

The Second Health Sector

# *5 Year Programme of Work*

*2002-2006*

## **Partnerships for Health: Bridging the Inequalities Gap**

Ministry of Health  
Government of Ghana  
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## List of Acronyms

ATF	Accounting, Treasury & Financial
BMC	Budget & Management Centre
CAGD	Controller & Accountant General Department
CMA	Common Management Arrangement
CSO	Civil Society Organisation
DP	Development Partners
DPF	Donor Pooled Fund
EMU	Estate Management Unit
GHS	Ghana Health Service
GoG	Government of Ghana
GPRS	Ghana Poverty Reduction Strategy
HASS	Health Administration & Support Services
IGF	Internally Generated Funds
KATH	Komfo Anokye Teaching Hospital
KBTH	Korle Bu Teaching Hospital
MDA	Ministries, Departments and Agencies
MDC	Medical & Dental Council
MoH	Ministry of Health
MoF	Ministry of Finance
MTEF	Medium Term Expenditure Framework
MTHS	Medium Term Health Strategy
NGO	Non-Government Organisation
NMC	Nurses & Midwives Council
NGP	Non-Government Provider
PC	Pharmacy Council
PoW	Programme of Work
PPME	Policy, Planning, Monitoring & Evaluation
PUFMARP	Public Financial Management Reform Programme
RHA	Regional Health Administration
SB	Statutory Bodies
SI	Specialised Institution
SWAp	Sector-wide Approach
TA	Technical Assistance
TAM	Traditional and Alternative Medicine
TH	Teaching Hospital

## PREFACE

The End-Term Review of the implementation of the Medium Term health Strategy 1997-2001 spelt out in the Health of the Nation Report 2001 acknowledged the significant improvement made within the sector. There were marked achievements in several areas of public health delivery including immunization coverage with a corresponding reduction in maternal and child mortality.

However, there are continuing problems with other areas such as HIV/AIDS, malaria, TB and Guinea Worm. The inadequacy of attention that these priorities were given in work programmes at the lower levels has been identified as a reason for their persistence. It is also recognized that targets have not been appropriately set to serve as benchmarks for measuring our efforts. Disparities in inter and intra regional performance in all programme areas, which go a long way to affect total performance and quality, was also noted.

Effective partnerships continue to be developed with both health donors and other providers. Here again, further progress has been constrained by the delay in establishing inter-sector linkages thus resulting in limited inter-sectoral action for goal and target achievement. Sector financing from both government and donors are still below expectation even though IGFs continue to increase exceeding projected figures. Although this may be attributed to improve financial reporting, there is the need to ensure that this does not constitute a health access barrier.

The new Health Sector 5-Year Programme of Work 2002-2006 with the theme 'Partnerships for Health: Bridging the Inequalities Gap' seeks to address these issues and improve upon the various gains made and develop new strategies to in tackling the lapses identified. Clear strategies have been developed for both service and systems interventions to ensure that this happens. The major focus being strategies for delivering pro-poor services, gender sensitivity, care for the elderly, the disabled and financial risk protection especially in terms of emergencies and other catastrophic events. Inter-sector action and private/CSO partnerships will play a key role in all of this.

Now is the time for us to take the necessary steps in consolidating the framework to guide the delivery of the goals and aspirations of the new 5-year programme of work. We should together take the necessary steps to deliver on the first set of necessary action in terms of service delivery and interventions.

It is government's sincerest hope that all health professionals and partners alike will commit to this programmed of work to ensure that we deliver on this task that we have set ourselves.

Hon. Dr. Kwaku Afriyie  
Minister of Health

## **I. Introduction**

This document details the principles, objectives, policies, and strategies for the Second Health Sector Programme of Work (5Y POW 2002-2006). The program intends to consolidate the gains made during the first Five Year Programme of Work (1997 – 2001) and apply the lessons learned to finding new solutions.

The program's overall goal is to help reduce health inequalities in Ghana – between the North and South, urban and rural areas, as well as inequalities linked to gender, education, and disability. For instance, the northern regions' under-five mortality rates are 2.52.7 percent higher than those of the Greater Accra Region, which is in the south of the country. The increase in noncommunicable diseases is adding to the existing burden of communicable disease, leading to a possible "double burden of disease." This makes it more difficult to ensure that the limited resources available will target public health priorities, and that the vulnerable will not be excluded.

However, the greatest challenge to health in Ghana is HIV/AIDS, which could undermine all the progress of the last five years. The health sector will play a key role in the national multisectoral response to HIV.

The document serves as a guide, not only for the Ministry of Health and its various implementing agencies (the Ghana Health Service, teaching hospitals, etc.), but also for stakeholders that contribute directly or indirectly to improving the nation's health.

### **1.1 Government health priorities**

The government is determined to improve access and equity of access to essential health care, and ensure that the health sector plays an essential role in the Ghana Poverty Reduction Strategy.

Key components of government policy include:

- Deal with the HIV/AIDS threat, using the national HIV/AIDS control strategy.
- Shift from facility-based services by emphasizing community-based care.
- Reduce financial barriers by abolishing the cash and carry system, thereby ensuring that no one lacking funds at the time of need is denied essential health care.
- Reforms financing arrangements for the entire sector by replacing the requirement to pay at the time of service with prepayment and insurance arrangements.
- Increase the use of non-government and private health providers, reflecting the government's focus on private sector led development
- Emphasize control of Malaria, TV, and the elimination of Guinea Worm, and strengthen reproductive, maternal and child health, and EPI services.

- Improve staff motivation and health worker incentives
- Undertake inter-sectoral collaboration for health related issues like sanitation and nutrition.

## **1.2 Links with the Ghana Poverty Reduction Strategy (GPRS): Bridging the Inequalities gap**

The Second Five year Health Sector Programme of work is an integral part of the GPRS. The GPRS recognizes that improving the health of the poor is crucial for reducing poverty, given that ill health is both a consequence and a cause of poverty.

### **1.2.1 Key objectives for health care in the GPRS: 2002-2004**

The GPRS highlights three priority issues for the period.

- Bridging equity gaps in access to quality health and nutrition services (improved resource allocation to target poor areas and groups, health worker redistribution to deprived areas, cost-effective interventions and improved outreach to deprived areas).
- Ensuring sustainable financing arrangements that protect the poor (for example, better application of the exemptions policy, enhanced protection for the elderly)
- Enhancing efficiency in service delivery (basic quality improvements and more effective, decentralized management and monitoring arrangements)

The GPRS recognizes that health, and especially HIV/AIDS, are affected by the actions of a range of other sectors. It also identifies a number of priority vulnerable and excluded groups: women and children, the disabled and the elderly, people living with HIV and AIDS. These groups are specifically targeted for basic services. The three northern regions and the central Region have also been identified as priority areas.

## **1.3 International health initiatives**

At the international level Ghana has signed on to a series of key international development targets. These include:

- Reduction by two-thirds the rate of infant and child mortality by 2015
- Cut the rate of maternal mortality by three-quarters by 2015
- Attain universal access to reproductive health services by 2015
- Reduce HIV infection rates by 25 percent among 15-24 year olds globally by 2015
- Decrease TB and malaria mortality 50 percent by 2010

These targets have been translated into national targets and will be further translated into regional and district level targets to guide and inform local priority setting in a decentralized system.

## **1.4 Scope of the Health Sector**

The definition of the “health sector” has been expanded to include government health services, private, traditional and non-governmental providers, civil society, and community groups. A well functioning health system also depends upon collaboration and partnership with other ministries, departments, and agencies (MDAs) whose policies and services have a major impact on health outcomes.

The 5Y POW 2002 – 2006 comprises all the activities whose primary purpose is to promote, restore or maintain health. Within these boundaries fall:

- Formal health service including individual clinical care
- Traditional health care
- Home care of the sick, estimated to account for about 60 percent of care
- Public health activities, including health promotion, disease prevention, environmental safety
- Health-related education, including actions to enhance girls’ school enrolment
- Information to improve better care giving actions.

The environment in which people live including poverty levels, access to nutritious food and safe water, education, and social cohesion also determines health. And health knowledge, which allows more informed health choices and healthier lifestyles, is part of improving people’s well-being.

Improved health services technologies, higher health service standards, better access to health care, or higher public health service expenditure will not alone reduce inequalities. In order to achieve better health for all Ghanaians, particularly the poor, public initiatives from outside the health sector will be needed. This means forging partnerships – between households and communities on the one hand, and public service providers on the other, and between government sectors, the private sector, and non-government service providers.

Reforms to the public role, begun under the Sector-Wide Approach (SWAp I) as operationalized in the First Five-Year Programme of Work, will be pursued more vigorously during (SWAp II), as determined in the Second Five-Year Programme of Work. These will deepen and extend partnerships between public health service purchasing and non-governmental provision in order to capture the comparative advantage of all health service providers.

## **1.5 Lesson from the past**

A review of the first Programme of Work, which has been documented in “The Health of the Nation” report, revealed that, while under-five mortality had declined by 27 percent between 1988 and 1998 to levels below those of neighbouring countries of comparable income, childhood deaths still account for 50 per cent of total mortality.

Nationally, regional differences exist and are still growing. Declines in under-five mortality rates vary between 25 per cent in rural areas to 41 percent in urban areas. Regional inequalities are growing too. Under-five mortality rates have increased in the Brong Ahafo Region, compared with 46 per cent decline in Ashanti Region. For all of the indicators and targets set to measure the performance of the health sector, there will be a progress analysis region, by gender, on an urban-rural basis, and by poverty quintiles in order to ensure that the most vulnerable are seeing health benefits. This will be done towards the end of the program.

A number of key lessons emerged from the “Health of the Nation” report that guided the strategic focus of the new programme of work.

- The availability and use of government health and health related interventions were low
- Growing financial barriers to access exclude poor people from taking advantage of available health services
- The health care delivery system has not been responsive to consumer needs
- The potential for contributions from non-governmental health service providers and from collaboration with other government sectors remains largely untapped
- The loss of human resource from the sector is high, and almost equal to the number of people being trained
- Productivity in the sector is generally low; reconstructing effective staff incentives, both financial and managerial, pose sharp dilemmas.
- The per capita expenditure on basic health service is below the level necessary for good service provision.

## **1.6 What health care do Ghanaians want?**

The evidence shows that Ghanaians want:

- Responsive, high quality emergency health services
- Exemptions for households that cannot always afford to pay out of pocket at time of service
- Health services that are close to their place of residence
- A clean environment and good sanitation
- Humane, compassionate, and dignified treatment
- Established and protected consumer rights
- Access to information about which health services will benefit them most and where they can obtain them cheaply.

## **1.7 Design principles for the 5Y POW 2002 – 2006**

The design of the Second Five-Year Programme of Work is based on five principles:

- Health services should respond first to health needs that support households, and provide services that they cannot provide for themselves.
- Community actions to improve health should be given priority

- The range of financing mechanisms will be extended to include prepayment schemes and social insurance
- Comparative advantage should determine the choice of providers for publicly-financed services
- The government will adopt modified roles to fulfill coordinating, regulatory, and purchasing functions, and will provide health services directly only if it is more equitable and efficient to do so.

Within the design principles, the health sector response to HIV/AIDS will be a vital component of the national response. The Health Sector HIV/AIDS Policy and Strategic Plan 2002 – 2006 provides the framework for the response.

## **1.8 The process**

This Programme of Work is the result of information gathering, studies, and nationwide consultations involving key providers, consumers, civil society groups, development partners, and government stakeholders. The preparatory work was divided into three main phases: the review process referred to earlier, a design phase and a development phase. A technical committee, under the overall guidance of a MoH Steering Committee, drafted the document.

## **1.9 Purpose of the document**

This document is, first, the basis for consensus development with related sector ministries and departments, with community, civil society groups and local government stakeholders, with district and regional government health managers, with nongovernmental healthcare providers, and with managers in government sectors outside health. In particular, it provides an overall framework within which more detailed district and regional health plans, including intersectoral activities, can be developed. It is also designed to help align health strategies with development priorities defined by the Planning Commission and with government budget allocations managed by the Ministry of Finance. Finally, the document is intended to be the basis for reaching agreement with Ghana's development partners on their financial and technical contributions, and the way in which they will be managed.

## **II The Sector's Strategic Direction**

### **Vision**

'Improved overall health status and reduced inequalities in health outcomes of people living in Ghana'

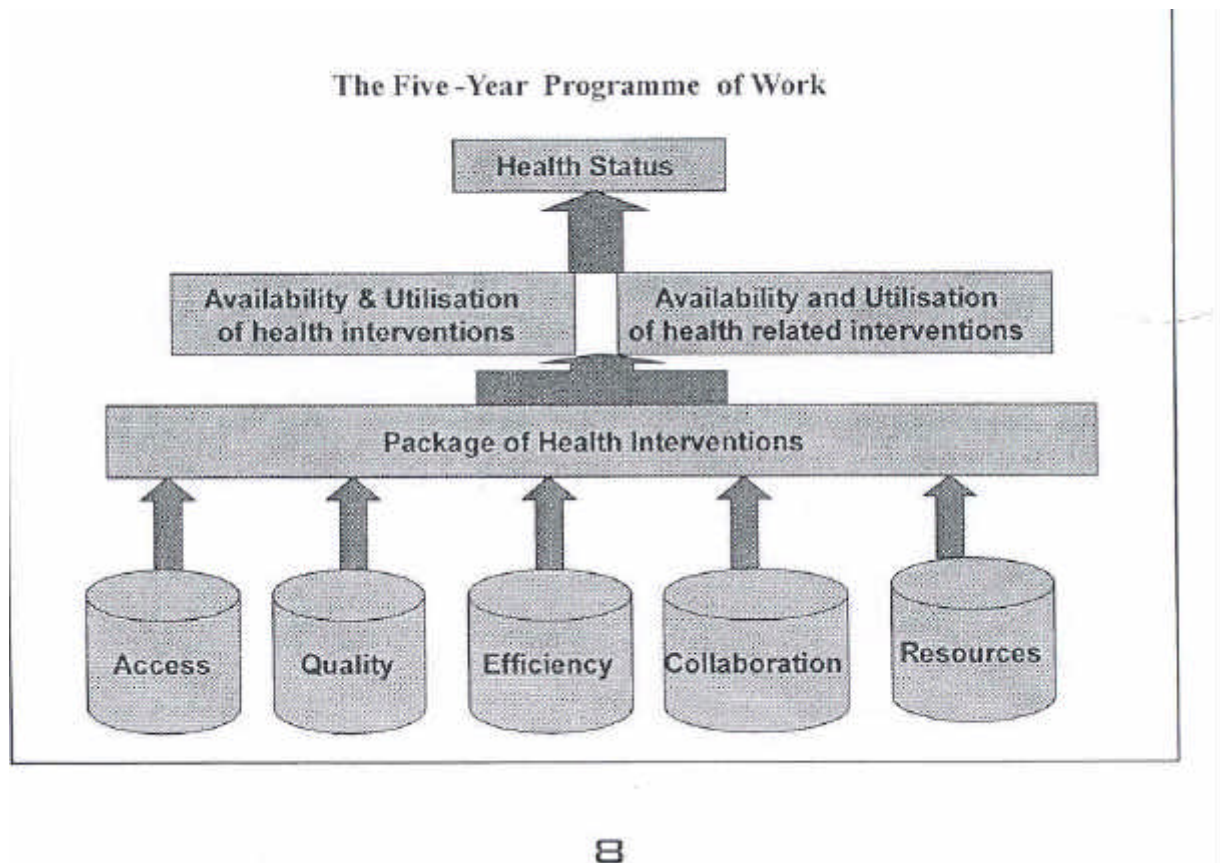
### **Mission Statement**

"The Ministry of Health will work in collaboration with all partners in the health sector to ensure that every individual, household and community is adequately informed about health; and has equitable access to high quality health and related interventions"

### **Policy Goal**

Working together for equity and good health for all people living in Ghana

## 2.0 The Conceptual Framework



The focus of the reform was captured in a Medium Term Health Strategy. The package of interventions identified must be made available to all and used as a basis for service delivery. These will be delivered using five key strategic objectives or critical intermediate performance criteria serving as the pillars, Increasing Access, Improving Quality, Improving Efficiency, Partnerships and Collaboration and Increased Resource: See 1 above

The five strategic pillars

- To improve quality of health delivery
- To increase access to health services
- To improve the efficiency of health service delivery
- To foster partnerships in improving health
- To improve financing of the health sector

## **2.1 Strategic Pillars**

The strategic pillars, or the essential performance criteria of the First Programme of Work (1997 – 2001), are still relevant and continue into the Second Programme of Work (2002 – 2006). However, the lessons learned call for the adoption of different strategies to achieve the policy goal.

## **2.2 Key areas of intervention**

### *2.2.1 Improving quality*

#### **A. Improving Health Worker Performance**

Develop incentives for improved performance; improve basic and in-service training; improve supervision and management; improve the supply of essential drugs and diagnostics to enable health workers to cooperate more effectively; improve logistics support; conduct and disseminate clinical audits regularly, and build these into the performance management system.

#### **B. Improving Responsiveness to Client Needs**

Establish and protect client rights through the development and promulgation of a Citizens Health Charter; ensure that essential information (for example, about fee schedules and exemptions) are posted publicly at all facilities; ensure that complaint procedures are in place and operated fairly; ensure that service provision is humane, compassionate, and dignified, including privacy for women; promote gender awareness and understanding of the different health needs and experiences of women and men; encourage the participation of men in reproductive health services; re-orientate specialized services at the secondary and tertiary level to support and develop service quality at lower levels, and improve referral practice.

### *2.2.2. Increasing access*

#### **A. Improving Geographical Access**

Work with communities to ensure the availability of appropriate community-based services and address all barriers to access at the local level; ensure improved geographical access to emergency services and primary services (basic health care); review facility capabilities to cope with common emergencies and develop, as appropriate, community ambulatory services, taking into account all health service providers; review patient emergency transfer facilities, and develop them as appropriate.

#### **B. Improving Financial Access**

Ensure that financial barriers do not prevent access to health services; improve access to services for the financially vulnerable – the very poor, the elderly, children, people living with chronic

diseases; review and develop exemption policies and practices, and ensure provider compliance; develop community prepayments schemes/health insurance plans to replace cash and carry systems in both the formal and informal sectors; focus public expenditure on priority package of health interventions and supporting people who cannot or will not pay for themselves.

### **C. Improving Socio-cultural Access**

Reduce socio-cultural barriers to access to health services; ensure appropriate access to services for priority groups (for example, women and children); ensure improved access to services for the socially vulnerable, especially people with special needs (the disabled and people living with chronic diseases).

#### *2.2.3 Improving Efficiency*

##### **A. Improving Cost Effectiveness**

Ensure maximum value for money from public expenditure on health services at all levels; from private expenditure on health services at all levels; and through better integration of service delivery where target populations or communities are the same.

##### **B. Improving Planning, Management, And Administration**

Review the location of government facilities and avoid duplication with non-government facilities; relate staff deployment to levels of service required and case loads (decentralizing staff budgets and management); move towards caseload-based hospital allocations (allocating global budgets for priority services); and move towards a comparative advantage based choice of providers to supply publicly-financed services.

#### *2.2.4 Fostering partnerships*

##### **A. Improving Partnerships With Households And Communities**

Ensure that households are well-informed about good health behavior and health care seeking behavior; ensure coordinated inter-sectoral support for community action to reduce environmental causes of disease; and by develop and extend public information programs.

##### **B. Improving Partnerships Between Private And Public Sector Providers**

Develop a common regulatory framework for both government & non-government health service providers; commission and/or encourage non-government service providers to supply services where they have a cost or location advantage; extend continuous learning programs to non-

government providers, including traditional providers; and increase the contribution of nongovernmental health service providers to national health priorities.

**C. Improving Partnerships With Other Ministries, Departments And Agencies (MDA)**

Ensure coordinated inter-sectoral support for community action to reduce environmental causes of disease; implement inter-sectoral health improvement programs fashioned in response to local health priorities; work with the Ghana Education Service to develop curricula and teach good health behavior; establish support for District Assemblies to define health need priorities and plans for addressing them; advocate for a Cabinet lead on priority inter-sectoral health actions; and advocate, support, and promote proactive policies and implementation by other MDAs, non-government providers (NGPs) and civil society organizations too improve environmental sanitation, access to safe water, road safety and populations control.

**D. Expanding Relations With Development Partners**

Revise the Memorandum of Understanding; institute performance-hearing systems for development partners to improve efficiency; and increase the number of development partners contributing to the common fund.

*2.2.5 Improving equity in financing*

**A. Reducing The Budgetary Burden Of Healthcare For Poor People**

Extend prepayments schemes to replace cash and carry systems in both the formal and informal sectors; and develop the appropriate regulatory and policy environment for health insurance.

**B. Increasing Public Expenditure On the Poor And Vulnerable**

Base public budget allocations explicitly on poverty-related indicators to ensure access to care regardless of ability to pay; develop exemption policies and practices, and ensure provider compliance; and ensure that diseases and ailments with gender-differentiated incidence receive appropriate allocations and attention; and reduce the differences in provision and service standards between rich and poor areas.

### **III Priority Health Interventions**

#### **Policy thrust**

Although progress against some key health indicators has been made over the last 5-Year Programme of Work, a renewed commitment to achieving measurable improvement in the nation's health by addressing inequalities in health outcomes is central to the Second 5-Year POW.

Government will focus on financing services that tackle the major public health priorities – a defined core set of priority diseases and services. It will work with and through all providers and sectors, including local government, to ensure that these priority health needs are met in poorer areas and for the most vulnerable. Government will concentrate on engaging the most efficient providers while working to improve its own service provision.

#### **3.1 Priority health interventions**

A number of diseases have been designated priorities because of their potential or actual impact on health, or because of the current large disparities in health outcomes between regions, and between urban and rural areas. Other interventions and diseases have been selected because of their impact on household resources, particularly for the poor, or because they are targeted for eradication.

- HIV/AIDS/STI
- Malaria
- Tuberculosis
- Guinea worm
- Poliomyelitis
- Reproductive, maternal and child health
- Accidents and emergencies
- Noncommunicable diseases
- Oral health and eye care
- Specialist services, including psychiatric care (community, secondary and tertiary)

The preventive aspects of these issues would be pursued with a strong emphasis on promotion of health and education.

## 3.2 Challenges

Several challenges persist in addressing priority health needs effectively.

- The threat of HIV/AIDS is growing
- The information required to improve health behavior is inadequate
- Significant treatment occurs in the household or community level, but the information needed to allow informed choices about treatments and providers is lacking
- There is not enough attention given to the design and implementation of intervention packages that address the needs of the poor and vulnerable
- Standards and treatment guidelines are not readily available or are not used regularly
- Progress has been slow in engaging nongovernment providers (NGPs) and in recording private sector activity and performance
- There is a lack of continuity in service delivery, with poor referral mechanisms between levels and between NGPs and government services.

## 3.3 Strategic objectives

- Implement a package of priority health interventions
- Empower communities to improve their health improvement and gain access to basic health care
- Improve the efficiency and effectiveness of health service provision
- Institutionalize quality in all health facilities
- Reorient secondary and tertiary services to support access to primary care

## 3.4 Key Activities

### 3.4.1 *Implementing a package of priority health interventions*

#### **A. IMPLEMENTING THE HEALTH SECTOR HIV/AIDS STRATEGY**

- Introduce ARV drug to children and immediate family at point of birth
- Promote safer sex, prevent mother to child transmission, ensure safe blood and blood products for transfusion, and improve STI management to prevent new infections
- Develop and implement a workplace HIV/AIDS programme
- Scale up national programme for Voluntary Counseling and Testing (VCT)
- Provide a continuum of care for PLWHA: counseling and palliative care in the households and community, and management of opportunistic infections
- Develop and expand national surveillance to strengthen the evidence base for action
- Improve access to anti-retroviral therapy for HIV/AIDS in health facilities.

A number of these strategies will require strong partnerships with NGOs and MDAs to strengthen service delivery, particularly at the community level.

## **B. STRENGTHENING MALARIA CONTROL**

- Promote home-based care of fevers, with emphasis on symptoms detection and early treatment
- Encourage the use of prepackaged chloroquine
- Improve the management of complicated and uncomplicated malaria in health facilities
- Promote the use of Insecticide Treatment Materials for children under five and pregnant women
- Provide chemo-prophylaxis-intermittent treatment for pregnant women
- Advocate for improved environmental sanitation
- Undertake a study on resistance to chloroquine drugs

## **C. IMPLEMENTING THE TUBERCULOSIS DOTS STRATEGY**

- Review TB community strategy to make it more integrated in public facilities and include civil society organizations
- Improve case detection
- Reduce defaulters rates
- Work to improve cure rates
- Increase access to anti-TB Drugs through innovative ways of distribution
- Set Regional and District level performance targets for improved case detection and cure rates.

## **D. ERADICATING GUINEA WORM AND TRACHOMA**

- Extend inter-sectoral programs to provide potable water for Guinea Worm and trachoma endemic communities
- Improve Guinea Worm and trachoma surveillance
- Strengthen case containment
- Expand and improve health education

## **E. REPRODUCTIVE, MATERNAL AND CHILD HEALTH**

- Strengthen the delivery of family planning services (including integration of STI management, services for men)
- Improving the skills of health workers in life saving skills
- Provision of essential obstetric care (basic and comprehensive) in levels B and C respectively,
- Improve Growth Monitoring Skills of professionals
- Scaling up of IMCI services
- Strengthening adolescent health services
- Scaling up cervical cancer screening and management

## **F. ENHANCNG EPI**

- Introduce new combination vaccines (Pentavelent DPT-HepB-Hib)
- Initiate accelerated measles control
- Ensure the availability of vaccines
- Work to attain polio free certification
- Increase health education and promotion

### *3.4.2 Empowering communities for health improvement and access to quality basic health care*

The Community-based Health Planning and Services Strategy (CHPS) is the main initiative to achieve this strategic objective. It moves health services to community locations, develops sustainable voluntarism and community health action, empowers women and vulnerable groups, and improves health provider, household, and community interaction. Specifically, the initiative will:

- Implement CHPS as the frontline health care delivery mechanism
- Increase outreach programs to make relevant, specialist, periodic and time-bound services available close to clients
- Strengthen delivery of effective health promotion on environmental and lifestyle related diseases at community level
- Commission civil society and nongovernment providers to supply publicly financed services on the basis of comparative advantage
- Pursue rehabilitation and development of programs to increase access for the disabled, the vulnerable, the elderly and the poor.

### *3.4.3 Improving the efficiency and effectiveness of health service provision*

Single interventions will be replaced with clusters of interventions, for example:

- Integrated management of childhood infections (IMCI) as the basis for the treatment of malaria, diarrhoea, RTI, malnutrition
- EPI, Pentavalent as the basis for vitamin A supplementation
- CDTI plus other drugs (Ivermectin, albendazole, praziquantel, Arithromycin)
- HIV with TB
- Guinea Worm, trachoma programme with water provision and surveillance, sanitation and personal hygiene.

Collaboration with other sectors, including the private sector, will be developed in order to implement an effective system for emergencies, accidents, disasters, poisons and trauma. An effective ambulance service will be established in partnership with the private sector. The service component of the Hospital Strategy will be completed and implemented.

### 3.4.4. Institutionalizing quality in all health facilities

- Community needs for services will be assessed, and, where appropriate and feasible, action will be taken to address these for example, opening hours will be adjusted
- Ambulatory care at the primary level will properly designed to give basic care
- The Patients Charter and the Code of Ethics for Health Professionals will be completed and adopted
- Commitments made in the Patients Charter such as information on exemption policy, complaints procedures, and consumer protection will be implemented
- Continuous learning programs for all health staff (government and non-government) will be developed and implemented
- Total quality management and quality assurance procedures will be developed further and implemented in ways that involve civil society and communities; results will be publicized.
- A Hospital Waste Management Plan will be developed and implemented in collaboration with the EPA.

Targets to be achieved

	Impact and output Measures	1998-2000	GPRS: 2004	2006
Health Status	U5M per 1000	107.6	95	95
	IMR per 1000	56.7	50	50
	MMR per 100,000	214	160	150
	Life expectancy	58	58	58
HIV/AIDS	HIV Prevalence	3	3	2.6
TB	Cure rate	43%		60%
	Case detection rate			
Malaria	% Use of ITMs for 5/pregnant women	10		56
	Case fatality rate of 5 years			
Guinea worm	Number of cases	7,402	0	0
Reproductive health	ANC coverage	47		70
	% supervised deliveries	44		50
	FP	14.3		40
Clinical, pharmaceutical, and laboratory practice	% meeting international quality Standards	66%		80%

#### *3.4.4 Re-orientating secondary and tertiary services*

- Clinical and service quality will be improved at the secondary and tertiary levels
- Appropriate mechanisms will be developed for effective referral systems form both public and private institutions
- Access to the appropriate level of care will be assured according to the complexities of disease profile or health intervention
- Specialist outreach programmes will be strengthened
- Total quality assurance and management in clinical and laboratory services will be strengthened
- Uniform standards for practice in clinical, pharmaceutical, and laboratory practice in both private and public facilities would be established and enforced
- Clearly designed exemption categories will be developed for tertiary institutions

## **IV Human Resources For Health**

### **Policy Thrust**

Human resource management has been a major challenge, with problems of staff retention and their distribution in relation to health needs, especially in the northern regions and remote areas. A human resource strategy will be developed with emphasis on incentives to retain and attract staff with the appropriate skills to where they are most needed. Performance related management systems will be introduced to reward hard work. Opportunities for further studies will be provided especially for persons working in hardship areas.

### **4.1 Priority interventions**

The development of a highly trained and motivated workforce with the skills appropriate to implement the Five Year Programme of Work's strategic objectives is of the highest priority. In reaching this goal, there are four areas of emphasis:

1. Match staff numbers and skills with health needs across the country
2. Decentralize human resource administration, budgets, and management
3. Recognize and reward performance
4. Promote gender equity in employment

### **4.2 Challenges**

- The brain drain among health professionals at all levels of service delivery
- An affordable package of incentives that encourages staff retention within the public sector
- The mal-distribution of health personnel geographically and by level of service delivery
- The legacy of past failures to take human resource implications into account in hospital and health facility planning and expansion of services
- The dilemma of a wage bill constraint in the face of expectations for improved financial incentives and remunerations.

### **4.3 Strategic objectives**

Restructure the sector's personnel numbers, distribution, and skills mix, develop and implement programmes of continuing professional development for all professional staff. Set up a decentralized management systems that recognize and reward hard work and, particularly,

service in hardship/deprived locations. Promote collaboration between public sector health providers and private practitioners.

## **4.4 Key Activities**

### *4.4.1 Restructuring the sector's personnel numbers, distribution, and skills mix*

- Develop a strategic HR Plan for the health sector
- Improve output and pass rate from pre-service training institutions
- Redistribute staff to bridge the inequalities in staff placing, using short-term placing and incentive system
- Increase intakes into all pre-service training institutions
- Review the curricula of community health nursing and field technician training to support community-based care
- Find innovative ways of funding pre-service and post basic training of health staff
- Develop a new cadre of auxiliary health staff to support professional clinical duties
- Develop a new cadre of para-medics to support CHPS program.

### *4.4.2 Developing and implementing Continuous Professional Development Programmes*

- Develop national programmes to ensure that all health workers receive continuing education in their various fields
- Link in-service training/continuing education to staff promotions and career progressions
- Orient community health nurses, midwives, and field technicians to improve clinical and service delivery
- Establish local post graduate medical programmes
- Develop new post basic nursing and allied health programmes – e.g. ENT, A&E nursing, together with basic surgical skills programmes for medical assistants para-medics.

### *4.4.3 Decentralizing health staff management*

- Recruit HR managers for Regional BMCs and teaching hospitals
- Develop and use personnel procedure manuals at all levels
- Set up benchmarking and monitoring systems to promote good HR practices at all levels
- Develop an integrated human resources information system for regional, district, and facility levels
- Decentralize the management of recurrent PE budget in phases after further BMC management training
- Localize recruitment into pre-service training and the bonding systems.

### *4.4.4 Developing performance management systems*

- Develop an affordable performance-related incentive package for all levels of staff, related to skills and responsibilities as part of the strategic HR plan

- Strengthen staff performance appraisal systems
- Decentralize performance management systems in phases

#### 4.4.5 Promoting collaboration between public sector health providers and private practitioners

- Provide pre-service and in-service training opportunities for private practitioners
- Develop the capacity of non-government providers for the delivery of health services in areas where they have comparative advantages
- Give output-related commissions to accredited non-government providers
- Explore collaboration with private providers for new training schools for health staff
- Strengthen the capacity of staff of the MoH and agencies at all appropriate levels to deal with inter-sectoral collaboration
- Implement a strategy for dealing with intramural practice.

#### Targets to be achieved

	Impact and output measures`2006	
Strategic HR Plan	New incentives and performance management system in place HR budgets & management decentralized % nurse/med assist/doctors posts filled by category and by regions	80% of staff appraised  100 of BMCs
Staff training	% graduating at first sitting % Increase in intake	80% 50%
Staff retention	% of core staff working 3 years after graduation	70%
In-service training	% of staff receiving in-service training	80%
Training of NGPs	% NGP trained	20%
Professional support to the north/deprived areas	% of health professionals with short-term placements to the north/deprived areas	35%
Staff redistribution (equity)	% change interregional and inter-district distribution of key staff in favour of deprived regions and districts % change in intra-district rural/urban distribution in favour of rural areas	40%  40%

## **V Infrastructure and Support Services**

### **Policy Thrust**

The Hospital Strategy will be a standard for hospital development and management. Infrastructure development will focus on rehabilitation of existing facilities and only limited new development in the deprived, low access areas. The transport policy will aim to reduce the overall age of the fleet, and favour allocation of vehicles in deprived areas.

Equipment will be standardized across the public sector for better efficiency and maintenance, and appropriateness criteria for equipment at all levels will be defined.

The national drugs policy will determine the purchase of essential drugs through a unified drugs and procurement management agency. The central medical stores will be franchised with a strong commitment of government that ensures it protect the consumer. The use of the posteriori third party review system will remain the main monitoring tool.

### **5.1 Priority interventions**

- The provision of community services will be through community-based arrangements and enhanced specialized service provision, without necessarily building large health facilities
- Infrastructure planning will take into account the infrastructure that already exists (government and non-governmental) and the kinds of services required by consumers; and it will involve technical end users, District Assemblies and communities
- An improved transport management system will be pursued to ensure that an adequate fleet of well maintained and managed vehicles of all categories are deployed, particularly at the district and community level to support service delivery.

#### **A. INFRASTRUCTURE**

### **5.2 Challenges**

- In the past infrastructure development planning (IDP) was not backed by realistic funding plan, which is likely to put pressure on any rationalization process
- IDP did not follow the agreed procedures, is over centralized and not based on clear policies
- IDP did not address recurrent cost implications
- Generally, the private sector has not been considered during IDP development
- There is no hospital and other health facility development policy or strategy in place

- There is no coordination among source, donor, districts initiated projects, and the MoH

### **5.3 Strategic Objectives**

- Develop and implement a capital investment strategy, including recurrent cost component and a realistic funding plan
- Review and develop policies, protocols, and guidelines to support capital investment plans
- Strengthen the capacity and institutional arrangements to implement capital investment.

### **5.4 Key Activities**

#### *5.4.1 Capital investment management*

- Value and map the sectors physical assets (private and public), in relation to population to determine the extent to which these facilities are consistent with sector policies and priorities.
- Review all land and fixed property titles and regularize any shortcomings in their acquisition
- Develop an infrastructure investment/diversification plan to reduce duplication and align infrastructure with the health care service delivery policies
- Assess the future costs and benefits of planned and on-going projects
- Estimate and document the recurrent costs of current, planned, and further public investment projects as decision support material.

#### *5.4.2 Policies, protocols and guidelines*

- Develop a consensus on policies and principles for infrastructure investment both in the public and private sectors
- Develop a model for integrated capital planning and policies and guidelines for use by the public and private sectors on size and location of facilities
- Compare and implement the Hospital Strategy
- Adhere to the agreed procedures in the development of new infrastructure.

#### *5.4.3. Capacity development and institutional changes*

- Determine the levels of responsibility for capital investment management as part of the decentralization process
- Develop the capacity for infrastructure planning and management further by all sector agencies and at appropriate levels
- Strengthen the capacity of lower levels to undertake preventive maintenance management

Targets to be achieved

Activity	Impact and Output Measures	2006
Capital Investment	Rehabilitate Health Facilities	30% of District Health Facilities
Hospital development strategy	Costed strategy approved	40% facilities brought in line with strategy
Improve facilities in deprived areas	Established Community-based Health Centres	40% of new facilities developed in 4 deprived regions
New facility development	Value of new investments	>3% of current level

## B. TRANSPORT

### 5.5 Priority Interventions

The transport policy will be reviewed with an emphasis on replacing the lower level vehicle fleet. The national level vehicles fleet may not be increased from the public system because of personnel or individual allocation.

### 5.6. Challenges

- The fleet is aging (7.7 years in 2000) due to inadequate funds, resulting in rising running costs
- High staff attrition is causing a capacity gap and structural weaknesses in the system
- There is an over-reliance on earmarked funding for fleet replacement
- Transport in deprived and hard to reach areas is inadequate to support service delivery
- There is low patronage of in-house mechanical workshops
- Vehicle standardization conflicts with procurement regulations.

### 5.7 Strategic Objectives

- Adopt and fully implement a revised transport policy
- Decentralize transport management and maintenance system to different agencies
- Continue to build capacity of transport management at all levels
- Strengthen the boat and ambulance service

## 5.8 Key Activities

### 5.8.1 *Reviewing and implementing a new Transport Policy*

- Review the current transport policy, taking into consideration alternate transport systems (boat services) and the private sector
- Build a consensus and implement the policy

### 5.8.2 *Decentralizing transport management and maintenance*

- Develop national strategy together with guidelines for transport maintenance
- Support different agencies to build transport management capacities
- Build partnerships with the private sector at all levels to ensure high quality maintenance and value for money
- Redirect transport resources to the periphery and lower levels.

### 5.8.3 *Building capacity for transport management*

- Develop and implement continuous professional development framework for drivers and transport managers
- Review the qualifications for employing drivers and managers to improve efficiency

Targets to be achieved

Activities	Impact and Output Measures	2006
Vehicles distribution	Vehicle available at lower levels	70%
Fleet condition	Proportion serviceable vehicles	80%
Revised transport policy	Average fleet age	<5 years
Private sector involvement	% BMCs using private sector maintenance	70%

## C. EQUIPMENT

### 5.9 Challenges

- There is a lack of adequate and standardized equipment for service delivery
- There is inadequate capacity for equipment management under the decentralized policy
- Turn-key projects and commercial loan facilities do not adhere to equipment policy

## 5.10 Strategic objectives

- Develop a national equipment policy with specifications
- Ensure that all equipments are in a serviceable state for safe use
- Build capacity for both the public and private sector

## 5.11 Key Activities

### 5.11.1 *Developing a national equipment policy*

- Develop and implement appropriate policies on equipment in line with international standards
- Decentralize procurement and replacement of equipment to main MoH agencies

### 5.11.2 *Ensuring that all equipment is in a serviceable state for safe use*

- Undertake a national survey to update the state of biomedical equipment in Ghana
- Develop a national strategy providing technical and servicing support to all agencies and the private sector
- Monitor adherence to the implementation of the medical equipment policy, and produce annual audit reports
- Continue the re-equipping of health facilities through the various agencies.

Targets to be achieved

	Impact and Output Measures	2006
Equipment condition	% of functioning equipment by value	85%

## D. SUPPLIES

### 5.12 Priority interventions

The national drugs policy and standard treatment guidelines and protocols will determine the purchase of essential drugs. The use of the posteriori third-party review system will remain the main monitoring tool. International procurement would be undertaken based on a single system for all partners. The Central Medical Stores will be reviewed to enhance its operational efficiency in line with quasi-marketing principles.

## 5.13 Challenges

- Existing legislative instruments for procurement are weak, and seem vague and inconsistent
- There is inadequate capacity at all levels to carry out procurement of supplies following agreed upon procedures
- There is no systematic approach to pricing health commodities at health facility levels, which has led to overpricing and a lack of uniformity in prices
- There have been delays in taking a firm decision on the future status of the Central Medical Stores, leading to perpetuating ineffectiveness
- There are fragmented systems for international procurement by MoH and development partners
- Monitoring procurement is weak at all levels

## 5.14 Strategic Objectives

- Align sector procurement policy with the national procurement reform agenda
- Finalize the reorganization of the Central Medical Stores into an efficient, strategic, and client-focused organization
- Decentralize procurement to MoH agencies and other providers

## 5.15 Key Activities

### *5.15.1 Aligning sector procurement policy with the national procurement reform agenda.*

- Streamline procurement arrangements to adopt a uniform procurement code for Ghana
- Adopt a common procurement agency strategy for all partners for offshore procurement to ensure efficiency gains
- Review and strengthen procurement capacity at the lower levels through monitoring and support

### *5.15.2 Finalizing the reorganization of the Central Medical Stores*

- Develop and implement a financial strategy and a management plan based on private sector participation for the Central Medical Stores
- Review contracting and monitoring capacity and develop an appropriate staff mix to implement, monitor, and supervise the CMS strategy
- Develop the capacity to manage drug and logistics pricing by the CMS at cost benefit to the consumer.

### 5.15.3 Decentralizing procurement to MoH agencies and providers

- Develop the procurement capacity of MoH, THS, and GHS at all levels
- Improve Stores management capacity at all levels
- Review the policy on cost recovery of drugs and consumables
- Enforce a drugs pricing policy

#### Targets to be achieved

	Impact and Output Measures	2006
Distribution efficiency	Tracer drugs available	80%
Market efficiency	% Drug purchased from the CMS	80%
Procurement efficiency	% transactions meeting agreed standards	85%

## **VI Promoting Partnerships for Health**

### **Policy Thrust**

Because good health is not only a function of the health service delivery, other government sectors, communities and civil society must be involved.

The Second Five Year Programme of Work will adopt a two-pronged policy: (a) give an active role to other government sectors, communities, and civil society in policy formulation, in service delivery, and in service monitoring and evaluation; and (b) reorganize resource flows to support these partnerships. The issues are:

- Address inequalities based on gender, poverty, and disability
- Promote the right to basic services
- Increase community and civil society participation in policy formulation, planning, and in monitoring and evaluation of service delivery at all levels
- Expand water availability, sanitation and the health environment
- Improve the quality of life through population management
- Improve nutritional status

### **6.1 Priority interventions'**

MoH and GHS staff have been involved in the design of the Ghana Poverty Reduction Strategy. Although there was a conscious attempt to engage communities, civil society, and local government institutions during the First Five Year Programme of Work, future emphasis will focus on:

- Working with other ministries, departments, and agencies to deal with the major determinants of good health food, water, sanitation, and education
- Developing capacity and framework for working with civil society and communities at all levels
- Developing priorities for inter-sectoral action with specific objectives, strategies, and activities

### **6.2 Challenges**

- Although inter-sectoral collaboration was thought important for comprehensive health service delivery, it did not develop as a core strategy for health planning and service delivery
- NDPC, the key national agency responsible for coordinating the different public service organizations did not fulfill its expectations

- The arrangements for joint working at both national and local level are either weak or ineffective. The legislation underpinning the health sector arrangements (Act 525, 1996) is widely considered to be in conflict with the legal framework for decentralization (Act 462)
- There are no guidelines, policies, and effective mechanisms in place for the health sector to work with other government departments and agencies. Some work has been done in this direction, but this has to be improved and supervised
- There is a limited capacity for developing composite (multi-sectoral) plans and budgets at the district level.

### **6.3 Strategic objectives**

- Strengthen the role of the community, civil society, and community-based organizations so that they can support client access to services and protect and promote client rights to quality health services
- Build effective partnership with other ministries, departments, and agencies and with district assemblies in pursuit of reduced health inequities and better health for all
- Strengthen the capacity of all sector levels to plan and facilitate intersectoral programs
- Reorganize the sector's resource flows to support collaboration with other sectors, communities, and civil society.

### **6.4 Key Activities**

#### *6.4.1 Empowering individuals, households, communities and community-based organizations*

- Facilitate the development of a strategic framework to help households identify the main sources of ill-health and solution finding, and incorporate this into health planning
- Develop an appropriate model for communities to identify the poor and vulnerable in society in order to promote access to care
- Develop and implement plan of action to provide information on domestic safety, emergency, and first aid principles at the individual, household, and community level ("Facts of Life")
- Build a national strategy to create demand for basic services
- Create and implement a national policy for engaging communities and civil society organizations so that they can operate more effectively within the health arena
- Support the development of sustainable civil society and community-based organizations by identifying and implementing actions that require collective effort
- Promote the participation of key partners in the replication of CHPS in all communities
- Pass a Patients Right Charter into law, with operational guidelines on its implementation, mediation, and monitoring.

#### *6.4.2 Building effective partnerships with other ministries, departments and agencies*

- Develop guidelines for working arrangements with other ministries and departments

- MoH will work with NDPC, MOLG, MOA, GES, EPA, and Ministry of Works and Housing to develop guidelines for joint health/health related plans with District Assemblies
- Build framework to include joint financing and monitoring arrangements at all levels
- Create a national framework for working and responding to Cabinet and parliamentary initiatives that require an inter-sectoral response.

*6.4.3 Strengthening the capacity of all sector levels to plan and manage inter-sectoral programs*

- Strengthening human resource capabilities in different agencies and redefine their functions to include the promoting and monitoring of partnerships with other sectors, communities, and civil society; identify, train, and assign at regional levels to fulfill these functions.

*6.4.4 Reorganizing the sector's resource flows to support collaboration with other sectors, communities and civil society*

- Create an innovations fund to support innovative approaches for dealing with health issues initiated by other sectors, communities, and civil society
- Create a budget line for supporting civil society organizations at the district and sub district levels to be managed through the District/Unit Committees.

Targets to be achieved

	Impact and Output Measures	
Health and Safety	Knowledge Practice	80% households 50% households
District health plans	% districts implementing DHPs	40% in each Region
Patients Charter	Consumer knowledge of rights & responsibilities	80% of households
CHPS expansion	No. of sectors & CSOs engaged	80% of CHPS districts
Community initiative	No. of Community Initiatives funded	4 in each District
Innovation fund	% of health budget allocated	0.5%

## **VII Promoting Private Sector Participation In Health Service Delivery**

### **Policy Thrust**

The private health sector is an important and growing source of health services in Ghana, providing about 42 per cent of the healthcare services. In addition, there are a large but unknown number of traditional healers and drug sellers. A major strategic thrust during the Second Five Year Program of Work will be to improve and establish formal commissioning arrangements with non-government service providers. These service providers would be integrated into the health system, recognized for their capabilities, coordinated, supported, and regulated through appropriate mechanisms to enhance the equity focus of the sector.

There will be continuing development of private sector participation in aspects of government provision for hotel type services, infrastructure and transport development

### **7.1 Priority interventions**

- Develop a comprehensive strategy to support and engage non-government providers
- Complete the Memorandum of Understanding formalizing commissioning arrangements with the private sector agents to supplying services as envisaged in the last program o work, and begin commissioning
- Build capacity of the Ministry of Health/GHS and the private health sector to undertake contract negotiations and management functions in public/private partnership at all levels

### **7.2 Challenges**

- The scope of the private sector is not clear
- Collaboration between the Ministry and the private practitioners in providing service is still on a volunteer or ad hoc basis
- The engagement of NGOs, in both policy formulation and implementation, is still limited and mainly involves international rather than local, NGOs
- The MoH Private Sector Unit has limited capacity to develop strategies for wider private-public sector partnerships in core healthcare or in support services
- The potential to involve public sector health workers in intramural practice had not been explored in any detail

- There is a Minister for Private Sector Development and the challenge for MoH is how to source funding for the private health sector from that office.

### **7.3 Strategic Objectives**

- Create innovative ways of promoting private sector and non-government provider participation in health service delivery
- Develop the appropriate capacity for commissioning and/or contracting out of services in line with comparative advantage criteria
- Support the development of private sector capacity to implement public sector contractual arrangements
- Promote procedures that would ensure additional resource allocations to the private sector

### **7.4 Key Activities**

#### *7.4.1 Developing innovative ways of promoting NGP participation in health service delivery*

- Establish a forum for channeling the views of the private sector and non-governmental providers on health policy and service issues.
- Review and implement national policies on the privatization of appropriate services and facilities in public health institutions
- Strengthen the Private Sector Unit in the Ministry of Health to facilitate wider private sector participation
- Ghana Health Service and teaching hospitals will develop clear policies, systems, and instruments to promote private/public partnerships, public/public commissioning and service contracts and include explicit time-bound plans in their annual work programs
- Identify and orient private practitioners to participate in the CHPS program

#### *7.4.2 Developing capacities for commissioning services*

- Review and sign Memorandum of Understanding and convert it into service contracts
- Develop criteria for assessing the comparative advantage of providers, and choose preferred providers
- Identify expertise in contractual arrangements and management in other sectors and seek their experience
- Devise and implement training in managing and monitoring contractual arrangements
- Undertake a workload analysis to determine if specialist staff are required; and employ as appropriate

#### *7.4.3 Supporting the development of private sector capabilities*

- Include NGPs in public policy deliberations
- Devise and implement training in managing and monitoring contractual arrangements
- Undertake a workload analysis to determine if specialist staff are required; employ as appropriate.

7.4.4. *Developing and promoting procedures that ensure additional resource allocations to private sector providers*

- Develop a framework that assists the private health sector to have access to financial support for providing better (effective and efficient) services, including from donor agencies
- Lobby the Government (Minister for Private Sector Development) to ensure that the private health sector is supported.

Targets to be achieved

Activity	Impact and Output Measures	2006
Commissioning arrangements	% of MoUs and Agreements signed	60% of Mission institutions 20% of other NGPs
Public-private partnership policies	Non core health service delivery functions contracted out	50% of non essential services contracted out
Private Sector Unit	Full complement of staff mix	100%
Shifts in resource flows	% of recurrent budget allocated to NGP commissions	2.0%
District Level Private Practitioners	% of facilities at district that are private facilities	10%

## **VIII Regulation**

### **Policy Thrust**

Protocols and directives, enforced by employment contracts, have regulated health service volumes, quality, and price in the government health system. Statutory bodies have applied legislation governing professional qualifications and registration more generally to professional practice. The safety of pharmaceutical products is the subject of separate legislation. However, these instruments are inadequate to provide quality assurance and consumer protection in a more pluralistic provider setting.

Action will be taken to rectify weaknesses in health sector regulation, and the fragmented and weak enforcement of regulatory regimes. The statutory and regulatory bodies will be strengthened to become more proactive and effective in promoting quality of practice and service provision. The Ministry will focus on coordination and supervision.

The rights of the consumer within the health sector will be assured through the establishment of an independent advocate and the publication of a Patient's Charter

### **8.1 Priority interventions**

- Protect and strengthen consumer rights within the health sector
- Improve funding and strengthen the regulatory functions of professional bodies mandated with professional self-regulation; such as the Medical and Dental Council, the Pharmacy Council, the Food and Drugs Board, the Private Hospitals and Maternity Homes Board and the Nurses and Midwives Council
- Update and disseminate existing legislation
- Decentralize the regulatory function to the region and district level.

### **8.2 Challenges**

- The lack of incentives for the limitations in the enforcement of sanctions by the statutory bodies
- Too few qualified personnel to enforce standards
- The unenforceability of some laws and statutes governing health service provision, as well as broader public health protection, because of a lack of clear procedures
- The dearth of advocates with knowledge about health practice and health related legislature and its enforcement
- Resource flows to the regulatory bodies are inadequate; their weak management systems and their contribution to the sector's outcomes is not monitored

- The increase in commercial interests in health services – e.g. health insurance and new pharmaceutical industries.

### **8.3 Strategic objectives**

- Increase consumer protection and representation in service quality
- Empower statutory bodies, making them more effective and accountable
- Modernize existing legislation.

### **8.4 Key activities**

#### *8.4.1 Increasing consumer protection and representation in service quality improvements*

- Develop a national policy framework that allows all stakeholders, including knowledgeable health consumers, to participate and be represented in developing and implementing the principles guiding sector-wide regulatory reforms
- Involve civil society in the implementation and monitoring of the regulatory environment
- Pass into law a Patients' Charter of Rights
- Mount an information campaign to inform consumers about standards of care targets
- Establish an ombudsman for Health
- Revise treatment protocols, guidelines, and standards with knowledgeable consumer involvement
- Use IE&C, including the establishment of websites and other modern IT tools, to make the provisions of legal and other regulatory instruments more easily accessible to the public.

#### *8.4.2 Empowering statutory bodies, making them more effective and accountable*

- Review the responsibilities and legal framework of statutory bodies to ensure that their authority extends to cover service quality in both the private and public sectors
- All statutory bodies will develop costed biannual strategic plans
- Develop procedures and mechanisms to support and streamline regulatory procedures
- Develop the appropriate institutional framework, supervised by statutory bodies, for handling complaints, for enforcement and sanction procedures, for monitoring activities, and for sharing experience
- Decentralize the functions of regulatory bodies to make them more effective
- Assess and improve the capacity of regulatory bodies
- Establish budgets and budget management procedures for statutory bodies

#### *8.4.3 Modernizing legal instruments*

- Review and revise laws to reflect modern practice, public health, and safety
- Develop new laws to deal with the merging healthcare markets
- Develop the appropriate legislative instruments to make existing and new legislation enforceable

- Review and strengthen legislation on the sale and advertising of drugs and allopathic, traditional, and other alternative
- Review the existing regulations, handle emerging and new responsibilities of the respective regulatory bodies

Targets to be achieved

Activity	Impact and Output Measures	2006
Patients Charter established	% of people understanding their rights & responsibilities	60%
Ombudsman's office established	No. of complaints handled successfully	80%
Public information systems in place	Patients satisfaction level	60%
Functions of statutory bodies enhanced	Full complement of staff established	100%
Legislative reform	Proportion of Legal Instruments Reviewed	30%
Law on Private Health Facilities up-dated to reflect other practices	Facilities operating according to legal requirements	80%

## **IX Organizational Arrangements**

### **Policy Thrust**

The reorganization of the MoH with the creation of the Ghana Health Service, teaching hospitals, and autonomous agencies will be completed and consolidated

As a priority, agreement will be reached upon the relationship of District Health Committees with District Assemblies in order to ensure that district level health plans are developed that address the priorities and policy thrust of the decentralized district administration. The autonomy of the health sector at the district level in relation to District Assemblies, which is reinforced by Act 525, will not be allowed to prevent the contribution of the health sector to District Assembly priorities.

The functions of the Ministry of Health will be re-aligned to be more effective in defining national health policy and fostering/advocating intersectoral action and partnerships among different sectors.

Coordination of development partners' contributions will continue to be through the enhanced system of the Sector-wide Approach (SWAp II)

### **9.1 Priority Institutional Issues**

- Continue the reorganization of the health sector by establishing of the full staffing complement; clarify roles and responsibilities of both the MoH and its executive agencies.
- Develop guidelines and capacity for working with other government sectors, district assemblies, non-government providers, and communities at the national and operational levels
- Enhance the current process of engagement between government and its funding partners through regular health summit meetings.

### **9.2 Challenges**

- The full implications and efficiency gains to be derived from the separation of the service agencies (GHS and THs), in line with Act 525, from the civil service is not yet clear to all stakeholders.
- The pluralistic nature of nongovernment providers and the limited knowledge on their full capacity make it difficult to develop comprehensive mechanisms, contractual or

otherwise, to coordinate and guide these agencies without creating mistrust and suspicion among the different stakeholders

- There is weak administrative support for the implementation of the Budget management Center concept at the teaching hospitals.
- There is a lack of clarity between the MoH, GHS and MoE (Ministry of Education) in the management of the teaching hospitals and training institutions.
- There is lack of clarity between Act 525 and Act 462, requiring removal of contradictions between the two Acts.
- A clarification of the relationships of referrals between primary, secondary, and tertiary levels is required to eliminate double costing.

### **9.3 Strategic objectives**

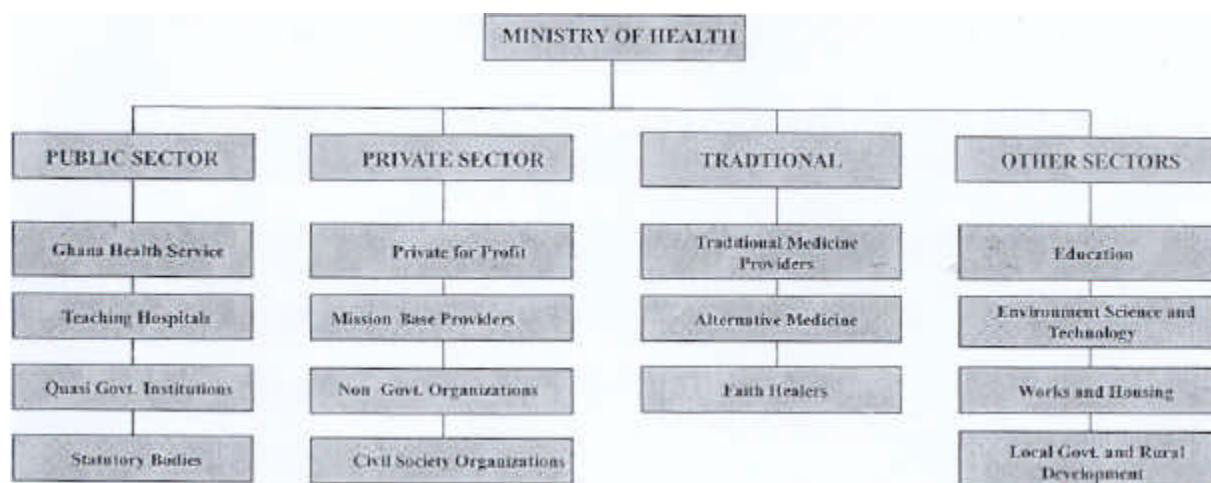
- Complete the reorganization of public agencies in the sector
- Agree upon and implement new institutional arrangements governing different agencies in the sector, with new legislation if necessary
- Develop capacity for all agencies in the health sector
- Establish a system for intersectoral action, advocacy, and coordination between the MoH and all other agencies within and outside the health sector
- Institute systems that will ensure the implementation of the legal mandate of the statutory bodies
- Involve the private sector (e.g. Private for Profit, NGOS, Missions) in all health sector endeavours

### **9.4 Key Activities**

#### *9.4.1 Completing the reorganization of the health sector*

The sector would be reorganized to maximize efficiency gains by involving all the key agents (Figure 1).

## Key Players in the Health Sector



### Households

#### A. MINSITRY OF HEALTH

- Complete the establishment of the Ministry as a policy coordination and strategic management agency of government, with the appropriate staff and capacity based on acceptable conditions and schemes of service
- Negotiate contractual arrangements with service agencies
- Review the staff manual with critical attention to the Ministry's core functions
- Develop a national strategy for resource mobilization and disbursements within the sector, with emphasis on decentralization and equity achievement
- Develop a national policy and strategic framework for coordination and collaboration to ensure corporation with all government organizations involved in the health sector
- Prepare and implement a referral policy to cover both private and public sector facilities, focusing on cost benefit to the consumer
- Strengthen planning guidelines to all agencies.

#### B. TEACHING HOSPITAL

- Develop a strategy to address the constraints impeding the decentralizing of management of the clinical departments
- Prepare business plans for each large business management unit, indicating key functions, sources of finance, referral relationships, fees administration, and client records management between the different service providers
- Develop an appropriate legislative instrument for the applying of administrative functions

- Clarify the responsibilities of the MoH and MoE in managing of the teaching hospitals.

### **C. GHANA HEALTH SERVICE**

- Complete the staff appointments process with appropriate conditions and schemes of service
- Implement annual service agreements with all BMCs as a basis for resource allocation
- Establish clear guidelines for performance measurement
- Develop the capabilities required to manage financial and human resources and service contracts with NG service providers
- Decentralize management functions further to lower levels, with a goal increasing authority and responsibility
- Develop institutional capacity at all levels to deal with community participation, inter-sectoral collaboration, and civil society engagement
- Develop an appropriate legislative instrument for applying administrative functions
- Strengthen planning capacity at the regional and district levels to ensure that such plans conform with national priorities and complement district assembly plans.

### **D. STATUTORY BODIES**

- Establish a consultative forum for all statutory bodies to ensure interdisciplinary dialogue and coordination
- A desk will be created in MoH for statutory bodies affairs
- Strengthen the management capacities of the statutory bodies

### **E. DEVELOPMENT PARTNERS**

- Continue regular policy dialogue between the MoH, its agencies, and other development partners
- Staff and develop country offices in ways that are consistent and in dialogue with MoH and its agencies
- Realign country programs and processes to draw increasingly on public sector systems and procedures for implementation, procurement, and accounting
- Adopt uniform criteria to compliment partner representation and capacity
- Increase accountability and have annual hearing sessions on performance of partners

Targets to be achieved

Activities	Impact and Output Measures	2006
MoH & Executive Agencies operational with full staff complement	% of staff positions filled by category at HQ	80%
Partners report on performance	% of partners with annual/end of term performance report and performance hearing	100%
Executive Agency Contracts Signed	% of Executive Agencies with defined contracts	100%
Inter-sector action strengthened	Capacity built for managing partnerships and collaboration	No persons trained
MoH Agencies Performance reviewed	% of agencies with annual/end of term review reports	100%

## **X Financing the Health Sector**

### **Policy Thrust**

The GPRS commits the Ministry of Finance to increase allocation of resources to the Ministry of Health, and re-allocation of resources within the Ministry in favour of the deprived regions. A plan will be developed to respond to this initiative. The government is committed to removing financial barriers to treatment due to out of pocket payments at point of service. Prepayment mechanisms will be developed to replace fee for service. The exemption scheme to take care of the vulnerable will be reviewed to make it more accessible.

### **10.1 Priority Finance Activities**

- Abolish Cash and Carry
- Social insurance and health insurance schemes introduced
- Enhance and expand prepayment schemes
- Clarify exemption policy clarified and develop clear implementation guidelines
- Revise resource allocation formulae to address geographical inequalities, poverty and gender issues
- Capture global resources available for health care consumption in a health care expenditure profile to be used for planning purposes.

### **10.2 Challenges**

Resource allocation to the health sector has increased over the last five years, with increasing shift from the center to the district level. However, a number of issues have emerged as a result of the changing environment over the last five years:

- Although the expenditure targets in the previous POW were met, it was through unanticipated sources – i.e. IGF and commercial loans, and not as intended through an increase in sector-wide fund expenditures over the years.
- Ghana has accepted the HIPC status but initial reviews do not indicate any substantial additional resources to the sector
- The policies of the current government call for a critical review of the “cash and carry” system to increase access for all. This means that other methods of financing health care would be required

- A major policy shift towards introduction of National Health Insurance Scheme was beset with problems, and a pilot is yet to be launched; the few community schemes in place are yet to show evidence of sustainability
- With the increase in IGFs the question of exemptions continues to be a problem, especially with wide variations in the implementation of the policy and reimbursement difficult.
- With the introduction of the MTEF, budget ceilings were expected to include all sources of funds, but the uncoordinated nature of earmarked funding makes this difficult
- The proportion of the expenditures needed to finance the wage bill seems to be rising and needs critical review in order to improve sustainability.
- The MoH is yet to design more rigorous resource allocation formulae that will address health inequalities, gender, deprived areas, and poverty issues
- There is no overview over the global resources available for health services consumption, since the focus has been on sources available to MoH only.

### **10.3 Strategic objectives**

- Increase real per capita expenditure on health
- Increase financial access to health care through the introduction of social insurance and prepayment schemes
- Increase financial access to health care through the improvement of the exemption scheme
- Improve resource allocation to address health inequalities (regional, district, gender, rich/poor)
- Prioritize services and financing within the constraints of the budget.

### **10.4 Key activities**

#### *10.4.1 Increase real per capita expenditure on health*

- Secure GPRS commitment for increased resource allocation to health
- Secure GOG commitment to increasing proportional recurrent budget allocation to the health sector based on projections
- Increase donor partner contributions through the health fund
- Explore other avenues for financing the health sector

#### *10.4.2 Prepayment schemes enhanced and expanded*

- Introduce and support prepayment schemes for the population
- Review revenue collection system in favour of prepayment schemes nationwide
- Conduct public education programs to increase community awareness and involvement in the financing of healthcare
- Explore arrangements to provide re-insurance and risk management for prepayment schemes

#### 10.4.3 Exemption policy rationalized and clear implementation guidelines developed

- Clarify the exemption policy, including assessment of funding needs
- Develop clear implementation guidelines to ensure consistent implementation
- Streamline rules for reimbursement for exempted patients.

#### 10.4.4 Resource allocation formulae revised to include health needs, poverty and gender issues

- Develop appropriate weightings and indices for health needs, poverty, and gender
- Revise resource allocation formulae to reflect government policies
- Create a framework for reporting all funds used in the sector
- Ensure agreement between health partners to capture all funds for the purpose of planning and budgeting
- MoH and agencies will agree with health partners on how the earmarked funds should be used and monitored.

### 10.5 Resource Mobilisation Target

The table below provides estimates of the resources likely to be available to the sector from various sources. Its structure distinguishes between the extent to which funds can be pooled at different levels, and are therefore available according to need rather than ability to pay. This provides the link between the resource envelope and allocations to priority uses, shown in the tables that follow.

#### A. Estimated resource envelope

The estimated projections are based on available information at the time of writing this work program and may vary based on real accruals. The annual resource release from government sources is the key variable since most of its allocations are determined on funds available from internal and external sources. Internally generated funds (IGFs) are facility specific, thus though captured as an aggregated national figure, are not available for re-allocation nationally.

	Low Case Scenario					
	2002	2003	2004	2005	2006	Total
GOG	63.30	71.34	80.93	91.45	103.33	410.35
External Aid	60.00	60.00	60.00	60.00	60.00	300.00
IGF	14.00	16.00	17.50	19.00	20.00	86.50
Total	137.30	147.34	158.43	170.45	183.33	796.85

	High Case Scenario					
	2002	2003	2004	2005	2006	Total
GOG	66.66	89.18	101.14	114.31	129.17	500.46
External Aid	60.00	70.00	90.00	90.00	90.00	400.00
IGF	14.00	19.00	21.00	23.00	25.00	102.00
Total	140.66	178.18	212.14	227.31	244.17	1,002.46
Exchange Rate	7000	7000	7000	7035		
Inflation Assumption		22%	12%	7%		
Cumm. Inflation		22%	34%	41%		

	Resource Shift					
	2001	2002	2003	2004	2005	2006
MOH HQ	7	7.4	6	6	6	5
Statutory	1	2.31	2	2	2	2
Teaching	12.8	12.11	13	13	13	14
Psychiatry	6.2	5.97	7	7	7	7
GHS HQ	8	8.85	7	7	7	7
RHS	23	19.89	23	23	23	23
DHS	24	23.47	22	22	22	22
SDHS	18	20	20	20	20	20
Total	100	100	100	100	100	100

	Allocation to Items				
	2002	2003	2004	2005	2006
Personal Emoluments	38	40	44	46	48
Administration	18	18	18	17	16.8
Services	26	26	24	25	25.2
Non Wage Recurrent	44	44	42	42	42
Total Recurrent	82	84	86	88	90
Investment	18	16	14	12	10
Total Health Allocation	100	100	100	100	100

Proposed Shift  
Health Sector Non-Wage Recurrent Budget Allocation (Budget Items 2 and 3)

	2001	2002	2003	2004	2005	2006
LEVEL	16	15.5	15	15	15	15
Headquarters	0.27	19.67%	19.67%	19.67%	19.67%	19.67%
Ministry of Health	0.13	0.0951	.51%	9.51%	9.51%	9.51%
Ghana Health Service	0.113111461	10.16%	10.16%	10.16%	10.16%	10.16%
Tertiary	19	20.00	21	22	22	22
Teaching Hospitals	10.98	13.40	13.40	13.40	13.40	13.40
Korle-Bu	0.00552	6.69	6.69	6.69	6.69	6.69
Komfo Anokye	0.00424	4.65	4.65	4.65	4.65	4.65
Tamale	0.00122	2.06	2.06	2.06	2.06	2.06
Psychiatric Hospital	4.96	6.6	6.6	6.6	6.6	6.6
Accra	0.00215	2.64	2.64	2.64	2.64	2.64
Pantang	0.00167	2.11	2.11	2.11	2.11	2.11
Ankaful	0.00114	1.85	1.85	1.85	1.85	1.85
	8.2	22	21	20	20	20
Regional Health Service	0.26608912	22	21	20	20	20
National and Regional Reference Laboratories	0.015	2.50	2.00	2.00	2.00	2.00
Regional Hospitals	0.096	7.50	7.50	7.30	7.30	7.30
Training Institutions	0.004	7.00	7.00	6.50	6.50	6.50
Innovations Fund	0.20	0.40	0.60	0.65	0.85	1%
District Health Services	42	42.5	43	43	43	43
Non-government	1.20%	1.45%	1.55%	1.60%	1.80%	2.00%

providers						
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## **XI Financial Management Systems**

### **Policy Thrust**

The financial management system will support further decentralization of resource management as well as improve the efficiency of financial resources management. It will focus not just on handling funds, but also on the linkage between financial information and health management information to allow for analysis of cost, service delivery, and health outcomes over time as well as within and across BMCs. In addition, the dissemination of such information will be strengthened in order to promote informed decision-making.

### **11.1 Priority financial management activities**

- Strengthen internal control procedures
- Build and support human resource capacity building for all agencies
- Focus on management reporting for decision making.

### **11.2 Challenges**

The completion of the health sector finance procedural manual – “Accounting Treasury and Financial Reporting Rules and Instructions” (ATF rules) has established uniform accounting procedures. All 311 Budget Management Centres (BMCs) created were appraised, with 287 certified to hold and manage funds directly. The challenges are:

- Accounting personnel are subject to periodic transfers made by the Controller and Accountant General, affecting the willingness of MoH to train accounting staff for fear of losing them.
- Not all BMCs have capacity for further decentralization of financial management, for example the wage budget.
- Differences in the Government’s timing of public financial management reforms has delayed full computerization of financial reporting in MoH
- Delays in GOG cash flows to BMCs have hampered the implementation of planned activities

- Restoring the linkage between activities and budgets at BMC levels has not yet been done.

### **11.3 Strategic Objectives**

- Improve the efficiency of financial management
- Enhance capacity for financial management
- Build capacity at the BMC level to handle a decentralized Personal Emoluments vote
- Strengthen planning and budgeting systems for decentralized resource utilization and management
- Establish mechanisms at BMC levels to determine efficient utilization of resources

### **11.4 Key Activities**

#### *11.4.1 Improving the efficiency of financial management*

- Negotiate with CAGD to ensure full subvented status for the Ghana Health Service and teaching hospitals
- Develop a management accounting system for internal use and a financial statement analysis for external purposes
- Produce quarterly and annual financial statements with a focus on strategic analysis of key trends
- Develop analytical capacity to assess value for money and to assess the alignment of public resources with health needs (public priorities)

#### *11.4.2 Enhancing capacity for financial management and utilization of resources*

- Develop mechanisms to retain existing staff and to recruit more quality staff
- Review the requirements of stakeholders and agree on the redesign of the financial statements (taking into account the ongoing design of the sectors management information system)
- Develop capability for managing health insurance fund
- Develop strategies to improve cash flow management

#### *11.4.3 Strengthening planning and budgeting systems for decentralized resource utilization and management*

- Strengthen MTEF planning and budgeting and improve standardized activities
- Improve the quality of plans at all levels
- Strengthen capacity of BMCs to prepare business plans through the MTEF methodology

#### *11.4.4 Establishing mechanisms established at BMC levels to determine efficient use of resources*

- Develop activity reporting formats for BMCs
- Develop appropriate analytical capacity for optimal use of activity reports
- Ensure feedback mechanisms for cross-BMC comparisons
- Introduce activity reports by BMCs

#### Targets to be achieved

Activity	Impact and Output Measures	1998-2000	2006
GHS/TH financial status	Subvented status	N/A	100%
Financial mgt. Capacity	% staff turnover due to MDA transfers	N/A	10%
Decentralised resource mgt.	% BMCs managing Pes	20%	80%
Resource efficiency analysis	% BMCs using activity-based efficiency analysis	N/A	80%
Monitoring and Audit	% BMCs with timely audit reports	80%	100%

## **XII Management Information & Performance Monitoring**

### **Policy Thrust**

Over the next five-year POW the emphasis of the monitoring and evaluation system will shift to support more use of data at the point of collection for local planning. A performance monitoring system will be developed that is relevant at the district and sub-district level, building upon a core set of indicators. The separate systems for measuring cost, service delivery, and clinical outcomes will be linked, and a set of relational performance measures will be developed.

The role of the public sector in monitoring the performance of the private and not for profit sector will become increasingly important with the expansion of contracting. Monitoring the implementation of contractual arrangements and measuring the cost and quality of output will permit inter-district and inter-regional performance comparisons, as well as comparisons between government and other service providers. A system for measuring workload, productivity, and cost per item of service will be developed to inform these comparisons.

### **12.1 Challenges**

- The data collected are often not used for decision-making
- Performance is not linked with resource allocation
- Some of the data collected is of poor quality due to low capacity, lack of appreciation, and inappropriate data collection tools
- Sector information is incomplete due to the low level of representation from the private service providers (this will become more critical as more reliance is placed on non-governmental service provision)
- Some performance indicators are difficult to interpret
- The use of research findings is limited, and there is a lack of baseline data for the first programme of work.

## 12.2 Strategic objectives

- Develop indicators that link clinical outputs and outcomes to inputs
- Provide an evidence base for policy, service quality, the budget and preparation of program plans
- Build capacity to monitor the implementation of contractual arrangements
- Strengthen the capacity for operational research of all service providers
- Improve the application of appropriate technology for data collection, storage, analysis and dissemination of health information.

## 12.3 Key Activities

### *12.3.1 Developing performance indicators*

- Establish national working groups (finance, CHIM, surveillance, statistical services, etc.) to develop guidelines for all levels and all sectors
- Develop relational performance measures for benchmarking, inter-district and inter-regional comparisons
- MoH will liaise with the Ghana Statistical Service to enhance the design of the national households surveys.

### *12.3.2 Providing an evidence base for policy and practice*

- Develop a Decision Support System that ensures a flow of information based on user friendly technology
- Implement a national policy on information collection, collation and management, paying close attention to the principles of right to information and privacy
- Develop appropriate data management and simulation programs to be used nationally to ensure effective budget preparation.

### *12.3.3 Building the capacity to monitor contractual arrangements*

- Develop standard guidelines for monitoring contractual arrangements
- Develop capabilities at national and regional levels to monitor contractual arrangements

### *12.3.4 Strengthening the capacity for operational research*

- Identify capacity requirements together with gaps in competency areas for effective performance measurement and data analysis; develop strategies to address them
- Strengthen the capacity to undertake operational research by MoH agencies relevant for their policies and programs
- Forge linkages between research and routine health information systems
- Develop sentinel site surveys to complement sector-wide indicators obtained from routine data
- Create national database of research findings and a forum for dissemination.

### 12.3.5 Improving the use of information technology

- Streamline the deployment and use of information and communication technology the implementation of the ICT policy
- Develop in-service training for staff to improve capacity for using information technology
- Develop multimedia mechanisms for the dissemination information and improvement of communication in the health sector, including increased use of the Internet and local area networks to improve internal and external communication for BMCs.

#### Targets to be achieved

Activity	Impact and Output Measures	1998-2000	2006
Performance monitoring	% of BMCs with performance monitoring systems	80%	100%
Information coverage	% of NG providers reporting	30%	60%
ICT policy	% Agencies using standard ICT	-	100%
Decision Support	% Timely half year/annual report based on priority sector-wide indicators	90%	100%

## **XIII TRADITIONAL & ALTERNATIVE MEDICINE**

### **Policy Thrust**

It is estimated that more than 80% of people living in Ghana use herbal medicine in their raw state, semi-processed or manufactured. However very little documentation has been done on the efficacy and safety of these products. The thrust during the second Five Year Programme of Work is to promote and encourage research, development and the rational use of herbal and alternative medicines that are efficacious, safe, and of good quality. Regulation of the activities of the traditional and alternative medicine practitioners would be intensified to eliminate quackery and other harmful practices.

### **13.1 Priority Interventions**

- Develop a national agenda for herbal and alternative medicine research
- Continue to improve technical and financial support to all research institutions (including the Centre for Scientific Research into Plant Medicine and the universities)
- To set-up a functioning traditional and alternative medicine practice
- Design and implement quality assurance programmes in TAM
- Initiate basic and advance training programme for TAMPs
- Set-up system for self-regulation of TAM in order to eliminate quackery
- To continuously improve public awareness on the dangers of using unsafe TM products on the market.

### **13.2 Challenges**

- Collaboration between the Ministry of Health and the traditional and alternative health sector is clearly defined
- The directorate of Traditional and Alternative Medicine has limited capacity to implement all the programme objectives
- There is the lack of coordination between the activities of all the research institutions

- There is no established for a for discussing development issues regarding traditional and alternative medicine practices
- The Traditional and Alternative Medicine Council which is the main regulatory agency is yet to be formed.

### **13.3 Key activities**

#### *13.3.1 Develop a National Agenda for Herbal and Alternative Medicine*

- Carry out a review of all research conducted on traditional and alternative medicine in all institutions
- Build technical and management capacity in all institutions
- Hold annual meetings to define herbal and alternative medicine needs
- Setting up functioning Traditional and Alternative Medicine Council
- Collect data on Traditional Medicine Practitioners
- Analyse and produce a report on the data base on TMPs

#### *13.3.2 Design and Implement Quality Assurance Programmes*

- Develop guidelines for efficacy and safety of traditional and alternative medicine
- Disseminate and implement the guidelines
- Monitor the implementation of the guidelines
- Design a self-inspecting system for traditional healers and implement the system
- Provide logistic support for self-enforcement of standards, ethics and regulations
- To develop user-friendly manual to assess adverse effects of drugs at the point of care

#### *13.3.3 Initiate basic and advance training programme for TAMPs*

- Provide basic training to TAMPs
- Produce a user-friendly pharmacopoeia for the training of TAMPs
- Review university programme in Traditional Medicine (Faculty of Pharmacy, KNUST) and develop institutional support for the training of TAMPs

#### *13.3.4 To continuously improve public awareness on the dangers of using unsafe of untested TM products on the market*

- Develop an IEC strategy paper on public education on TAM
- Organise fora for discussing dangers of traditional medicine products (FM, TV Shows).

Targets to be achieved

Activity	Impact and Outputs Measures	2006
Set-up a functioning TAMC	TAMC set-up with a registrar and secretariat	TAMC set-up and functioning
To train researchers in the use of guidelines for efficacy and safety studies	To increase the % of safe herbal drugs on the market	25% increase of safe herbal products on the market
Basic training provided to TAMP	Increase the no. of TAMPs who receive MoH approved structured basic training	6000 TAMPs trained
Improve (KNUST) training	Improve training	30 graduates in TAM
Creation of public awareness of dangers on unsafe TAM products	Improve knowledge attitudes and practices of public with regard to the use of unsafe herbal products	20% over baseline figure

## Annex 1

	SECTOR-WIDE INDICATORS
Health Status	<ul style="list-style-type: none"> <li>• Infant mortality rate</li> <li>• Under five mortality rate</li> <li>• Maternal Mortality ratio</li> <li>• % Under five years who are malnourished (underweight)</li> </ul>
Service Delivery	<ul style="list-style-type: none"> <li>• Number of outreach services carried out by specialist from tertiary, secondary and district hospital by region</li> <li>• Population to doctor and nurse ratio by region</li> <li>• Outpatient visit per capita</li> <li>• Hospital admission rate</li> <li>• Number of community resident nurse per district/region</li> <li>• % of maternal audits to maternal deaths</li> <li>• Under five malaria case fatality rate</li> <li>• % tracer drug availability</li> <li>• HIV seroprevalence (among reproductive age, 15-19, 20-24)</li> <li>• Tuberculosis cure rate</li> <li>• Number of guinea worm cases</li> <li>• AFP non polio rate</li> <li>• % Family Planning acceptors</li> <li>• % ANC coverage</li> <li>• % PNC coverage</li> <li>• % Supervised deliveries (skilled attendants)</li> <li>• Bed occupancy rate</li> <li>• EPI coverage (DPT3, measles)</li> </ul>
Partnership	<ul style="list-style-type: none"> <li>• % recurrent budget from GOG and Health Fund used by private sector, NGOs, CSOs and other MDAs</li> <li>• % earmarked funds used for private sector, NGOs, CSOs and other MDAs</li> </ul>
Financing	<ul style="list-style-type: none"> <li>• % GOG budget spent on health</li> <li>• % GOG recurrent budget for health</li> <li>• % of earmarked/direct donor funds to total donor funds (per partner)</li> <li>• % of IGFs coming from pre-payment and community-insurance scheme</li> <li>• % recurrent and capital expenditure by level, by region,</li> </ul>

	<p>and by source</p> <ul style="list-style-type: none"> <li>• % recurrent budget spent on selected cases by category (exemption)</li> </ul>
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## Annex 2

### PARTNERSHIPS FOR HEALTH: AREAS OF COLLABORATION WITH OTHER MDAs

Ministry, Department, Agency (MDA)	Areas of collaboration in the next 5 Year Programme of Work
District Assemblies	<ul style="list-style-type: none"> <li>• Development of integrated, multi-sectoral district health &amp; HIV/AIDS plans which involve all local stakeholders</li> <li>• Integrated action on water and environmental health/sanitation</li> <li>• Health care financing: health insurance and exemptions schemes</li> </ul>
Ministry of Local Government & Rural Development	<ul style="list-style-type: none"> <li>• Policies and capacity-building to develop role of district and metropolitan assemblies in health and HIV/AIDS</li> <li>• National environmental health and sanitation policies and capacity-building</li> </ul>
Ministry of Finance	<ul style="list-style-type: none"> <li>• Mobilisation of adequate resources for health and HIV/AIDS</li> </ul>
Ministry of Education	<ul style="list-style-type: none"> <li>• Health benefits of continued educational improvements especially girl child education and female literacy</li> <li>• Health promotion, family life education and HIV/AIDS education in schools</li> <li>• Nutritional supplements; school-based health services</li> </ul>
Ministry of Food and Agriculture	<ul style="list-style-type: none"> <li>• Action on food security, nutrition, rural livelihoods and income generation</li> <li>• Role of extension workers in HIV/AIDS and health education</li> <li>• Health and safety of agricultural workers</li> </ul>
Environmental Protection Agency	<ul style="list-style-type: none"> <li>• Reducing negative health impacts of environmental degradation, pollution, poor air and water quality</li> <li>• Impact assessment of projects</li> </ul>
Ministry of Works and Housing/Ghana Water Company/Community Water and Sanitation	<ul style="list-style-type: none"> <li>• Reducing negative health impacts of homelessness, overcrowding and unsanitary conditions</li> <li>• Reducing the incidence of communicable diseases through promoting access to affordable water especially in rural areas/deprived urban communities</li> </ul>
Ministry of Roads & Highways	<ul style="list-style-type: none"> <li>• Promoting road safety and action on vehicle emissions</li> <li>• Enhancing access to health facilities</li> <li>• Promoting healthy forms of transportation (cycling, walking)</li> <li>• Prevention of spread of HIV/STIs by transport and construction workers</li> </ul>
Ministry of Economic Development & Regional Integration/NDPC	<ul style="list-style-type: none"> <li>• Addressing cycle of ill-health and poverty</li> <li>• Integration of action on inequalities in health, and HIV/AIDS into MDA plans and the GPRS</li> </ul>
Ministry of Manpower Development & Employment (including Social Welfare)	<ul style="list-style-type: none"> <li>• Occupational health safety; workplace HIV/AIDS policies and programmes</li> <li>• Community development: strengthening community capacity</li> <li>• Identifying needs of and support for vulnerable groups: disabled, vulnerable women and children, the elderly</li> <li>• Policies to promote government-NGO partnerships</li> </ul>
Ministry of Communication & Technology	<ul style="list-style-type: none"> <li>• Health promotion and HIV/AIDS prevention at national and local level</li> </ul>
Ministry of Youth & Sports	<ul style="list-style-type: none"> <li>• Health promotion for young people</li> <li>• Promotion of sports and healthy lifestyles</li> </ul>
Ministry of Women and Children's Affairs	<ul style="list-style-type: none"> <li>• Tackling of gender inequity; tackling traditional practices harmful to women and girls</li> </ul>
Ministry of Tourism	<ul style="list-style-type: none"> <li>• Action to prevent spread of HIV/AIDS</li> </ul>
Commission on Human Rights and Administrative Justice	<ul style="list-style-type: none"> <li>• Promotion of the right to health; implementation of the Patients Charter</li> </ul>

This list is not exhaustive either in terms of MDAs identified or potential areas for collaboration, but is rather designed to illustrate the range of areas where the health sector intends to forge stronger partnerships to support action on health and poverty/inequality, linked to the GPRS. A consultative process with MDAs will be carried out to develop more detailed policies and plans

### **Annex 3**

#### **Country Portrait**

##### **A.1 Ghana's economy**

Ghana is a tropical country situated in the west of Africa and located between latitudes 4 and 11 degrees north of the equator.

The national population of Ghana, according to the 2000 census is 18,412,247 million. Out of this number 50.2 percent are male and 49.8 per cent are female. Life expectancy currently stands at 58 years. Forty-six percent of the population is below the age of fifteen. There is a growing trend in rural-urban migration. The regional distribution is between the range of 17.3 percent in the Ashanti Region and 3.1 percent in the Upper West Region. There are about 240,000 households with over 45,000 communities, of which 80 percent are below 1000.

The population density is equally varied. Nationally, it is put at 77 per square kilometer (km<sup>2</sup>) but the distribution reflects a range of 897 in the Greater Accra Region to 31 in the Upper West Region (see table) In effect, the population density in the northern half of the country, which also is the poorest economically, is very sparse.

The density and population data has considerable implications for the kind of health professionals and providers required in the different regions and their distribution patterns nationally. Thus, areas with high population and small density would indicate a need for community based care community/public health staff, with less emphasis on stationary clinical facilities. Where the population is high and the density is high, the rule of synergy would require that staff and facilities are appropriately mixed to delivery more and better services.

There is a wide diversity in ethnicity and socio-cultural practices. However, each of these in themselves represents fundamental social capital. The principal religions are traditional, Christian and Islamic. Poverty levels have been in the region of 29.4 percent, with vast geographic disparities especially for the Northern, Upper West, Upper East, and Central regions. The national per capita income is about \$400 with an inflation level of about 18 percent and annual growth rate of 2 per cent (1999)

REGION	AREA SQ. KM	POPULATION	DENSITY
All Regions	238,833	18,412,247	77
Western	23,921	1,842,878	77
Central	9,826	1,580,047	161
Gt. Accra	3,245	2,909,643	897
Volta	20,570	1,612,299	78
Eastern	19,323	2,108,852	109
Ashanti	24,389	3,187,852	131
Brong Ahafo	39,557	1,824,822	46
Northern	70,384	1,854,994	25
Upper East	8,842	917,251	104
Upper West	18,476	573,860	31

## A.2 Political administration

Ghana is a multi-party democratic country with a presidency, a cabinet, a parliament, and an independent judiciary system. These constitute national level structures with day-to-day functions administered through an established bureaucracy ministries, departments and agencies. The national institutions are responsible for policy and strategy development.

The country is divided at the intermediary level into 10 regions and with 10 decentralized districts constituting the lower level of political administration. Decentralization to the district is a statutory requirement enshrined in the constitution of Ghana. In effect, the districts or District Assemblies are autonomous agencies responsible for the implementation of public service functions and governance at the local level.

The District Assemblies operate through a general assembly system supported by sub-committees that have the responsibility for collating, harmonizing, and coordinating plans, budgets, and implementation of all activities at the district and sub-district level. There is an executive committee headed by a district chief executive who is responsible for managing district level public officials and the administration and management of their functions.

Within their broad mandate, the District Assemblies are the de facto institutions for facilitating civil society participation, agenda setting, and problem solving, as well as the involvement of the community in policy, planning, and implementation of socio-economic programs.



Regional Map of Ghana

The administrative system in Ghana has profound implications for the organization and management of the health sector, especially within the pluralistic paradigm of health and health-related service delivery. It represents considerable opportunities for intersectoral collaboration and action at all levels as well as the monitoring and supervision of programs targeted for the benefit of the poor and vulnerable in society. This opportunity has not been adequately explored and utilized in the past. The focus at the district level will require a major re-orientation and capacity building within the health sector and among stakeholders.

