate with the other sectors.

In the 2007 Programme of Work (POW) of the Ministry of Health which is year one of the 2007-2011 Medium Term Strategic Plan, *Regenerative Health and Nutrition* are some of the priorities with emphasis on improvement in life styles, health promotion, disease prevention and restoration of life. Key components of the Regenerative Health concept (which are similar to those of the Alma-Ata Primary Health Care) are as follows:

- Improving Food Security.
- Healthy Eating.
- Regular Exercise.
- Resting.
- Drinking Potable Water.
- Improving Environmental Sanitation.
- Improving Personal Hygiene.

The concept of Regenerative Health recognizes that, the major disease burden of the country can be effectively reduced if individuals, households and the community are *empowered* to make the right choices. This will however, be possible if the Health sector collaborates closely with other Ministries, Departments and Agencies whose actions have direct and impact on health. Behavioural Change Strategies shall form important part of promoting the Regenerative Health.

For the medium term when the 2007-2011 POW of the Ministry of Health is being implemented, emphasis should be put on the areas so far identified under Regenerative Health.

Diet-related Risk Factors and Physical Inactivity

Whilst emphasizing child and women's food and nutrition, attention needs to be paid to the society at large. This is because substantial disease burden is attributable to risks that are related to over-consumption of certain foods or food components, low intake of fruits and vegetables and physical inactivity.

Control of non-communicable diseases continue to pose a great challenge to the health sector with chronic diseases and its complications accounting for more than two-thirds of all medical admissions (MoH, 2007 POW).

Contrary to popular perception, poor households suffer higher burden of chronic diseases. In one study, the death rate from circulatory diseases was more than twice as high among residents of poor areas in Accra as that among those in the more affluent parts (MoH, 2005 POW).

Fruit and vegetables are important components of healthy diet. Accumulated evidence suggests that they could help prevent major diseases such as cardiovascular diseases and certain cancers principally of the digestive system. Low intake of fruit and vegetables is estimated to cause about 19% of gastrointestinal cancer, about 31% of ischaemic diseases and 11% of stroke worldwide; overall, 2.7 million (4.9%) deaths (WHO, 2002 World Health Report).

According to the WHO (2002) overall physical inactivity was in 2002 estimated to cause 1.9 million death. Opportunities for people to be physically active according to the WHO exist in the four major domains of their day-to-day lives.

- At Work – especially if the job involves manual work.
- For Transport eg. walking or cycling to work.
- In Domestic Duties eg. housework or gathering fuel.
- Leisure Time eg. participating in Sports or recreational activity.

3.2 Structures and Mechanisms of ISC for Health

In promoting Health in its totality as the Ministry of Health is vigorously trying to pursue, the need to bring on board all stakeholders through the concept of Inter-Sectoral Collaboration cannot be overemphasized. There are existing structures and mechanisms to promote ISC however, they do not appear to be effective. Options available include the following:

- Make the existing Structures and Mechanisms more effective to respond to ISC for Health.
- Create new Structures and Mechanisms to support ISC for Health.
- Create new Structures and Mechanisms to support the existing ones which are not effective.

National Level

At the National Level, the National Development Planning Commission (NDPC) is the statutory body mandated to coordinate all planning systems (District through Regions to National). It is evidently clear that, NDPC has not been effective in discharging this duty and the reason has been the inadequate number of qualified professionals to support the planning system. If manpower is the main reason for non performance, then key stakeholders in Health (eg. Ministry of Health, Ministry of Food and Agriculture, Ministry of Water Resources & Works and Housing, Ministry of Education/Ghana Education Service and Ministry of Local Government, Rural Development & Environment) should team up and lobby Government to act appropriately.

Since Government is very much committed to its Vision of making Ghana become a middle-income country by 2015 via achieving the aims of the Ghana Poverty Reduction Strategy (GPRS) and the Millennium Development Goals (MDGS), it is expected that attention shall be given to ISC for Health.

A common voice of health-related MDAs to lobby Government shall be effective if these MDAs are in themselves, committed to operate in a coordinated manner through the concept of ISC. A body which may be called an *Inter-Ministerial Committee on Health & Development* (IMCHD) should be created. Key Development Partners, Religious Bodies, Civil Society Groups, the Private Sector in Health (including CHAG) and the Mass Media should be co-opted to the Committee. In order to make the IMCHD operate as team, the health related MDAs and the other stakeholders of the ISC need to establish close working relationship. The Minister of Health should lead such team building exercise. Where it becomes necessary, the Chairman of the National Development Planning Commission may in the initial stages chair the meetings.

The IMCHD should serve as common platform where:

- Health related policies and programmes needing ISC are discussed. The Ministry of Health whose mandate it is to ensure the health of the nation should lead the ISC by critically identifying priority issues for ISC.
- Guidelines for ICS plans are prepared to guide the Regions and Districts. Priorities for the plans should emanate from informed data of the health situation of the nation.
- Roles and responsibilities are clearly spelt out.
- Specific objectives and targets set.
- Budgets are drawn to take account of programmes each MDA shall pursue including the transaction cost of the ISC eg. organization of meetings.
- Monitoring and Evaluation mechanisms agreed upon. Performance reports from the respective MDAs in the regions and districts should be discussed and appropriate actions taken at the national level.

Scenario 1 : The NDPC shall be strengthened to effectively coordinate the ISC. The proposed Inter-Ministerial Committee on Health and Development (IMCHD) should still be formed and strengthened to support the work of the NDPC through the activities outlined above.

Scenario 2: Should efforts at strengthening the NDPC to be more effective in coordinating the ISC fail, the proposed IMCHD should be formed and serve as the platform for ISC. Its operations should however, complement rather than usurping or supplanting those of the NDPC

The Ministry of Health should invest more in Advocacy

The steps given above shall lead to effective ISC and ultimately improvement in the health status of Ghanaians only when the collaborating MDAs are convinced that they

should be involved. In order to achieve this, the Ministry of Health should invest more in advocacy. In order for the Ministry of Health to achieve the aim of the advocacy, its capacity for effective advocacy should be assessed. Where it becomes necessary to build its capacity, resources should be allocated for that. Moreover, the mind-set of key players within the Ministry of Health, the Ghana Health Service (eg. Regional and District Directors of Health), CHAG and the privately financed Private Sector in Health should be changed to accept ISC as key strategy for accelerating health improvement in Ghana.

Regional Level

The current structures and mechanisms at the Regional Level in coordinating plans of the respective Districts ie. the Regional Coordinating Council, the Regional Planning Coordinating Unit and the Regional Health Committee should continue to serve as platforms for ISC. A more critical look at their operations may however, be necessary to unearth the factors responsible for the inactiveness of some of them. The Ministries of Health and Local Government should play pivotal role in making these structures live up to expectation.

Once the Regional Directors of Health are themselves committed to ISC, they could lobby people in the respective structures to be more serious with the ISC. Any appropriate incentives to commit members to ISC should be explored.

District Level

The District Assembly, the District Assembly's Sub-Committee of Social Services, the District Planning Coordinating Unit and the District Health Committee are more than enough structures that could be used to champion ISC for Health. The District is very key in the advancement of ISC for Health in Ghana since all policies and programmes converge here for implementation.

The current situation where the District Director of Health is not adequately answerable to the District Chief Executive needs to change since it does not promote ISC in the District. The Ministries of Health and Local Government should start to initiate steps towards the change. A Committee of experts may be formed to make the necessary recommendations for consideration by Parliament.

The following steps need to be followed to ensure effective ISC at the District Level:

Step 1: Win the District Assembly and the Health-related Decentralized Departments to Support the ISC Concept.

Before the District Health Directorate can win the District Assembly and the Health-related decentralized Departments for the ISC concept, the District Director and his/her team should themselves be committed to the cause. Through a National, Regional and District Consultative Meetings of ISC Stakeholders, the District Health Team shall not only be convinced to embrace the ISC concept, its capacity to lobby

would have been built. The District Director of Health should in particular win the District chief Executive to his/her side.

Step 2: Form and Train People for a Sector-Wide District Health Situational Analysis

Team (DHSAT).

The Sector-Wide District Health Situational Analysis Team shall be responsible for critically analysing the health situation of the District. The unique health issues of the District shall guide planning and priority setting for ISC. The capacity of the team may be built through training by the experts of the Ghana Demographic and Health Survey Institution and the Regional Health Directorate. The composition of the Team may include but not restricted to that of the District Health & Development Planning Team as listed below:

- The District Coordinating Director or his Deputy.
- The Chairman of the Social Service Sub-Committee.
- The Chairman of the District Health Committee.
- The District Director of Health Services.
- The District Finance Officer.
- The District Planning Officer (of the District Assembly) or his Deputy.
- The District Environmental Health Officer.
- The District Director of Food and Agriculture.
- The Coordinator-School Health Education Programme (SHEP).
- Representative of the Private Sector in Health eg. CHAG
- Representative of the Mass Media.
- Representative of Religious Bodies.

Step 3: Outdoor the District Health Status Report

The objective of out-dooring the District Health Status is to sensitize all stakeholders of health to provide input into the plan preparation and to give their support in the implementation. Stakeholders of the dissemination forum should include but not restricted to members of the District Assembly, Traditional Authority, Member(s) of Parliament, Heads of Decentralised Departments, District Health Committee members, Unit Committee members, Religious Bodies, Civil Society Organisations, NGOs, CBOs, Women's Groups, the Mass Media, the Regional Health Directorate and the Regional Coordinating Council.

Step 4: Prepare a Sector-Wide District Health & Development Plan

The Sector-Wide District Health & Development Plan shall not conflict with the plan the District Assembly shall prepare; it will rather emphasize priority health issues and assign roles and responsibilities to stakeholders of the collaborative effort.

Step 5: Mobilise Resources for the Health & Development Plan

In order to effectively execute the Plan, there is the need to mobilize adequate resources. Each Department which is expected to play any role shall budget fully in the Annual Plan and Budget. For instance, the District Water and Sanitation Programme shall prepare a full budget for its operations. On the other hand, if the District Health Administration should receive financial support from its development partners for a specific project like guinea-worm eradication, such funds may be channeled to the appropriate body competent enough to provide potable water and to ensure better sanitation. Some amount of money needed for joint action should also be budgeted for by each Department.

Step 6: Monitor and Evaluate the Health & Development Plan.

Institute a Monitoring and Evaluation Team to comprise some members of the District Situational Analysis and Planning Teams. The M&E Team should develop tools for their work. The Team should be properly trained to discharge their duties.

Step 7: Disseminate the Findings of the M&E Team

A forum similar to that of the Health Status one should be prepared to disseminate the findings of the work of the M&E. Departments and other stakeholders whose input contributed significantly to the achievement of specific targets should be rewarded. The reward or appreciation should not necessarily be an expensive venture. It may take the form of recognition eg. award of certificate. Care should however, be taken in the award giving. It should be seen to be as fair as possible.

The achievements, opportunities, challenges, constraints, gaps and lessons learnt should be used to improve upon the quality of future plan preparation.

Roles and Responsibilities of Collaborators

In order for the ISC to be effective in achieving the desired result, roles and responsibilities need to be clarified. Factors necessary for considering who does what include but not restricted to:

- Legal Mandate to perform certain duties in the society.
- Interest and Commitment.
- Track Record.
- Availability of Resources to perform and or ability to mobilize the required resources.
- Ability to impact significantly on health improvement.

Organizations might not voluntarily decide to collaborate in spite of the numerous benefits of the synergy it brings. Collaboration itself is not easy, it requires resources and great commitment. Collaborators should be prepared to share responsibilities, resources, risks, and benefits based on transparency and mutual trust. Consensus needs to be built to appreciate the need to come together and to work for a common goal of improving the socio-economic well-being of individuals and the nations as a whole. Unless there is clear understanding of why there should be inter-sectoral collaboration, not much can be realized in terms of added value to each organizational

work. The mind-set of individuals, policy makers and organizations need to change to favour effective ISC.

Faith Based Organisations/Religious Bodies, Civil Society and the Private Sector

The potentials of Faith-Based Organisations/Religious Bodies, the Private Sector, Civil Society and the Mass Media appear not have been fully exploited for health promotion within the context of ISC. Attention in the past and present have focused more on Ministries, Departments and Agencies. Churches and other religious bodies for instance, have structures and systems which will lend themselves for collaboration. For instance, there are children, youth, women and men's groups in many Churches which can be used for collaboration in health. For instance, behavioural change messages on food and nutrition, environmental cleanliness, personal hygiene, regular exercise and rest may be emphasized. In the same way, the mass media in Ghana has of late become a powerful tool for information dissemination. Almost every District in Ghana has one or two Local FM Radio Stations which can be used in behavioural change communication (BCC) and for other purposes.

One District Director of Health who was a key informant for this report stated that in his District, one strategy which helped to increase the coverage of immunization (NID) was to use a powerful and respected opinion leader. That opinion leader is a big scale timber merchant. When the man used the Local FM Radio to educate mothers and fathers to bring their children for immunization, the attendance for that period was unprecedented . The common message on the lips of many people in that town was “ Mr....says immunization for your child is good”. This is typical case of innovation on the part of the District Director of Health and an example of how useful it can be when all stakeholders of health are involved in health matters.

3.3 Collaboration for Food Security and Nutrition

In responding to the issue of Food Security and Nutrition (Healthy Eating), four areas are identified.

- Policy Makers.
- Funding
- Implementers, and
- Regulators

In order to ensure Food Security and Nutrition, there is the need to broaden the base of policy makers. It is only when organizations which matter in the implementation are also involved in policy formulation that, the system will operative effectively and efficiently. In the light of this, the private sector, Faith-Based Organizations/Religious Bodies, the civil society, farmer associations and the mass media shall work in concert with orthodox bodies like the Ministry of Food and Agriculture, Ministry of Health, Ministry of Education and Development Partners as depicted in Fig. 2 below.

The implementers shall include Ghana Health Service, the Ghana Education Service, Farmers, FBOs, the Private Sector, the Civil Society and the Mass Media. The

FIG. 2. SOME KEY COLLABORATORS IN FOOD AND NUTRITION



Roles and Responsibilities of Stakeholders in Food Security and Nutrition

Policy on Food Security and Nutrition shall be the responsibility of the NDPC and or the Inter-Ministerial Committee on Health & Development (IMCHD). The Development partners shall support Government and other stakeholders in the implementation of the plan.

Extension workers shall educate and support farmers to grow food with high nutritional value. They will also educate the farmers to as much as possible eat what they themselves produce.

The Ghana Health Service (GHS), the Ghana Education Service (GES) and the Mass Media shall play key role in health education. The GHS and the GES shall continue to support vulnerable segments of the population i.e. children and pregnant with

nutritional support during their routine activities. Personnel of the Environmental Health Department should be supported to do more in screening food vendors for any communicable diseases. This should cover food vendors for the school feeding programme.

The mass media, civil society, religious bodies and the private sector shall be sensitized and supported by the District Health & Development Planning Committee to educate their constituencies on issues of food security and healthy eating. The eating of more fruits and vegetables should be vigorously promoted at all levels. It should start with MDAs during their meetings to demonstrate commitment to the policy. Additionally, the mass media, religious bodies, civil society and the School Health Programme should champion the issues of exercise and rest as vital activities for good health.

3.4 Collaboration for Water, Sanitation & Personal Hygiene

For the community to have access to safe and adequate water, sanitation and to be conscious of personal hygiene, the following key players need to work in close collaboration with each other. For policy formulation, the Ministry of Water Resources, Works and Housing, the Ministry of Local Government, Rural Development and Environment and the Ministry of Health shall collaborate with their Development Partners, the Private Sector, Faith-Based Organisations, Civil Society and the Mass Media. This shall be done under the NDPC and or the proposed Inter-Ministerial Committee for Health & Development. The Development Partners besides policy formulation, shall support the other policy makers with funds and other resources for the effective implementation of planned programmes and activities.

The implementers shall include the District Assembly, Community Water and Sanitation Agency, the World Vision International, ADRA, the Zoom Lion, the Ghana Health Service and the Ghana Education Service.

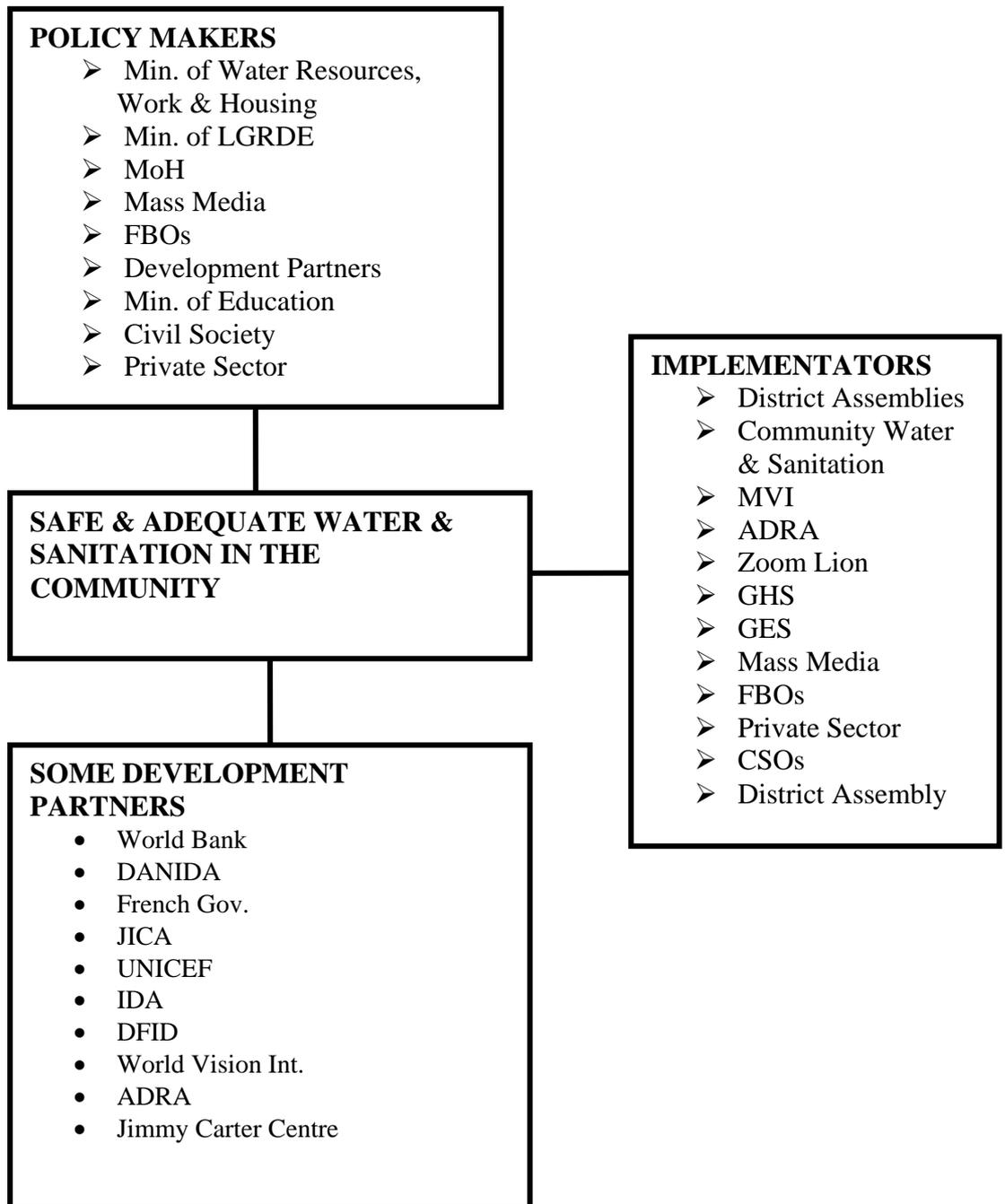
The current situation where Ghana is second to Sudan in reported cases of guinea worm globally is not only embarrassing, its rapid eradication should attract all policy makers and development practitioners. All stakeholders in health and development should play their respective roles. It should be possible for the health sector to allocate reasonable amount of its health budget to supplement to funds of development partners. Education on the need to use safe water should be sustained. The mass media, religious bodies, NGOs, CBOs, and civil society should be supported by the District Assemblies to use their constituencies for vigorous health education.

The potentials of the Environmental Health personnel is woefully under-utilised mainly due to the inability of the District Assemblies to provide them with the necessary support. Opportunities for further training is very limited, transport facilities to facilitate their work are limited and their conditions of service are unattractive. This situation has led to brain drain from the Environmental Health service to other organizations. With the new arrangement proposed in this report, these personnel should be supported to fully discharge their duties for which they were trained.

The cleaning work currently contracted to Zoom Lion, a private organization appears to be yielding dividends. It should be sustained. Personnel of the Environmental Health Department should continue to supervise staff of this organization.

The Mass Media should be supported to intensify campaign on environmental cleanliness and personal hygiene. A common phenomenon where most washrooms even in organizations where people are enlightened do not have soap to wash hands should attract special educational package. Children are good agents of change therefore, issues of environmental cleanliness and personal hygiene should be given priority in the School Health Programme. Awards should be given to schools which practice what they are taught. Similar award should be instituted by the District Assembly or the proposed District Health & Development Planning Committee for Communities assessed to be practicing environmental sanitation.

FIG. 3 SOME KEY COLLABORATORS IN WATER AND SANITATION



3.5 Financial Mechanisms for the Inter-Sectoral Collaboration

The necessary resources including funds for the ISC, planning, implementation, monitoring and evaluation of programmes under the ISC should be adequately budgeted for. At one level, each collaborator shall fully budget for programmes and activities mandated to perform. For MDAs and other subvented organizations, funding shall come from Government and its Development Partners. For Civil Society, Faith-Based Organisations and the Mass Media, funds may have to come from Government and the Development Partners for the implementation of planned activities.

At another level, the Ministry of Health may have to release funds for some specific programmes or a set of activities a collaborator is committed to implement but funds are either insufficient or unavailable. In all cases, there should be accountability of resources given.

3.6 Expected Outcomes and Timeframe for the ISC Programmes.

Ultimately, the concerted efforts of all collaborators should lead to the improvement of the health status of Ghanaians. For the medium term (2007-2011) however, the real impact of all the interventions might not be visible. What rather needs to be done therefore, is to ensure that reliable information exists as Baseline for all the areas targeted for intervention. It is upon the Baseline data that realistic targets can be set. Additionally, access to services like safe water and sanitation needs to be closely monitored to ensure that investments made in those areas are gradually yielding the desired dividend. Where an outcome of health improvement can clearly be associated with a particular intervention, this shall be recognized as such

4.0 Conclusion

Inter-Sectoral Collaboration (ISC) for accelerated Health improvement in Ghana is a strategy the Ministry of Health has committed itself to pursue with its health-related Ministries, Departments and Agencies. Information from key informants of this report share the same vision with the Ministry of Health and have stated their interest and commitment to it.

What is rather uncertain is how any future attempt at ISC shall be different from the previous ones which did not appear to achieve much gains. Statutory institutions, structures and mechanisms responsible for championing the concept of ISC for health have not succeeded in accelerating growth in the health sector through collaborative effort. The interest and commitment of MDAs are positive signs of what can be done when all stakeholders resolve to make the ISC work.

Analysis has been done on why past efforts at ISC have not succeeded in improving the health status of Ghanaians. Based upon the analysis, recommendations have been made which when implemented shall see a more effective collaborative efforts at health promotion.

Annex 1. Terms of Reference

Scope of Work

- Identify and meet with key stakeholders at central, regional and district levels (both rural and urban districts). At least the Consultant should meet with:
 - Ministry of Local Gov. and Rural Dev.
 - Ministry of Food and Agric.
 - Ministry of Education.
 - Ministry of Works and Housing.
 - Ministry of Health.
 - Ghana Health Service.
 - CHAG
 - NPDC
- Review the current ISC activities that impact health in Ghana both at the central level, regional and district levels. Recommend ways to improve existing administrative and collaborative structures for ISC.
- Identify main priorities for ISC in relation to health.
- Identification and definition of responsibilities among stakeholders.
- Financial mechanisms at central level ie. annual sector budgets.
- Financial mechanisms at district level ie. DA financial management.
- Identify reasons why ISC in health has not been successful in the past.

Deliverables

A discussion paper on ISC in the context of Health. The paper will suggest realistic scenarios for each identified main priority. Each scenario will identify areas of improvement, expected outcomes, main stakeholders, division of labour responsibilities, financial mechanisms and timeframe. The discussion paper will be presented to by the Consultant at the Health Partners Summit in November 2007 and provide the basis for further discussions.

Based on the discussions at the summit and relevant Aide Memoire Recommendations, the Consultant will prepare a Road map for moving ISC in Health forward.

Annex 2. List of Persons Interviewed

1. Mr. Minnta A. Aboagye - Director of Water, Min. of Water Resources, Works & Housing
2. Mr. Jones Ofori - Head of Administration, Food & Drugs Board
3. Mad. Cynthia Bosomtwi Sam - Head of School Health Programme, Ghana Education Service.
4. Mr. Demedeme Naa Le Nason - Head, Environmental Health & Sanitation of Min. of Local Gov., Rural Dev. & Environment.
5. Mr. Alidu Fuseini - Director of Finance & Adm., Min. of Food & Agric.
6. Madam Florence N. Iddrisah - District Director of Health Services, Dormaa District.
7. Dr. Simon Antara - District Director of Health Services, Berekum District.
8. Dr. Alhaji Mohammed Ibrahim - Regional Director of Health Services, Sunyani.
9. Dr. Ernestina Quainoo - Tema Municipal Director of Health Services
10. Mr. Philibert Kankye - Executive Secretary, Christian Health Association of Ghana (CHAG).
11. Mr. Jerry E.O. Odotei - Deputy Director, National Dev. Planning Commission (NDPC)
12. Daniel Degotse - PPME, Ministry of Health.
13. Mr. George Dakpallah - Head of Budget, Ministry of Health
14. Dr. Edward Addai - Director, PPME, Min. of Health
15. Dr. Elias Kavinah Sory - Director General, Ghana Health Service.
16. Major Courage Quashigah (Rtd.) - Hon. Minister of Health.

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**INTERSECTORAL COLLABORATION FOR
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GHANA**

**A DISCUSSION PAPER PRESENTED AT THE HEALTH
SUMMIT**

19-23 NOVEMBER, 2007 AT GIMPA, ACCRA

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ACCRA-GHANA