THE HEALTH SECTOR

MEDIUM-TERM DEVELOPMENT PLAN

2010 – 2013

Theme: Accelerating programmes implementation towards attaining equitable universal coverage

Acronyms

A&E	Accident and Emergency
ABC	Activity-Based Costing
ACT	Artemesinin Combination Therapy
AFP	Acute Flaccid Paralysis
AIDS	Acquired Immune Deficiency Syndrome
ARI	Acute Respiratory Infections
ART	Anti-Retroviral Therapy
ARV	Anti-Retrovirals
ASRH	Adolescent Sexual and Reproductive Health
ATF	Accounting, Treasury & Financial Regulations
BCC	Behavioural Change Communication
BEmONC	Basic Emergency Obstetric and Neonatal Care
BMC	Budget Management Centres
CAGD	Controller and Accountant-General's Department
CEmONC	Comprehensive Emergency Obstetric and Neonatal Care
CHAG	Christian Health Association of Ghana
CHIM	Centre for Health Information Management
CHeSS	Centre for Health and Social Services
CHO	Community Health Officer
CHPS	Community-based Health Planning & Services
CHW	Community Health Worker
CMS	Central Medical Stores
C/S	Caesarean Section
CSM	Cerebro-Spinal Meningitis
CSRPM	Centre for Scientific Research into Plant Medicine
DHIMS	District Health Information Management System
DHMT	District Health Management Team
DHS	Demographic and Health Survey
DP	Development Partner
EmONC	Emergency Obstetric and Neonatal Care
EMT	Emergency Medical Technician
ENT	Ear, Nose & Throat
EPA	Environmental Protection Agency
EPI	Expanded Programme on Immunisation
FDB	Food & Drugs Board
FP	Family Planning
5YPOW	Five-year Programme of Work
GCPS	Ghana College of Physicians & Surgeons
GHS	Ghana Health Service
GLSS	Ghana Living Standards Survey
GOG	Government of Ghana
GPRS	Growth and Poverty Reduction Strategy
GSGDA	Ghana Shared Growth and Development Agenda
GSS	Ghana Statistical Service
H1N1	Human influenza A sub-type
HIRD	High Impact Rapid Delivery
HIV	Human Immunodeficiency Virus

HMIS	Health Management Information System
HO	Health Objective
HR	Human Resource
HSMTDP	Health Sector Medium Term Development Plan
IALC	Inter-Agency Leadership Committee
ICC	Inter-agency Coordinating Committee
ICT	Information Communication Technology
IE&C	Information, Education and Communication
IGF	Internally Generated Fund
IMCI	Integrated Management of Childhood Illnesses
IPT	Intermittent Preventive Treatment
ITN	Insecticide Treated Net
JANS	Joint Assessment of National Strategies
KATH	Komfo-Anokye Teaching Hospital
KBTH	Korle-Bu Teaching Hospital
LI	Legislative Instrument
MBB	Marginal Budgeting for Bottlenecks
MDAs	Ministries, Departments and Agencies
MDGs	Millennium Development Goals
MESW	Ministry of Employment and Social Welfare
MLGRD	Ministry of Local Government and Rural Development
MMDAs	Metropolitan, Municipal and District Assemblies
MOE	Ministry of Education
MOFEP	Ministry of Finance and Economic Planning
MOH	Ministry of Health
MLGRD	Ministry of Local Government and Rural Development
MOTI	Ministry of Trade and Industry
MOWAC	Ministry of Women and Children's Affairs
MTEF	Medium Term Expenditure Framework
NCD	Non-Communicable Diseases
NDPC	National Development Planning Commission
NGOs	Non-Governmental Organisations
NHIA	National Health Insurance Authority
NHIF	National Health Insurance Fund
NHIS	National Health Insurance Scheme
OPD	Out-patient Department
POW	Programme of Work
PPM	Planned Preventive Maintenance
PPP	Public Private Partnership
RBM	Roll-Back Malaria
RHMT	Regional Health Management Team
RHN	Regenerative Health and Nutrition
SAFE	Surgery, Antibiotic, Facial Cleanliness and Environmental Change
STD	Sexually Transmitted Diseases
STG	Standard Treatment Guidelines
TB	Tuberculosis
TMPC	Traditional Medicine Practice Council
TTH	Tamale Teaching Hospital
WHO	World Health Organisation

TABLE OF CONTENTS

List of Tables

List of Figures

List of Boxes

Executive Summary

Ghana has made significant progress towards attaining the Millennium Development Goals. The country continues to adopt different strategies to sustain its gains and improve on its performance. The Ghana Shared Growth and Development Agenda (GSGDA) 2010-2013 is the latest of national development frameworks adopted in 2010 to accelerate development and attainment of the MDGs. This is a follow up strategy to the two Ghana Poverty Reduction Strategy papers (GPRS) I and II. The Agenda prioritises five sectors one of which is health. The GSGDA outlines the **vision** of the health sector as: "*to have a healthy population for national development*". The **mission** is "*to contribute to socio-economic development by promoting health and vitality, through access to quality health services for all people living in Ghana using motivated personnel and promoting the development of a local health industry*".

The emphasis on health stems from observations that unless efforts are doubled, the gains may be reversed and progress stalled. For instance, the 2008 Ghana Demographic and Health Survey stated that the target to half the prevalence of underweight among children under five from 31 percent to15 percent under MDG 1 has already been achieved. Good progress is demonstrated to reduce by two-thirds child mortality under MDG 4 but insufficient progress has been made against the targets related to MDG 5. Maternal mortality ratio is slowly improving at an accelerated rate in the current decade compared to previous years. Between 1990 and 2007, the maternal mortality ratio had reduced from 740 per 100,000 live births to 451 per 100,000 live births (Maternal Health Survey 2007). At current rate, Ghana may not attain its MDG 5 target of 185 per 100,000 live births. It is estimated that the MMR will be 340 per 100,000 in 2015. The country is on track in halting the spread of HIV/AIDS and reversing the incidence of malaria and other major diseases.

The Health Sector Medium Term Development Plan (HSMTDP) 2010 – 2013, reflects the government's health development agenda for the medium term. It identifies the key priorities of the sector and provides five objectives for accelerating programmes implementation towards attaining equitable universal coverage. These are:

Objective 1 Bridge equity gaps in access to health care and nutrition services and ensure sustainable financing arrangements that protect the poor

This object aims at tackling the persistent problems of access in the sector, whether geographical, financial or related to socio-cultural factors. Country-wide community service delivery will be undertaken in partnership with district assemblies, the private sector and communities. The emphasis will be on addressing priority actions in Primary Health Care. The three main strategies to be employed are the following:

I. Strengthen district health systems with emphasis on primary health care
II. Develop sustainable financing strategies that protect the poor and vulnerable
III. Increase availability and efficiency in human resources for health

Objective 2 Strengthen governance and improve the efficiency and effectiveness of the health system

The health sector has undergone considerable institutional reforms since 1996. The Ghana Health Service and Teaching Hospitals Act, the Food and Drugs Board Act, the Pharmacy Council Act and the National Health Insurance Act among others were and implemented. For the next four years, the sector under this objective will address issues related to institutional strengthening and accountability, inter-sector collaboration and linkages within the Primary Health Care framework. Four strategies will be followed.

I. Develop capacity to enhance the performance of the national health systems
II. Strengthen the policy and regulatory framework governing the sector
III. Strengthen inter-sector collaboration including public-private partnerships
IV. Strengthen systems for improving the evidence base for policy and operations

Objective 3 Improve access to quality maternal, neonatal, child and adolescent health services

Recent experiences in Ghana demonstrate that success is possible and that evidence-based effective interventions can be identified for realizing the MDGs. Much work has been undertaken to define appropriate policies, strategies and interventions for improved maternal and newborn care. There are also known interventions that work to ensure efficient service availability for adolescents. This health objective aims to scale up efforts and provide the impetus for accelerating the attainment of MDG 4 and 5. The main strategies are the following:

I. Reduce the major causes contributing to maternal and neonatal deaths
II. Reduce the major causes contributing to child morbidity and deaths
III. Improve adolescent health
IV. Improve the nutritional status of women and children

Objective 4 Intensify prevention and control of communicable and non-communicable diseases and promote healthy lifestyles

Health objective 4 supports the achievement of MDG 4 and 6, and addresses the increasing burden of non-communicable diseases. The major strategies to be employed are the following:

I. Improve prevention, detection and case management of communicable diseases
II. Improve prevention, detection and management of non-communicable diseases

HIV/AIDS and tuberculosis programmes as well as vector control for vector borne diseases will be scaled-up. Malaria which is the leading cause of disease incidence in the country will see a renewed effort to tackle using multiple approaches. Emphasis will be put on attaining eradication status for guinea worm with control and elimination activities emphasised for onchocerciasis, yaws, trachoma and lymphatic filariasis. Healthy lifestyle, hygiene and proper sanitation will also receive increased attention. A national register of non-communicable diseases will be developed to map the patterns and develop a comprehensive response strategy.

Objective 5 Improve institutional care including mental health service delivery.

Health objective 5 supports the improvement of institutional care including mental health service delivery.
The major strategies to be employed are the following:

I. Improve access to quality institutional care and emergency services
II. Improve the availability of medical products, traditional medicines, blood safety and health technologies
III. Increase Access to Mental Health Services

Health care providers will be sensitised and trained in guidelines and protocols for health services with the aim of making quality health services available in all health facilities. In order to protect the rights of mental health patients, activities to improve early detection, community education on mental health, its prevention and rehabilitation, will be intensified. Emphasis will be placed on community-based mental health care, with the development and implementation of a community mental health care roll out plan for the country.

Based on an exchange rate of US$1: GH¢1.457 (at end June 2010), the total resources required over the four years will be GH¢6.5bn. This translates to roughly GH¢ 67 per capita each year over the HSMTDP period.

Assuming all funding gap is filled and programmes effectively implemented, the HSMTDP is expected to contribute towards a 30.8% reduction in under-five mortality and a 30.5% reduction in maternal mortality. Reductions of between 31% and 35% would be achieved in infant, neonatal, under-five and mortality rates. Reductions in under-five malaria incidence and in malaria mortality are predicted, at 14% and 12 % respectively, while mortality from AIDS and tuberculosis would show a greater decline. In terms of expanding access to important preventive and public health interventions, 40% of the family planning gap could be closed and with higher reductions in the treated water and sanitation coverage gaps. The HSMTDP contains clearly developed core set of health sector indicators to monitor and evaluate progress in implementation.

1 BACKGROUND AND SITUATION ANALYSIS

1.1 The national development context

Ghana's population is estimated at 23.4 million (GSS, 2009). Average life expectancy is estimated at 57. The economy remains predominately agrarian though it is suggested that the service sector may probably be contributing more to GDP. From 2001 growth began to accelerate and reached a high of 7.3% in 2008, which is the second highest growth rate in the past three decades after the 8.6% recorded in 1984. In the wake of the global financial crisis and economic decline in 2007/2008, the real GDP growth rate declined to 4.7% in 2009. The deceleration in growth in 2009 was largely on account of stabilization measures adopted in the year to arrest fiscal and trade deficits that emerged in 2007 and 2008 with threatening consequences for macroeconomic stability. With the large fiscal deficit of 14.5% recorded in 2008, it became imperative for Government to take appropriate policy measures to reduce the level of the deficit for 2009.

In 2010, the Ghana Shared Growth and Development Agenda (GSGDA) 2010-2013 was adopted as the national framework to accelerate growth and attain the Millennium Development Goals (MDGs). With the announcement of the outcome of the rebasing exercise in October 2010, Ghana joined the group of middle income countries. On the 18th of November 2010, the Government of Ghana (GoG) submitted the Budget Statement for 2011 to Parliament entitled "Stimulating Growth for Development and Job Creation". Table 1 provides an overview of the estimates for revenues, expenditures and the budget deficit.

Table 1 Budget 2011: Estimates of revenue and expenditure (GH¢ million)

Revenue Expenditure Revenue		**Expenditure**	
Total Domestic Revenue	**9,299.52**	Recurrent Expenditure	8,924.86
Grants	**1,301.60**	Capital Expenditure	3,745.90
		Total Expenditure (commitment)	12,670.76
		Arrears clearance and tax refunds	267.27
Total Revenue & Grants	**10,601.12**	**Total Expenditure (cash)**	**12,938.04**
		Overall balance (cash)	**-2,336.91**
		As % of previous GDP	**7.5**

Source: GoG Budget statement 2011

In 2009, Ghana's Human Development Index had declined with high inequalities recorded. Adult literacy (15 years and above) is stated at 65%. The overall poverty rate had declined substantively over the past two decades from 57.7% in 1991/92 to 28.5% in 2005/2006. The proportion of the population living below the extreme poverty line also declined from 36.5% to 18.2% over the same period against the 2015 national target of 26% and 19% respectively. Though current data on poverty is not available, trends in economic growth suggest a likely decline from the stated levels. Ghana benefitted from the Highly Indebted Poor Countries (HIPC) initiative. The health sector was allocated approximately 20% and 18% of poverty reduction related funds in 2007 and 2008 respectively.

1.1.1 Purpose of document

The Health Sector Medium Term Development Plan (HSMTDP) 2010 – 2013, reflects the government's health development agenda for the medium term. Its development coincides with the fourth year of implementation of the sector's third five-year Programme of Work 2007 – 2011 (5YPOWIII) which it replaces. The document defines the priorities and provides strategic direction for the coordination of policies and programmes in the short to the medium term in the health sector. The HSMTDP builds on the general principles of providing affordable primary health care to all people living in Ghana, developing cost-effective general health systems, bridging of current equity gaps in

access to health care services, and reinforcing the continuum of care. To ensure consistency, and alignment of programmes and investments around a common framework for health development, the HSMTDP and 5YPOWIII have been harmonised. The general principles reflect the government's health policy agenda of improving financial access through the National Health Insurance Scheme (NHIS); controlling endemic diseases; improving health infrastructure and emergency response systems; and creating an enabling environment for an efficient health care delivery in Ghana.

The current plan follows the broad guidelines of the National Development Planning Commission (NDPC). It was developed through a consultative process involving key stakeholders, development partners, and non-government actors in health and the health industry in Ghana. The consultation process was further enhanced by key stakeholder meetings at the national, regional and district levels involving development partners, non-governmental organisations (NGOs) in health, health workers and other Ministries, Departments and Agencies such as Ministry of Local Government and Rural Development (MLGRD), Ministry of Women and Children (MOWAC), and the Environmental Protection Agency (EPA).

The document was submitted to independent review through the process of Joint Assessment of National Strategies (JANS). This yielded useful recommendations on how to strengthen the document, which has been taken into consideration. The Common Management Arrangements (CMA), which outlines the implementation arrangements within the sector, and the associated monitoring and evaluation (M&E) framework for the HSMTDP were developed separately and form an integral part of this document.

1.1.2 Structure of the document

The document is divided into seven chapters and a number of annexes which serve as reference and background information to the main document. Chapter One presents the socio-economic context, and establishes the health status of the nation. It goes on to provide an outline of the current state of the health sector in terms of health financing, governance and accountability, partnership arrangements, infrastructure and human resource development. Chapter Two reviews the sector's performance under GPRSII and summarises the various challenges facing the sector. Chapter Three presents a hierarchy of sector objectives, strategies and priorities to be implemented in the medium term. Chapter Four provides more detail concerning the broad sector development programmes, key result areas and priority activities to be implemented over the four years while Chapter Five presents the detailed costing of the plan, its annual staging and the financing strategies through which the proposed strategies will be funded. Chapter Six summarises the implementation arrangements and describes the framework for monitoring and evaluation. Finally, a communication strategy is presented in Chapter Seven.

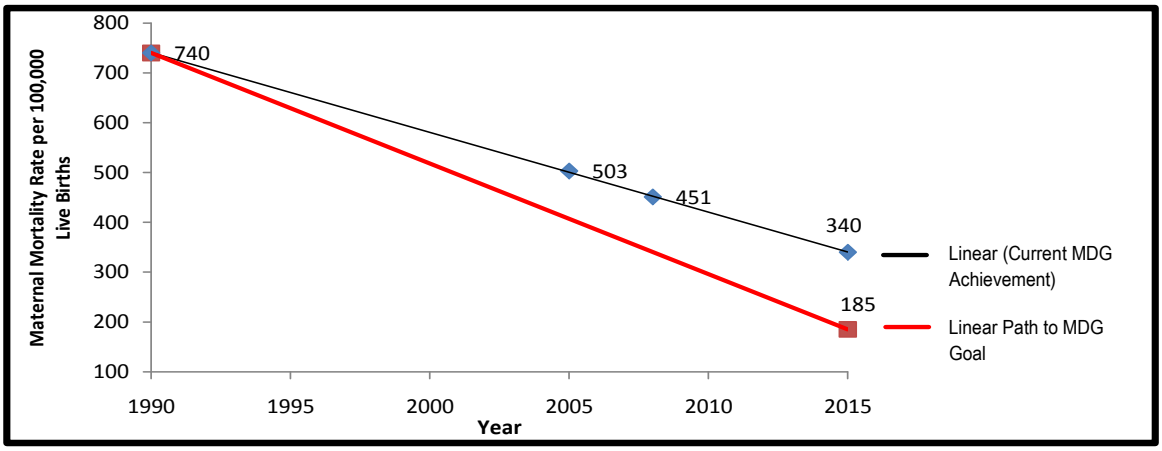
1.2 Progress in health status of Ghanaians

The current estimated life expectancy rate is 57 years; Total Fertility Rate is 4.0 in 2008 compared to 4.4 in 2006. Use of modern contraceptive is about 17% in 2009. The crude death rate is estimated at 8.93 deaths/1,000 population as of July 2010.

1.2.1 Maternal and child health

Maternal mortality ratio is slowly improving at an accelerated rate in the current decade compared to previous years. Between 1990 and 2007, the maternal mortality ratio had reduced from 740 per 100,000 live births to 451 per 100,000 live births (Maternal Health Survey 2007). At current rate, Ghana may not attain its MDG 5 target of 185 per 100,000 live births. It is estimated that the MMR will be 340 per 100,000 in 2015 (see figure 1).

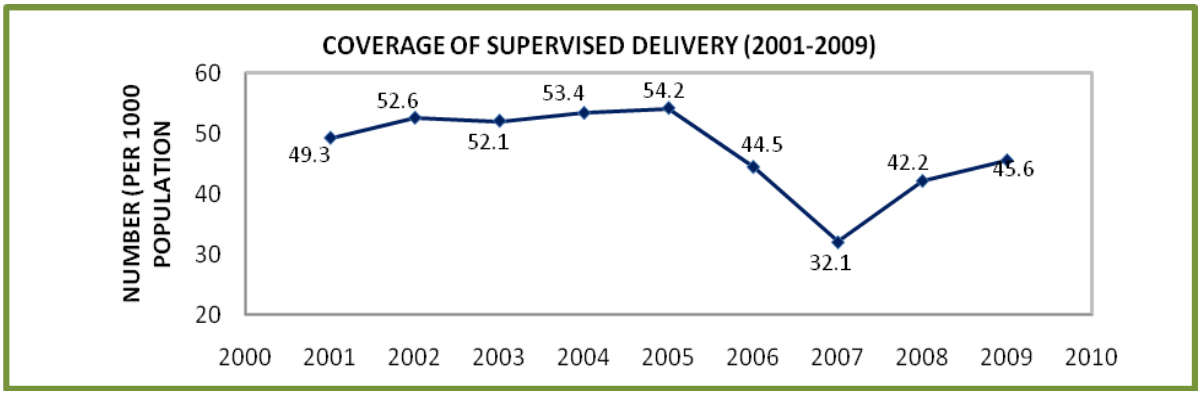
Figure 1 Maternal mortality ratio (surveys), recent and projected



Source: *Ghana MAF Action Plan (CAP) (August 2010)*

Most maternal deaths occur in facilities for various reasons that are related to the three delays (MoH 2010). The most significant being the second and third delays. There are regional disparities in mortality events. In 1996, the government directed that all maternal deaths should be reported within 7 days to the appropriate authorities. In 2007 approximately 72% of deaths were notified and 75.4% were audited. The major causes of maternal deaths remain excessive bleeding, hypertension-related disorders, infection and anaemia. Contributing factors are high unmet need for family planning, malaria and complications of unsafe abortion and under-nutrition. This persistently high rate of mortality has frequently been shown to be associated with poor skilled attendance at birth. Figure 2 shows the trend of supervised deliveries from 2001 to 2009, illustrating the apparent fluctuations, either in uptake of skilled deliveries or reporting of these.

Figure 2 Trends in coverage of supervised delivery (2001-09)



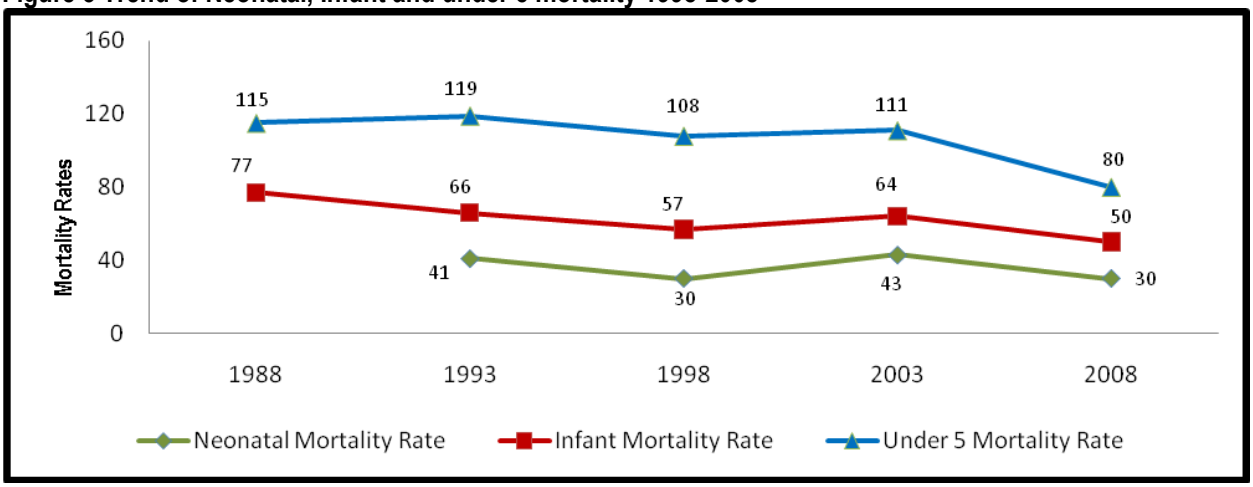
Source: GHS CHIM Facts and Figures 2009

The overarching strategy to achieve lower maternal mortality is to promote skilled attendance at birth, Comprehensive Emergency Obstetric Care (CEmOC), and family planning at all appropriate levels, from the community to teaching hospitals.

The Ghana Demographic and Health Survey (GDHS, 2008) showed a reduction in the under-five mortality rate from 111 per 1,000 live births in 2003 to 80 per 1,000 live births. Infant mortality rate was 50 per 1,000 live births in 2008

compared to 64 in 2003 with neonatal mortality rate decreasing from 43 per 1,000 live births in 2003 to 30 in 2008. With the reduction in the overall under-five mortality, the most significant contribution to child mortality is deaths occurring within the first 28 days of life as shown in figure 3.

Figure 3 Trend of Neonatal, Infant and under 5 mortality 1998-2008



Source: GDHS 2008

Routine data from health facilities indicates that the major causes of neonatal deaths are asphyxia, low birth weight, birth injuries, neonatal tetanus, neonatal infections, and severe congenital abnormalities.
Current coverage for penta3 has increased from 84.2% in 2006 to 89.3% in 2009. Malaria and acute respiratory infections are the most common diseases causing fatalities in children. Malaria accounted for 30% of all under-five mortality in 2008. Other diseases include pneumonia, diarrhoea, malnutrition and anaemia. Ghana is implementing the Health Impact Rapid Delivery (HIRD) to scale up key cost effective interventions delivered countrywide to improve child health with benefits for maternal health. The components of this programme have a broad spectrum of interventions aimed at addressing the most salient challenges associated with child health.

Generally Ghana is considered on course to attaining the child malnutrition target under MDG 1 ahead of 2015. However, according to the 2008 GDHS, 28% of Ghanaian children were stunted, with 10% being severely stunted. This represents a slight improvement on the 2003 figure which showed that 30% of children under five are stunted and 11% severely stunted. The extent of wasting which measures a more acute malnutrition had actually worsened within the last five years. Seven percent of children under five were found to be wasted and 1% severely wasted in 2003. In 2008 the number increased to 9% wasted, with 2% severely wasted. Wasting levels were found to be highest at ages 6-11 months thus making them more vulnerable to illness (GSS et al, 2003, 2008).

Where mal-nutrition continues to pose a problem, protein-calorie malnutrition remains the most common nutritional disorder in children. This is compounded by the problem of micronutrient deficiency; particularly of vitamin A, iodine, and iron. It is estimated that 78% of children aged between 6-59 months have some level of anaemia with 7% considered severely anaemic (GHS et al, 2003, 2008). Malnutrition amongst women of child bearing age, including micronutrient deficiencies (iron and iodine for example) also contribute to ongoing malnutrition, and other developmental issues amongst children. The inter-generational linkages between poor maternal nutrition and low birth-weight (LBW) babies are well understood, with strategies to improve the nutrition of women of child-bearing age playing a crucial role in breaking this component of the cycle of mother and child malnutrition.

The Independent review health sector programme of work 2009 report showed considerable inequities and inequalities across the country which is less favourable the northern part of the country.

1.3 Burden of disease and interventions

The epidemiological profile of Ghana shows a concurrent significant prevalence of communicable and non-communicable diseases. Table 2 below shows the top ten diseases recorded in health facilities in 2009.

Table 2 Top ten diseases reported at health facilities in Ghana 2009

	Disease	Total	%
1	Malaria	6,146,523	44.55
2	Other ARI (Acute)	1,151,132	8.34
3	Skin diseases and Ulcers	576,040	4.16
4	Diarrhoea diseases	536,846	3.89
5	Hypertension	494,125	3.58
6	Rheumatism and Joint pains	416,416	3.02
7	Acute Eye Infection	264,042	1.91
8	Intestinal worms	249,812	1.81
9	Anaemia	203,906	1.48
10	Pregnancy and related complications	176,888	1.28
11	All other diseases	3,582,264	25.96
	Total	**13,796,558**	**100.00**

Source: GHS CHIM 2009

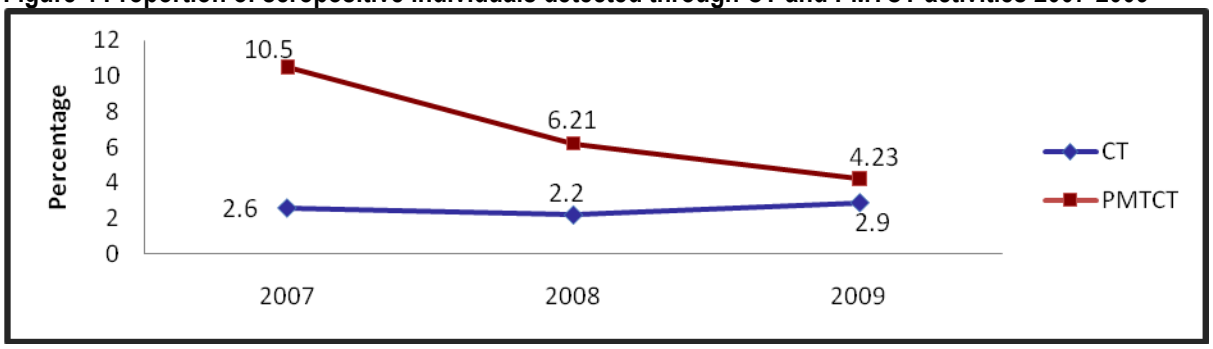
1.3.1 Communicable diseases

- **HIV/AIDS, tuberculosis and malaria**

HIV prevalence among the adult population as at the end of 2009 stood at 1.9% with an approximated number of 267,069 persons living with HIV/AIDS. This is made up of 112,457 (42%) males and 154,612 (58%) females. Centres have been established to assist in diagnosing sero-status across the country. In 2009 the two hundred and eighty-four (284) Counselling and Testing (CT) centres were established. This is 54% more than what was achieved in the previous year.

Approximately 865,000 people got to know their HIV sero-status in 2009. This figure represents 85% increase over the number of people who tested in the previous year. The HIV prevalence among the CT clients was 4.2% as against 6.2% for 2008 (see figure 4). Through the Prevention of Mother-To-Child Transmission (PMTCT) programme about 382,000 pregnant women got to know their HIV sero-status, of which 6,650 representing 1.7% were positive. Out of these positive pregnant women, 55% were given anti-retrovirals (ARV) as GHS is working with other partners to give food assistance and counselling to 6,000 food insecure PLHIV on ARV and their immediate family members.

Figure 4 Proportion of seropositive individuals detected through CT and PMTCT activities 2007-2009



Source: National HIV/STI Control Program 2009 Annual report

The burden of **tuberculosis** is estimated to be about 204 per 100,000 populations and a case detection rate of 36%, well below internationally set targets of 70%. Case notification rate is presently at 64 per 100,000 populations. The number of children diagnosed with TB also increased from 352 in 2008 to 649 in 2009. This is an indication that the index of suspicion for TB in children by doctors and clinicians is on the increase. TB case fatality rate is at 9%. Regional mortality trends indicate high mortality rates of 12.5/100 000 population in 2008 in Upper East Region compared with 4.2/100 000 population in Volta Region, the lowest in 2008.

Direct Observed Treatment Short-course (DOTS) strategy of the National Tuberculosis programme was scaled up through capacity building in the public sector. This has led to improved capacity for treatment. The TB success rate rose from 72.6% in 2006 to 84.7% in 2008 (GHS 2008). Default rates have declined from 11% in 2005 to 2.3% in 2008. There are several bottlenecks identified that affect TB case detection. The main challenges include weak procedures to detect TB, inadequate contact tracing, inadequate engagement of community based providers and inappropriate tools for effective supervision, monitoring and evaluation.

Malaria continues to be the largest contributor to the disease burden in Ghana. Malaria constituted approximately 40% of all out patient attendance in recent years. There has been significant reduction of more than 50% in malaria under-5 case fatality rate between 2002 and 2009. The disease accounts for 11% of mortality in pregnant women. The levels of insecticide treated material use are still low.

There has been significant scale-up in interventions under the National Malaria Control Programme focusing on effective diagnosis including the use of the Rapid Diagnostics Kits at lower levels, treatment compliance and preventive measures using insecticide treated bednets, indoor residual spraying and targeted larviciding and environmental management. There is a move towards subsidizing anti-malaria drugs in the country to make them generally affordable. Generally impact is yet to be felt significantly on case incidence. This is because most of the activities lie outside the direct control of the health sector and will require significant inter-sector collaboration to achieve the MDG target.

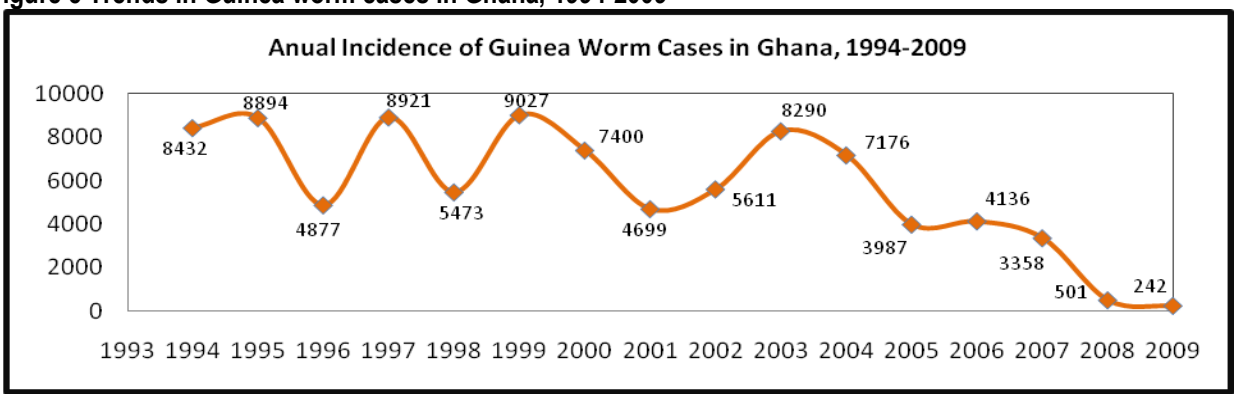
- **Diseases targeted for eradication or elimination**

Polio eradication is in line with the global strategy of improving coverage through routine and mass immunization activities. It also puts in place an effective clinical and virological surveillance of Acute Flaccid Paralysis (AFP) cases. In collaboration with the Noguchi Memorial Institute for Medical Research (NMIMR), a system for effective AFP surveillance has also been put in place.

Eradicating **Guinea worm** was one key challenge for the sector. Once a significant public health problem, the last case of Guinea Worm disease in Ghana was identified in May 2010, suggesting that Guinea Worm transmission has

been interrupted in Ghana. See figure 5 for the trend of incidence from 1993 to 2009. Challenges now include maintaining high quality surveillance to detect imported cases, and preparing for certification of eradication.

Figure 5 Trends in Guinea worm cases in Ghana, 1994-2009



Source: GHS 2009 data

Four other diseases were targeted for elimination. These are leprosy, yaws, blinding trachoma and neonatal tetanus. **Neonatal tetanus** is part of the antigens scale up strategy. Ghana has reached the global elimination target of one case of **leprosy** per 10,000 populations though Upper West Region has prevalence of 1.19 per 10,000 population with the Wa West district accounting for the highest number of cases (4.69/10,000). A major problem is the rehabilitation of cured patients and integration into the communities. With regard to **yaws**, the objective is to eliminate it by 2015, by which time it is expected Ghana will attain three consecutive years of no case. The 2009 prevalence is 0.7% (GHS 2009). Yaws elimination continues to face several challenges and reported cases have fluctuated depending on availability of logistics, medicine and funds for public education, case finding and supervision. A main issue is inadequate funding of the yaws programme.

Trachoma is mainly found in Upper West Region and, as a country, Ghana has reached the elimination target of <5% though there may still be communities in the endemic districts that have prevalence of active trachoma in children aged 1 - 9 years above 5%. The programme strategy is to carry out trichiasis surgery and improve surveillance to find cases. The WHO recommended Surgery, Antibiotic, Facial Cleanliness and Environmental Change (SAFE) strategy needs to be scaled up in the affected areas.

As a strategic focus, **onchocerciasis** is now considered an eliminable disease. The debilitating effect of onchocerciasis is still being felt around the country. Current standard prevalence rate for O. volvulus in the 93 sentinel sites is above 5%. Crude prevalence rate ranged between 0 – 55%. So far, O. volvulus is the only parasite found in Ghana. The highest focus of infection is observed in the Bui-Black Volta basin where 66.7% of communities surveyed in 2008 had prevalence of over 5% with indication of an increasing trend since 1997 while that of areas such as the Pru river basin are showing a declining trend. There is a new resolve during the 33rd Joint Action Forum meeting in Abuja in December 2010 for countries to move towards breaking infection in transmission zones and the elimination of onchocerciasis. Ghana is considered an appropriate candidate for this move (WHO/APOC 2010).

Aside of the four diseases mentioned above, the country has a high level of burden of disease resulting from lymphatic filariasis, schistosomiasis, buruli ulcer and leishmaniasis.

- **Epidemic-prone Diseases**

Control of epidemic-prone diseases has featured prominently in sector policies and priorities, particularly because of the continuing threat of outbreaks. Diarrhoeal diseases affect all ages. Over 500,000 cases are registered annually

accounting for 5% of registered OPD cases, of which 33% are in children below 5 years of age. Public education to improve food handling, promote hand washing with soap and water at home, functions and in schools, enforcement of food vending regulations and appropriate case management morbidity and mortality from typhoid and diarrhoeal disease are some of the interventions being promoted.

Yellow fever outbreaks have been reported in both the northern and southern sectors in an approximate 10-year cycle. The persistence of the disease in northern Ghana gives an indication of the potential of an outbreak. The main strategy has been to increase vaccination coverage to control and prevent outbreak. Performance in this direction has been significant leading to an increase in coverage especially among children from 76% in 2004 to 86% in 2008 which is near the targeted coverage of 90% (GHS, 2008).

Cerebrospinal meningitis is endemic in the northern savannah region with outbreaks in the dry season. This also follows a cycle of between 8 to 12 years. Ghana experienced an outbreak in 2010 which played an important role in sharpening the epidemic preparedness of the country. Subsequently, cases have been controlled effectively and efforts are being made to prevent future outbreaks. The main strategy has been improved disease surveillance and response systems at the national, regional, district and community levels.

1.3.2 Non-communicable diseases (NCD)

Non-communicable diseases, most of which are lifestyle-related, constitute a heavy and increasing disease burden. The most significant of these are cardiovascular related diseases, diabetes and sickle cell disease. Crude estimates suggest that these are expected to continue increasing in the next five to ten years. Generally, however, there is inadequate epidemiologic data to support decision making and strategy development.Since non-communicable diseases are largely caused by lifestyle and nutritional choices, continued efforts are needed in the area of behaviour change communication to the public, including integration into school curricula, in order to promote healthier future generations. Currently, the flagship programme “regenerative health and nutrition programme” developed under the 2007-2011 program of work is aimed at addressing some of these lifestyle and nutrition issues.

- **Mental health**

According to WHO estimates (WHO, 2009) the proportion of Disability Adjusted Life Years (DALYs) lost in Ghana due to psychiatric disorders are 8.8% of total lost DALYs. In comparison, HIV/AIDS accounts for 7.6% of all DALYs lost in Ghana. The ten top cases of admission to psychiatric hospitals are as in table 4 below.

Table 3 Ten top causes of admission to psychiatric hospitals in Ghana

	Condition	Number
1	Schizophrenia	1,599
2	Substance Abuse	1,101
3	Depression	736
4	Hypomania	629
5	Acute Organic Brain Syndrome	495
6	Manic Depressive Psychosis	343
7	Schizo–Affective Psychosis	284
8	Alcohol Dependency Syndrome	215
9	Epilepsy	191
10	Dementia	131
Total from Top ten causes		**5,724**

Source: http://www.who.int/countries/gha/publications/MENTAL_HEALTH_PROFILE.pdf

With few psychiatric facilities and a poor system for detecting and treating psychiatric disorders at the primary level, patients are often left untreated resulting in chronic conditions. Currently, mental health care is largely centralised in three large institutions with little integration into primary health care, which would enable prevention and early treatment of psychiatric disorders. There are over 1,000 patients in admission at the Accra Psychiatric Hospital, a facility built to accommodate 600 patients.

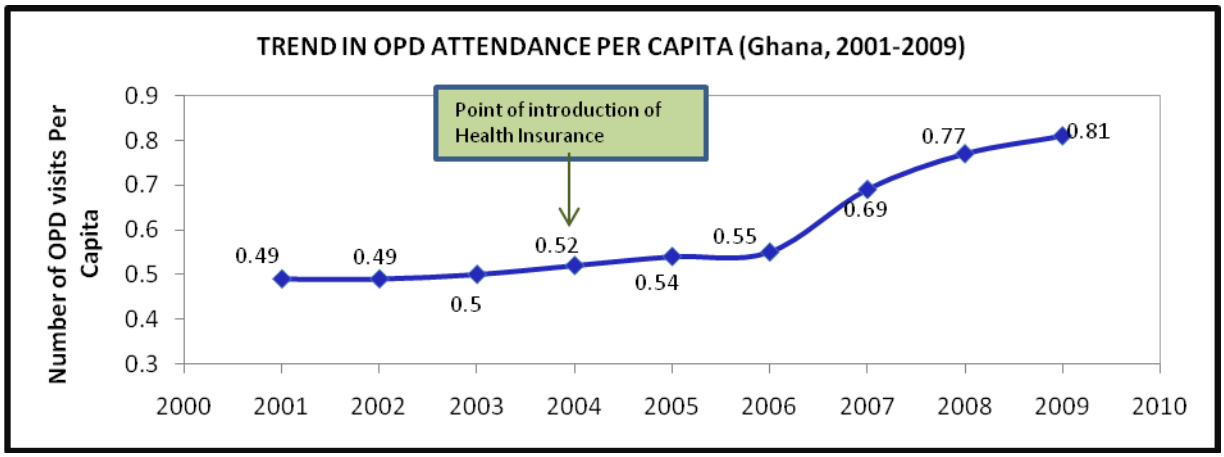
It is also known that majority of people with mental illness are not accorded fundamental human rights, including a right to proper treatment, privacy and confidentiality; rights relating to education, employment, protection from harm and abuse; and rights to freely associate and belong to groups.

1. 4 The Health System

1.4.1 Organisation of health services

The Health Sector in Ghana is organised at three main levels: national, regional and district; with the district having a sub-district level and incorporating a community health delivery system. The health sector has adopted an integrated approach to delivery of health interventions. Access, quality and coverage of health information, preventive care, clinical care and emergency services are all important aspects of health service delivery. To improve access to health care, health interventions are packaged and delivered in health centres, and in district, regional, tertiary and teaching hospitals. These relate to the minimum benefit package and accreditation status of each facility as provided for under the National Health Insurance Act 650, 2003 and LI 1809, 2004. Both access and quality of care are addressed through strengthening and provision of front line services as well as improvement in referral systems, trauma care, pre-hospital and hospital emergency care. Service utilisation has increased significantly over the last five years as shown in figure 6 below.

Figure 6 Trends in OPD attendance per Capita 2001-2009



Source: GHS Facts and Figures 2010

Though progress has been made in service utilisation, access to health service continues to be a major challenge to the sector especially in remote communities. Quality of care and infection control has not improved as expected. Blood products and blood safety requires special attention and emergency response needs strengthening. The public sector has adopted as part of the sub-district health system the Community-based Health Planning and Services (CHPS) approach. The approach involves the training and deployment of a trained Community Health

Officer (CHO) into an area served by a local Government Unit Committee through an embedding strategy that involves extensive consultation and participation of the local community and their assembly person.

The Ministry of Health supervises public sector health delivery. However, performance of this oversight responsibility remains weak. This situation does not encourage effective and efficient service delivery that protects the rights of patients using the public sector service. The Private Hospitals and Maternity Homes Board is mandated to license and regulate practice in the private sector. Under the current situation, the operation of the PHMHB is too weak to make any impact and has not seen an active constituted Board for over a decade. Though private sector laboratories and imaging centres are increasing, there is currently no national institutional framework to regulate their practice.

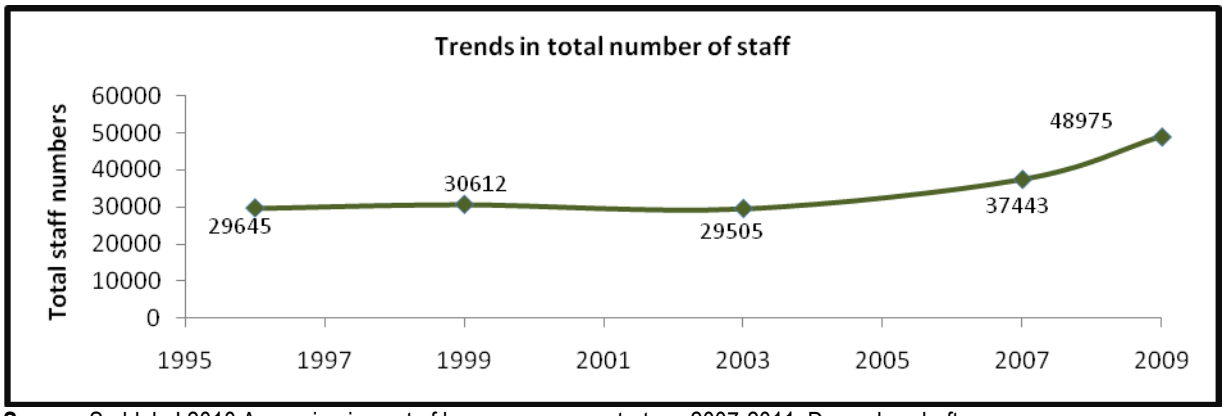
1.4.2 Human resources for health

Ghana developed a Human Resource Policy in 2003 and a 5-year Human Resource Development Strategy 2007-2011. The goal of the policy and strategy is to increase production, retention of trained professionals and equitable distribution of the health workforce. The impact of these strategies has been an increase in the health workforce and an improvement in staff/population ratio.

The growth of the various categories point to significant proportional increase of 60% in favour of clinical and community health nurses in 2009 compared to 44% in 1996. The policy governing the production of community health nurses is weak (see figure 7).

Medical officers' numbers have seen a marginal increase of about 5% compared to 1996. Compared to the early 2000, health worker emigration has reduced significantly. This is generally attributed to the implementation of innovative policies including enhanced salaries, the introduction of incentive schemes and the establishment of continuing education opportunities in the country e.g. the Ghana College of Physicians and Surgeons.

Figure 7 Trends in total number of staff



Source: Seddoh J 2010 Assessing impact of human resource strategy 2007-2011, December draft

Distribution of health workforce in terms of geographical areas remains a challenge. Currently, the distribution of medical officers, pharmacists, and professional nurses is skewed in favour of urban areas particularly in the southern sector of the country. A viable solution is yet to be found for the perennial problem of staff failing to take up postings in deprived areas. There is no effective staffing norm in place and the levels of staff commitment, productivity and attitude to work has been questioned in several reviews.

Production capacity has not increased significantly. Private sector participation and investment in training has not seen many new players in the field. The main problem here has been identified as inability to raise the needed capital without government support and the introduction of an effective private-public partnership policy. In-service training once an effective part of the district health systems strengthening strategy has not been effectively implemented in recent times. In a study by IOB (2010), it was realised that effective and structured leadership training for district health workers and facilitative supervision can significantly increase workforce productivity and performance.

1.4.3 Health infrastructure and technologies

The focus of **civil works** development is to increase geographical access to health facilities and training institutions, manage the maintenance of the same, and ensure rational implementation of capital projects. The development of a five year Capital Investment Plan 2007-11 guided the generation of detailed annual plans of work. Based on this, deprived and peri-urban areas received priority consideration. A recent district profile exercise revealed that 54 districts, across all regions, have no hospital. The absence of a hospital ranges from 3 out of 18 districts in Volta Region to 10 out of 17 districts in Central region. Districts in which a regional or tertiary hospital is located are excluded from this figure. It is worthy of note that 21 districts have non-governmental hospitals to complete their needs. The CHPS approach also requires that a number of compounds for the accommodation of CHOs are either provided or constructed in collaboration with communities and district assemblies.

The limiting factors to expansion of health infrastructure include inadequate financial resources, and the delay in the release of budgetary allocations, culminating in cost overruns. Availability of complementary inputs to ensure the functionality of new infrastructure also limits the pace of expansion. Other factors include the unplanned initiation of projects, without recourse to the Capital Investment Plan. Planned Preventive Maintenance culture remains weak, and is compromised by limited budgetary resources. In addition, the newly created districts often lack basic office infrastructure to operative effectively as a District Health Management Team.

Current progress in establishing functional CHPS zones has been slow relative to targets agreed. A functional CHPS zone is defined as placing a resident Community Health Officer in a resourced community health post with an attached residential accommodation with responsibilities for a defined geographical area where the CHO provides resident and itinerant services to the target population. An in-depth review in 2009 has led to renewed commitment to scale up in this area. This will necessitate a review of the CHPS strategy and accelerate implementation to establish CHPS zones within each Sub-District that are coterminous with Local Government Unit Areas. This level of establishment will require close collaboration with Local Government and the communities to provide residential accommodation for the CHO's to function from. There are potentially 16,000 Unit Committees available under the current Local Government Act. A lot of resources from multi stakeholder and public-private collaboration will be needed to place CHOs in at least 80% of the Unit Areas. Thus,

Medical equipment is an essential input in the promotion of health and includes all materials required for the promotion, protection and maintenance of health. Even though substantial progress has been achieved in equipment management, capacity in areas of acquisition, distribution, installation, use and maintenance require further strengthening. The equipment in most health facilities and national network of district hospitals is non-functional, antiquated or woefully inadequate. Several factors account for this situation. These include: (i) inadequate resources to purchase and deploy requisite equipment and to fully implement the maintenance and replacement policy; (ii) lack and poor maintenance of equipment in health facilities; (iii) limited levels of replacement purchases; (iv) mass upgrade of health centres to district hospital; and (v) unfinished projects due to changing priorities or inadequate resources. The full infrastructure and equipment needs are contained in the Capital and Equipments Investment plan of the sector.

A framework to ensure equity, safety, quality and efficacy of **medicines** was developed as part of the Ghana National Drugs programme. The NHIS has also developed a drug list as a subset of the national essential drugs list. The cost recovery policy for drugs and pharmaceuticals has enabled the development of a vibrant pharmaceutical sector in Ghana. On average, tracer drug availability is about 70% with differentials across the country. The main challenge has remained with regulation and effective drug supply management. Currently, the Pharmacy Council and the Foods and Drugs Board have continued within their limitations to monitor and regulate the pharmaceutical sector. Existing weaknesses in collaborating with Port and Customs authorities and the Ghana Standards Board have meant that sub-standard drug manufacturing inputs and medicines continue to slip into the country. Within the public health sector, the Central Medical Stores (CMS) as a main warehousing facility has performed below expectations, leading to large volumes of drugs and pharmaceuticals being procured from the open market and unregulated market (Seddoh and others 2010). This has contributed to the high prices for medicines currently being experienced in Ghana. At the service delivery end, enforcement of rational use, quality assurance programs, and supply chain management remain inefficient.

The sector continues to face a major challenge with **transport** to support service delivery and management including supportive supervision. Currently about 50% and 65% of the vehicles and motorbikes respectively are over-aged and due for replacement. This has led to high maintenance and running costs of the vehicles, particularly at the district level. The transport situation is therefore likely to get worse in the absence of adequate budgetary allocation for replacing vehicles.

1.4.4 Health financing

The three main sources of finance for the health sector are the following:

1) Government of Ghana budgetary funding, which flows through two main routes:
    a. annual budget allocations to the sector through the Ministry of Health as part of the routine budget; and
    b. funds accruing to or allocated to the National Health Insurance Fund (NHIF);

2) Development Partners (DPs) (including financial mechanisms such as the Global Fund to Fight AIDS, TB and Malaria), includes grants, loans and mixed credits, and is provided either as:
    a. Sector Budget Support (SBS) which is grant funding channelled through the Ministry of Finance and Economic Planning (MOFEP), programmed as part of the annual budget process; or
    b. earmarked funds, for specific projects or programmes, from a variety of bilateral and multilateral partners, including global health initiatives such as the Global Fund for AIDS, TB and Malaria (GFATM) and concessionary private financing arrangements.

3) The private sector, including household out of pocket payments, which although declining as a proportion of Internally Generated Funds with the advent of NHIS, still contribute to the sector budget at facility level as user fees.

Table 4 indicates the budgetary allocation to the sector during the GPRS II period. The health share of the national budget declined from 16% in 2006 to just below 13% in 2009.

Table 4 Health sector budget allocations against national budget, 2006-10 (GH¢)

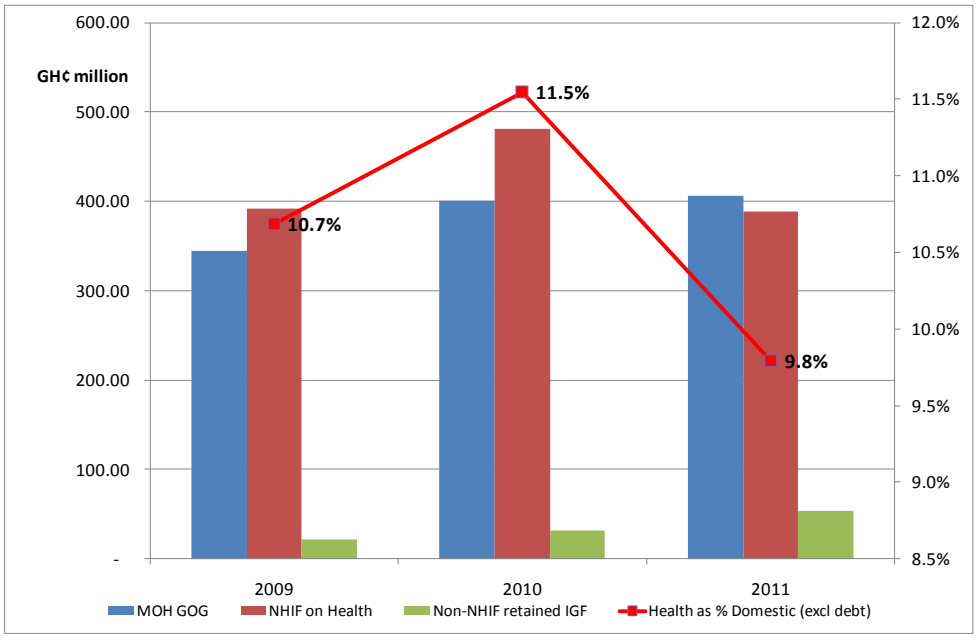
	2006	2007	2008	2009
Ministry of Health	478,654,800	563,756,400	752,233,368	**921,929,472**
National budget	2,948,398,300	3,869,832,200	5,059,808,063	**7,226,913,484**
Health share of national budget	***16.2%***	***14.6%***	***14.9%***	***12.8%***

Sources: Various annual Budget Statements

A National Health Insurance Scheme has been operating in Ghana following the enactment of the National Health Insurance Act (2004), Act 650 in 2003 and passage of Legislative Instrument, LI 1809 in 2004. The scheme was initiated to address the problem of financial barrier to health care posed by out-of-pocket payment for health care at the point of service delivery in both private and public facilities. By mid-2010, the NHIS had registered over 15m persons, representing 66% of the population. According to Seddoh and others (2010) a combination of the increased membership and rising tariffs has significantly increased the value of claims payments. The authors indicated that the US dollar equivalent weighted at year to year index amounted to a cumulative total of US$ 359,401,208 USD paid as at the end of 2009. Approximately 29 percent of this amount being US$105,492,855 went to meet all inpatient claims and 71% being US$253,908,353 was paid for claims registered under OPD services.

Figure 8 below shows the trends in the nominal contribution of the different financing sources, as reflected in annual budget statements. Key challenges pertaining to health financing include the declining share of the government budget allocated to the sector, as in Figure 9 below, unpredictable and increasingly fragmented flows of external resources.

Figure 8 Trend in share of government budget to Health, 2009-11



Source: Various annual Budget statements, MOH PPME calculations

1.4.5 Leadership and governance

The institutional responsibilities and relationships in the health sector are guided by the Constitution of Ghana, the Public Service Commission Act and the Civil Service Act, and the establishment Acts of the various agencies. The sector operates under the purview of these various Acts, with the Ministry of Health providing leadership and guidance. Several of the legal frameworks governing the sector are outdated, and are currently under review.

Aside from the mandatory responsibilities, the sector has developed successive Common Management Arrangements (CMA), the third of which was developed in 2010, which provide a framework for public sector actors to relate with various partners within the health sector. The CMA builds on the sector's long experience with the Sector-Wide Approach (SWAp), the Paris Declaration on Aid Effectiveness, Accra Agenda for Action, and the Ghana Joint Assistance Strategy, to re-affirm:

- the principles of one country plan, budget and reporting mechanisms;
- support for country-led approaches to health development, financing and systems strengthening; and
- a common monitoring and evaluation framework for all stakeholders.

Biannual Health Partners Summits are held to review sector priorities and programmes of work with an aide memoire signed by partners to represent their commitments to implement the adopted recommendations. Quarterly business meetings and monthly partners meetings are held in-between summits to review progress and address emerging challenges.

A forum of heads of agencies of the MOH, the Inter-Agency Leadership Committee (IALC), has been created to improve dialogue between health sector agencies within the framework of performance improvements, adherence to policies and accountability. One main challenge to the sector is the inability of the Ministry of Health to provide leadership in policy analysis and guidance, and to respond quickly to emerging issues and opportunities. Other challenges include the relatively weak monitoring and evaluation framework which hampers the availability of timely data for planning and decision-making.

1.4.6 Partnership and inter-sectoral collaboration

The Ministry recognizes that good health is not just a function of health service delivery, but that other partners have important roles to play in the health development in the country. The major ones are Development Partners, Faith-Based Organizations, Traditional Medicine Practitioners, Private Health Providers, Civil Society Organizations, and other Ministries Departments and Agencies (MDAs). The relationship with the various sectors differs in content and form at all levels. Table 5 shows the nature of the relationship with some selected sectors.

Table 5 Nature of partnerships in the sector

Sector/Organization	Nature of Partnership
Health Development partners	Provide funding, technical assistance, etc.
Faith-Based Organizations	Provision of health service delivery especially to underserved areas
NGOs in Health	Extension of health service delivery to deprived areas and advocacy.
Ministry of Employment and Social Welfare	Capacity building for health service delivery at all levels through NYEP; Facilitate access to service for indigents through linkages with LEAP and common targeting, regulate NGOs etc

Sector/Organization	Nature of Partnership
Ministry of Water Resources, Works and Housing and	Provision of potable water to reduce the incidence of water borne diseases and housing
Ministry of Transport, GPRTU	Provision of transportation to support emergency services and National Immunization Days
Traditional Rulers	Provide resource and land at the local level, mobilisation of communities for health programs
Ministry of Women and Children's Affairs	Advocacy for gender and children sensitive policies and laws on health
Ministry of Local Government and Rural Development	Coordination of inter-sector action for health at the district level
Ministry of Food and Agriculture	Collaboration to ensure food security to promote good health,
Ministry of Education	Supports school health programs; Training of health workers at the Tertiary level
Ministry of Youth and Sports	Youth policy and adolescent health, Development of sports and recreational programs
Ministry of Tourism	Key collaborators for the promotion of health tourism
Ministry of Interior, NADMO	Emergency responses
Ministry of Finance and Economic Planning	Funding of the sector, planning and budgeting
Ministry of Defence	Emergency responses, training
Ministry of Environment	Preservation of the ecosystem to protect health and livelihood

Cross sector planning is institutionalised in the National Development Planning Council Act 479 which ideally should provide the platform for joint planning, monitoring and evaluation. The health sector's contribution to this activity is limited to headquarters planning but weak at the decentralised level. The main challenge relating to inter- and multi-sectoral collaboration and partnerships is the absence of institutionalised fora or platforms for joint dialogue, planning, implementation and monitoring.

2 HEALTH DEVELOPMENT PRIORITIES

2.1 National development and health priorities

Ghana is a signatory to the Millennium Development Declaration in 2000 and is committed to attaining the eight Millennium Development Goals and other related international declarations including the Abuja and Ouagadougou declarations. A number of documents have been developed and actions taken to achieve this objective. Progress against these targets has been uneven. According to the 2008 GDHS, the target to half the prevalence of underweight among children under five from 31 percent to15 percent under MDG 1 has already been achieved. Good progress is demonstrated to reduce by two-thirds child mortality under MDG 4 but insufficient progress has been made against the targets related to MDG 5. The country is on track in halting the spread of HIV/AIDS and reversing the incidence of malaria and other major diseases.

The Ghana Shared Growth and Development Agenda (GSGDA) 2010-2013 is the latest of national development frameworks adopted in 2010 to accelerate development and attainment of the MDGs. This is a follow up strategy to the two Ghana Poverty Reduction Strategy papers (GPRS) I and II. The strategy aimed to prioritise five sectors: (i) Agriculture, (ii) Infrastructure (including energy, oil and gas), (iii) Water and sanitation (iv) Health and (v) Education (including ICT, Science, Technology and Innovation)

The GSGDA outlines the **vision** of the health sector as: "*to have a healthy population for national development*". The **mission** is "*to contribute to socio-economic development by promoting health and vitality, through access to quality health services for all people living in Ghana using motivated personnel and promoting the development of a local health industry*". The overall health goal and main policy objectives of the Ghana Shared Growth and Development Agenda are contained in Box 1 below.

Box 1GSGDA health Goal

To improve access to quality health care, *the policy objectives* will be to: bridge equity gaps in access to health care and nutrition services; improve governance in the health sector, improve access to quality maternal, neonatal, child and adolescent health services; intensify prevention and control of non-communicable and communicable diseases, and promote healthy lifestyles; and strengthen institutional care, including mental health service delivery

2.2 Health sector goals and development framework

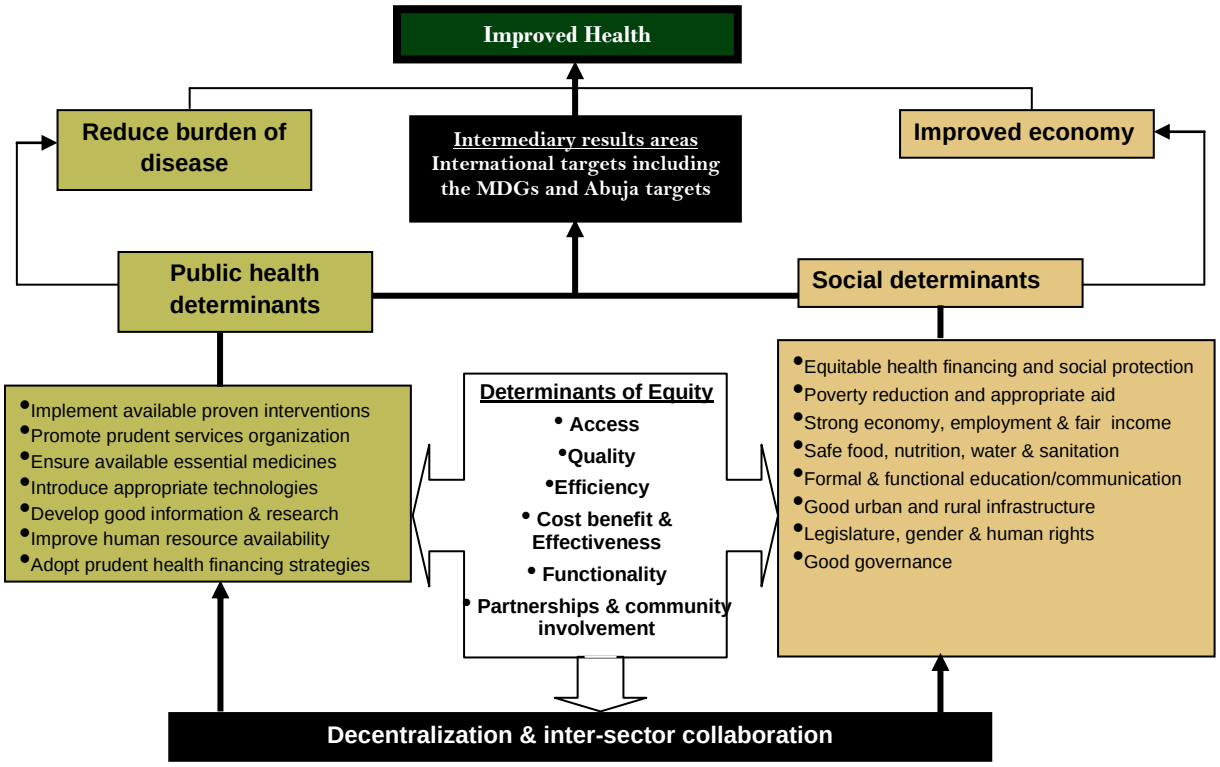
Progress towards attaining the health MDGs is relatively slow particularly in the rural parts of the country. The general analysis provided in chapter one gives an indication of the issues and challenges that the health sector should address within the four year period of this plan. This should consolidate the gains made so far and accelerate progress towards attaining the MDGs. Faster progress is not constrained by lack of technical knowledge. Affordable interventions that could address the bulk of the country's disease burden are available. The main challenges remain inadequate and untimely access to services by those who need them most, and the quality of those services.
The various health sector reviews, aide memoirs and sector dialogues have identified key areas where action is most needed. These have received broad endorsement and tackling this agenda has the support of both health sector stakeholders and development partners. The areas identified can be summarised into seven main areas:

Persistently high maternal and child mortality and high prevalence of malnutrition;

- Continuing inequities in access to essential health services in deprived districts and regions of the country;
- Limited attention to the staffing and infrastructure issues that impede service delivery;
- Lack of robust sector plans and a comprehensive financing strategy;
- Weak linkages between the health sector and broader development processes (public sector reform, infrastructure development, decentralization, and water and sanitation);
- Inadequate monitoring systems and research for tracking progress and outcomes and for developing evidence-based policies;
- Absence of an effective framework to promote community mental health practice and the integration of herbal medicines into the national health care system
- Inadequate capacity of the Ministry of Health to provide leadership and coordination of the sector, and to promote participation of the civil and private sectors.

It is recognised that the broad framework provided by the Ouagadougou Declaration on Primary Health Care and Health Systems in Africa, the Addis Ababa Declaration on Community Health, the World Health Report 2008 on Primary Health Care and other related documents provide a good basis on which to build action. These have been adapted to respond to country specific context of Ghana.

Figure 9 Attaining improved health in Ghana: a PHC-based conceptual framework



Drawing on the conceptual framework based on the Primary Health Care principles (see figure 9 above), this Sector Medium Term Development Plan 2010-2013 outlines a process for accelerating progress towards the MDGs in Ghana through action in each of these areas. These translate into **five policy objectives** as below:

1. Bridge equity gaps in access to health care and nutrition services and ensure sustainable financing arrangements that protect the poor
2. Strengthen governance and improve the efficiency and effectiveness of the health system

3. Improve access to quality maternal, neonatal, child and adolescent health services
4. Intensify prevention and control of communicable and non-communicable diseases and promote healthy lifestyles
5. Improve institutional care including mental health service delivery.

Box 2 Alma Ata definition of Primary Health Care

Primary health care is essential care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community can afford to maintain at every stage of their development in the spirit of self-reliance and self determination. … It forms part of an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. … proper nutrition, an adequate supply of water and basic sanitation … It involves in addition to the health sector, all related sectors and aspects of national and community development.

2.3 Action priorities at the various levels

The focus is to implement known best practices by building on lessons and experience gained from existing country and international work. A network of key stakeholders at all levels, from both the public and private sector, will be engaged in implementing planned activities supported by technical experts where necessary.
There will also be an active programme of research, monitoring and evaluation at all levels providing a direct linkage from lessons learnt in implementation at all levels to the evolution of policy and practice.

At **national level**, the **aims** are to:

- Develop national capacities for health policy, strategic planning and thinking, research, monitoring and evaluation in the sector. Emphasis will be on ensuring equity, rights, gender balance, efficiency and a results-based approach in health management;
- Support more and better use of effective aid and resources for health, by encouraging more predictable and flexible financing that protect the poor and vulnerable, and harmonizing and aligning external and national resources to promote effective service delivery within the country;
- Build a proactive response with emphasis on inter-sectoral collaboration; engagement and support to the private and civil society sector to expand the health industry;
- Facilitate the building and upgrading of health infrastructure and technologies, medicines and blood safety; and
- Development of a National Nutrition Policy
- Forster a health systems approach in all the functions and agencies of the MoH

At the **Regional level** the **aim** is to:

- Promote effective oversight capacity that supports facilitative supervision and attainment of high performance in set targets and infrastructure development;
- Develop efficient referral systems and facilitate a network of practice that is based on a clearer understanding of patient needs and client behaviour;
- Undertake effective planned preventive maintenance to secure the life-span of infrastructure, transport and equipment;

- Promote region-based performance incentives that attract personnel to the deprived areas;
- Map and address region specific endemic diseases in Annual Regional Health Plans that is truly representative of the various determinants of health drawing in all relevant sectors;
- Support the building of strong health information systems to provide information for policy; and
- Implementation of a National Nutrition Policy.

At the **District level** the **aim** is to:

- Strengthen district health systems to bridge the equity gaps in service delivery through an effective 5-year District Health Systems Development Plan for each district that responds to the district's specific needs;
- Broaden the participation of all services providers within the district in the District Health Management Team and to promote a network of practice;
- Strengthen the health information management system to capture essential health information from the districts and support operational research;
- Strengthen the sub-district management system and capacity to be effective at planning sub-district health services, outreach programmes and community service provision;
- Engage effectively with all communities to develop Community Health Systems that support Community Directed Interventions; and
- Promote the rapid expansion of Community-based Health Planning and Services.

To ensure optimum attainment of the sector objectives and the aims at the various levels, elements of capacity building including training, mentoring, and provision of targeted technical assistance will be pursued.

3 IMPLEMENTING THE HEALTH SECTOR POLICY OBJECTIVES AND STRATEGIES

3.1 Health Policy Objective 1 (HO1): Bridge equity gaps in access to health care and ensure sustainable financing arrangements that protect the poor

This object aims at tackling the persistent problems of access in the sector, whether geographical, financial or related to socio-cultural factors. Country-wide community service delivery will be undertaken in partnership with district assemblies, the private sector and communities. The emphasis will be on addressing priority actions in Primary Health Care. The three main strategies to be employed are the following:

IV. Strengthen district health systems with emphasis on primary health care
V. Develop sustainable financing strategies that protect the poor and vulnerable
VI. Increase availability and efficiency in human resources for health

Strategy I: Strengthen district health systems with emphasis on primary health care

The Community-based Health Programme and Services (CHPS) remain the main strategy of government to increase access to basic health interventions. The new policy and strategy to attain this level of availability will emphasis community ownership and multi-sector and private-public participation. Where a faith-based or private health facility already exist e.g. clinic, maternity home or chemical shop in a particular community, this facility will be supported with appropriate equipment, training and personnel as appropriate to serve as the CHPS facility for the community. For this purpose, a comprehensive community assessment will be undertaken before a new facility is built. In addition, the skills of CHOs will be progressively upgraded to make services available in the community or within reasonable reach of communities within a zone.

For the effective management of the CHPS strategy, the oversight responsibility of sub-district and district managers will be strengthened with an appropriate framework developed for performance management. An operational strategy that ensures effective community ownership of the programme will also be developed.

PHC requires multi-sector action. With the framework of the clinical determinants under the PHC approach, the sector will strengthen the provision of essential services are provided on a 24 hour basis for all District Hospitals, General Hospitals and Polyclinics.

Strategy II: Develop sustainable financing strategies that protect the poor and vulnerable

The development of a comprehensive financing strategy was identified as a priority in the previous 5YPOW but has not yet been finalised. Analytical work is on-going. A second round of National Health Accounts will be conducted and its routine conduct adopted. A rigorous process will be undertaken to develop a comprehensive "Health Financing Strategy for Ghana" with particular emphasis on ensuring universal coverage of all essential services. The document will look at all sources of funding that is available and likely to accrue to the sector within the next 10 years. Various scenarios will be developed to understand the needs and the funding gap. Based on this, innovative health financing mechanisms will be explored and strategies for implementing and mobilising funds will be put in place.

The current work between the MOH and the Ministry of Employment, Social Welfare to ensure the provision of pro-poor health programmes and other complementary services for National Social Protection Strategy targeted groups has been tackled and will continue to be consolidated. The Common Targeting Mechanism to identify the very poor for subsidised NHIS membership and ensure that the poor are able to access priority complementary health services will be developed between the two agencies. The proposed revision of the NHIS operating mechanisms will be used to improve the efficiency of the system and protect the indigent more efficiently. In a recent document, "Commentary

and Observations on Ghana's Health Insurance including issues for policy and research" sponsored by the Rockefeller Foundation will be considered for implementation, it was noted that the cost of care is increasing. Medicines account for 53% of claims cost. About 80% of medicines are acquired from an unorganized. As a result, current pricing and cost structures capture the inefficiencies of the market. The NHIA has also not been able to effectively use its market share and dominant position to leverage lower prices for medicines dispensed on the scheme. The G-DRG system has resulted in a number of inefficiencies. There are also major concerns of inappropriate categorization of conditions and diseases, up-coding, over-billing and deliberate misinformation and fraudulent practices among managers of schemes and service providers. Most of these are put down to weak capacity and supervision.

The government will support the introduction of an effective system that links identification numbers of schemes to users. The NHIA claims management centre will be strengthened including the possible admission of private sector participation. The NHIS will seek efficiency gains through the introduction of a performance based financing, cost containment and efficiency gains measures. The scheme will also pilot a capitation payment mechanism in an attempt to introduce a hybrid performance based financing. It is hoped that capitation will let all stakeholders share risk and streamline and ensure efficient use of financial resources. To ensure that all the health policy and financing issues under the insurance scheme are addressed effectively, other schemes as provided under the law are effectively developed, and a provider response developed and implemented, a National Coordinator for NHIS will be appointed within the Ministry of Health as a central coordination point for all stakeholders. The central coordination of the World Bank Health Insurance Project will revert to the Ministry of Health and its implementation accelerated to meet all revised goals and targets.

Strategy III: Increase availability and efficiency in human resource for health

Human resource constraints remain in terms of production, deployment and management. The existing five year strategy 2007-2011 is coming to an end. Current indications are that implementation has remained limited.

A thorough review of the 5-year-human resource strategy will be done and a new strategy will be developed. An evaluation of the impact of existing incentive mechanisms will be undertaken as part of this review. Following from the review, focus to 2013 will be on achieving implementation of the first phase of this strategy. Key activities will include determining staffing norms followed by a comprehensive redeployment exercise, and implementation of an incentive package for both private and public health sector workers in under-served areas.

Midwifery training through public and private sector production strategies with the re-introduction of the certificate course will be undertaken. Enhanced skills will be introduced for experienced midwives in the area of advanced midwifery, obstetric care, child health and health promotion to enable them operate as decentralised service centres to improve access to key services aimed at achieving MDGs 1, 4, 5 and 6.

A medical officers accelerated production plan will be actively pursued including the establishment of a new university college and teaching hospital. Other cadres which need expanding include medical assistants, laboratory technicians, orthotics, prosthetics, and core auxiliary staff. The initiative and agreement to support the start-up of an additional rural training school for this cadre will be completed.

3.2 Health Policy Objective 2 (HO2): Strengthen governance and improve the efficiency and effectiveness of the health system

As noted in the previous chapters, the health sector has undergone institutional reforms over the past decade. The Ghana Health Service and Teaching Hospitals Act, the Food and Drugs Board Act, the Pharmacy Council Act and the National Health Insurance Act among others have since been passed and implemented. All of these have been operating for more than five years. For the next four years, the sector will review the performance of these institutions

and other institutions of the sector and strengthening their stewardship and functional responsibilities. This Objective therefore aims to address issues related to institutional strengthening and accountability and inter-sector collaboration and linkages within the PHC framework. Four strategies will be followed.

V. Develop capacity to enhance the performance of the national health systems
VI. Strengthen the policy and regulatory framework governing the sector
VII. Strengthen inter-sector collaboration including public-private partnerships
VIII. Strengthen systems for improving the evidence base for policy and operations

Strategy I: Develop capacity to enhance the performance of the national health systems

Ghana is a fore-runner of the Sector-Wide Approach (SWAp) and has implemented three different five-year programmes of work. The sector has in 2010 reviewed its Common Management Arrangements and agreed on the CMA III which will guide the expectations of roles and responsibilities between the different agencies and partners for the period of implementation of the HSMTDP.

A conscious effort will be made to promote effective harmonisation and alignment between government-led programmes and health partner programmes in line with the Paris Declaration and the principles of the International Health Partnerships. To achieve this, a comprehensive non-government and development partner projects and programme mapping will be undertaken. It will be part of the holistic assessment of performance in the health sector based on a structured methodology to assess the quantity, quality and speed of progress in achieving the objectives of the projects and programmes. The primary aim of the assessment is to provide a brief but well-informed, balanced and transparent assessment of the sector's performance and factors that are likely to have influenced this performance.

An organisational assessment and staffing manual will be developed for the Ministry of Health. This will be used to re-organise the ministry, staff redeployed to fit into their qualified areas and vacant positions filled. The top management will be provided opportunities to attend senior management programmes in organisational management and leadership. Other agencies and departments of the health sector will be encouraged to undertake a similar exercise. However for each Region, the Ghana Health Service will be nominated to establish Regional Resource Teams to support various institutions to increase their technical competencies and attain set goals and targets. Part of the assessment will focus on the internal lines of communication within the Ministry within the health sector and provide the basis for developing an effective system of internal communication.

Based on recommendations from various assessment reports including the IOB report (2010), a structured in-service training programme on leadership will be implemented to train senior managers and supervisory officers in both the public and private sectors will be supported. This will be tied to a country-wide capacity development programme. To increase performance and improve staff efficiency and outcomes in service delivery, the long delayed performance based contracting will introduced as part of the results-based framework at all levels of the sector.

The Government has already embarked on the development and implementation of the Ghana Integrated Financial Management Information System. The sector has also developed the Public Financial Management Strengthening Plan which aims at strengthening PFM at all levels of the sector. The implementation of this plan will be accelerated. With the passing of key legislation, and updating of sector accounting, treasury and financial rules, a key activity is to build the capacity of health staff in PFM-related rules and regulations. The introduction of health insurance and the financial administration requirements in health facilities has also highlighted the need to strengthen institutional capacity to capture information and manage funds. This is linked to overall need to improve BMC capacity for integrated planning and budgeting. The last time BMC review and re-accreditation was done was in 2002. This exercise will be undertaken within the period and a structured capacity building and resourcing as a provider response will be implemented in all public and major key private sector health facilities.

Strategy II: Strengthen the policy and regulatory framework governing the sector

Recent reviews notwithstanding, many existing regulations within the sector are obsolete, inadequate to address emerging concerns and challenges and difficult to enforce. Regular update of health-related legislation and policies will be required throughout the period. Revised Acts regarding in particular the Ghana Health Service and Teaching Hospitals Act, the National Health Insurance Act and the Private Hospitals and Maternity Homes Board Act will be proposed and Regulations and Administrative Orders issued to guide implementation.

With new regulations come new provisions and expectations in conduct and response from the public and targeted population. A comprehensive training, education and sensitisation plan will be developed and implemented for each of the approved laws and regulations. This will target the implementers of the laws, the legal and law enforcement agencies and the general public using different approaches and communication support tools and channels.

Once the laws have been passed the new mandate may require basic changes to be made to the existing institutional framework or the establishment of new organisations. The institutional requirements and organisational systems will be established within the period specified by the laws or as directed by the Minister of Health.

Strategy III: Strengthen inter-sector collaboration including public-private partnerships

The MOH has been actively engaged the private sector in various aspects of health care delivery over the past years. There is a standing Memorandum of Understanding signed between the Ministry of Health and the CHAG institutions. With the advent of health insurance, the private health service providers have increasingly become more integrated within the sector. There is now to large extent common standards expected of both the private and public sector. The medical commodities pricing index under health insurance is weighted to reflect their peculiar situation. These notwithstanding there are concerns that the potential for private sector growth has been constrained by existing policies. The private health sector is not provided adequate incentives to operate as a viable industry for employment generation, economic growth and development. Following the successful completion of the private sector assessment undertaken by World Bank, Research for Development and Centre for Health and Social Services work will begin to review, finalise and implement the Private Health Sector Policy.

A Private Health Sector Fund (PHS-Fund) will be established in the Ministry of Health managed by a Private Sector Development Committee (PSDC) established by the Minister of Health. The PHS-Fund will be made available to support the purchase of primary care equipment for providers and training institutions, training of critical middle level health staff in local private institutions established in rural areas, policy dialogue, support for licensing documentation and coordination. This will include facilitating collaboration between local producers of key health commodities and WHO to achieve pre-qualification status. The PSDC will establish the criteria for disbursing the fund using MoH processes for disbursement. It will act as a private sector advisory body to the Minister of Health. Development partners will be encouraged to contribute to the PHS-Fund to promote a coordinated approach to private sector development financing.

The activities of the Coalition of NGOs in Health will be reviewed and recommendations made to strengthen their structures and coordination system. Proposal writing and project management training will be held for the various health sector non-government and civil society organisations to enhance their resource mobilisation and project management capacity. As part of the systems strengthening activities, a Directory derived from the partners assessment under the previous strategy will be developed to show NGO and CSO activities in Ghana. This will be made available to development partners who wish to engage with NGOs in health in Ghana.

It is often stated that the 70% of the causes contributing to morbidity and mortality are related to socio-economic issues outside the clinical determinants of health. Given the evidence, the socio-economic determinants of health

need to be addressed through effective inter-sector collaboration and linkages if the Millennium Development Goals are to be achieved. Within the next four years, the health sector will engage with some key ministries and departments. A multi-sector Technical Advisory Committee will be established to advise the Minister of Health. The Ministry of Local Government will be engaged to undertake composite planning and promote safe water and environmental sanitation. The collaboration with the Ministry of Education will aim to integrate the concepts of healthy lifestyles into the school health programme, while collaborations with the Ministry of Food and Agriculture (MoFA) will facilitate actions to address issues of food security in Ghana. The National Commission on Civic Education be engaged to create mass public education campaign to promote healthy lifestyles in the population. Dialogue will be opened with the Ministry of Works and Housing to improve staff housing and other infrastructure whiles the Ministries of Environment and Tourism will be engaged on issues of ecology, climate and health and opportunities for health tourism and recreational spa development.

An annual inter-sector forum as part of the Health Summit will be developed to discuss progress with these partners on the salient socio-economic determinants of health issue.

Strategy IV: Strengthen systems for improving the evidence base for policy and operations research

Good quality information is the foundation for evidence-based planning. The sector remains challenged at all levels in analysing and using available data. A comprehensive framework for monitoring, evaluation and research is currently under development, and will include the strengthening of information management, documentation, and reporting systems within MOH and agencies.

More specifically, a health sector Monitoring and Evaluation Framework will be established to respond to the general framework for monitoring the Ghana Shared Growth and Development Agenda and consistent with the sector-wide indicators included in this document. The Common Management Arrangement III will provide the institutional framework for determining the structures and roles and responsibilities of various agencies and partners in the monitoring and evaluation framework.

The health information management system will be overhauled with a specific focus on harmonisation and alignment of all systems within the sector needed to advance health information management. A central depository will be created to pull together all information for ease of standardisation, processing and dissemination. In addition regional data platforms will be established and linked to an upgraded District Health Management Information System (DHMIS II). The National Health Information Bulletin will be revived.

The information system development will be linked to a national e-Health Policy and Strategy. It will aim to focus the sector information and information technology expansion strategy within the framework of the Ghana ICT Architecture Framework being implemented by the Ministry of Information. Given the new orientation to open up the health sector to all key players, the e-Health Policy and Strategy once developed will be implemented in a phased approach through an innovative public-private partnership. This should allow for innovation and cost sharing to leap frog the sector ICT platform and take advantage of the new information technologies being introduced globally.

The use of evidence to guide policy will continue to be strengthened. A National Health Research Agenda will be developed. The resources for health research will also be increased with the aim to progressively meet the target set in the Algiers Declaration during the Global Health Research Forum held in Algeria. The three DHS sites will be supported to provide appropriate district population profiles. The private and civil society sector will also be given the opportunity to access funds from the Ministry of Health to undertake targeted research and conduct specific independent case reviews. The Ethics Committee will also be strengthened to meet regularly to review both proposals and the standards of research being conducted. A Directory of Health Research Organisations and Experts will be compiled under the purview of the Ethics Committee to ensure that the minimum standards comparable to international standards of research are met.

The Ministry of Health will also partner with the Ghana Medical Association to review the standards and improve on the current Ghana Medical Journal to reflect the aspirations of Ghana becoming a leading country in scientific health information in development countries.

3.3 Health Policy Objective 3 (HO3): Improve access to quality maternal, neonatal, child and adolescent health and nutrition services

Recent experiences in Ghana demonstrate that success is possible and that evidence-based effective interventions can be identified for realizing the MDGs. Although progress has been satisfactory in MDG 1,2,3,6, and 8, it has been less in other areas, MDG 4, 5 and 7. At the current pace of progress, Ghana may not meet the MDG target by 2015 unless efforts are made to accelerate activities. The slow progress is of great concern to policy decision-makers to the extent that maternal mortality was declared a National Emergency in July 2008. Much work has been undertaken recently to define appropriate policies, strategies and interventions for improved maternal and newborn care. There are also known interventions that work to ensure efficient service availability for adolescents. This health objective aims to scale these interventions up and provide the impetus for accelerating the attainment of MDG 4 and 5. The main strategies are the following:

V. Reduce the major causes contributing to maternal and neonatal deaths
VI. Reduce the major causes contributing to child morbidity and deaths
VII. Improve adolescent health
VIII. Improve the nutritional status of women and children

Strategy I: Reduce the major causes contributing to maternal and neonatal deaths

An MDG Acceleration Framework (MAF) - Ghana Action Plan has been developed by the Ministry of Health and Ghana Health Service in collaboration with development partners. The focus of MAF is to re-double efforts to overcome bottlenecks in implementing interventions that have been proven to have worked in reducing maternal mortality rate in Ghana.

As part of the evidence to policy process, the High Impact Rapid Delivery (HIRD) programme will be evaluated to access its impact so far since its scale-up to cover the entire country. A special emphasis will be placed on extended benefits to women's health in general particularly during the post-natal period. The Emergency Obstetrics and Newborn Care (EmONC) assessment being conducted will be finalised and the implementation of the recommendations initiated. Meanwhile, access to safe blood will be made possible to all women in delivery and their newborn.

There will be a renewed emphasis on promoting the uptake and use of modern contraceptive methods among the general population. This activity will be done through effective public private partnerships where contemporary marketing strategies will be used to promote consumption of the family planning products as a life-gain strategy. This strategy will be integrated into and expand on the existing Life Choices communication strategy being currently sponsored by partners. The new component will identify and tackle socio-cultural barriers to access to family planning services, maternal and newborn care.

Antecedent to all of the above is the building of capacity in midwifery and life saving skills. The curriculum for training schools will be enhanced to ensure that new graduates have the appropriate mix of skills in the areas of midwifery, obstetric care, child health and health promotion. The number of midwives produced each year will be increased through an expansion strategy that promotes both private and public sector production capacity growth.

Strategy II Reduce the major causes contributing to child morbidity and deaths

The new Child Health Policy and Strategy will be launched in 2010, highlighting key cost-effective interventions over the past years. Key activities to be implemented are the strengthening of community and facility growth promotion to address childhood health, scaling up and strengthening community and clinical case management of priority diseases (malaria, acute respiratory infection and diarrhoea) as part of Integrated Management of Child and Newborn Illnesses (IMCNI).

Over the next four years, the sector will work to break the barrier to attain a minimum 90% coverage for immunisation in all districts. This will include the introduction of the new vaccines, rotavirus and pneumococcus, planned for introduction in 2012. There will be special emphasis placed on training for the new vaccines introduction and wastage reduction for all vaccines.

A comprehensive in-service training for health professionals in the case management of Acute Respiratory Infections in children will be rolled out particularly for practitioners at the community and primary care level. A home-based case detection, management and care seeking programme will also be developed and used for wide public education. This will include prevention and the first aid home-based management of pneumonia, diarrhoeal diseases and malaria. The aim is to reduce incidence of morbidity due to these conditions by a quarter at the close of the period.

The now faltering Schools Health Programme will be re-launched with special emphasis laid on health and nutrition education, hygiene practices, equipping school clinics and training focal staff within nursery, primary and secondary schools. This will be done in collaboration with the Ghana Education Service.

Strategy III Improve adolescent health

Adolescence, the second decade of life (10-19 years), is a period of rapid development, when young people acquire new capacities and are faced with many new situations that create not only opportunities for progress, but also risks to health and wellbeing. It is a time when growth is accelerated, major physical changes take place and differences between boys and girls are accentuated.

During this period, more than twenty per cent of total growth in stature and up to fifty per cent of adult bone mass is achieved. Adolescence is also a time of mental and psychological adjustment. The main change is the development of an integrated and internalized sense of identity, involvement with groups of the same sex, to mixed groups and sexual pairing may take place. Adolescence is also a time to explore new interests and influences which can mould their thinking, ideas and actions. In traditional societies, the earlier maturation of girls has been acknowledged by early marriage. Adolescent behaviour during these years could range from exploring sexual relationships to alcohol, tobacco and substance abuse.
A comprehensive research will be undertaken to understand adolescent needs and risks within Ghana. The outcomes of the study will be used to guide the implementation of the National Adolescent Health Policy and Strategy.

The overall plan for adolescent health and development envisages the extensive involvement of NGOs towards providing adolescent-friendly reproductive health services, that are accessible and which will also provide information, education and counselling services. The strategy to be employed will aim to engender positive and healthy relationships between young persons and other members of society including family members, school teachers, and community workers, leading to positive actions within the existing cultural context.

With a strong participation and leadership of civil society organizations, the sector will support the resource mobilization, designing and building of Youth-Friendly Health Centres within densely populated communities to

include reproductive health (RH) within the broader context of the National Adolescent Health Policy and Strategy. Within health facilities, a structured Youth-Friendly Facilities Programme will be developed and facilities meeting the criteria will be accredited as Youth-Friendly Facilities and provided with resource incentives to encourage the uptake of youth focused services. The Youth-Friendly Programmes will also be incorporated into the Schools Health Education Programme. Strategies for adolescent nutrition will be incorporated into the Youth-Friendly Programme.

Strategy IV: Improve nutritional status of women and children

Iron deficiency anaemia is reported as the most common nutritional deficiency in Ghana. Iron deficiency anaemia and iron deficiency in the absence of anaemia affect work capacity, brain function and intellectual performance, behaviour and defence against infection. The focus of this strategy is to promote and protect the nutritional well-being of people of all age groups, with emphasis on women and children. To promote food safety, and the intake of adequate and nutritious food, the requirements of the Ghana Codex Alimentarius will be implemented under the auspices of the Food and Drugs Board.

Healthy pregnancy will be promoted. The community management of severe acute malnutrition is a key strategy adapted by the Ghana Health Service to address acute malnutrition (wasting). Emphasis will be placed on implementing this strategy in full. More specifically, the sector will seek to address micronutrient deficiencies, promote supplementation iron and folate for pregnant women, Vitamin A for children 6-59 months, food fortification and diet diversification. To address stunting and improve Infant and Young Child Feeding, exclusive breastfeeding will be promoted and attention given to improve complementary feeding. The exclusive six months breastfeeding programme will be strengthened with a renewed campaign based on appropriate messaging.

For children, the growth chart will used routinely and staff trained on behavior change communication techniques for them to engage in effective dialogue with parents, communicating results and their meanings to parents to enable them take ameliorative measures where the child is growth faltering. In health service facilities and in collaboration with the Ministry of Education, the Ghana School Feeding Programme, under the Ministry of Local Government and Rural Development, as well as the UN World Food Programme support for school feeding, the complementary child feeding programmes will be strengthened. This will target children above six months for age-appropriate feeding with nutrient-dense food. Adequate attention will be given to therapeutic and supplementary feeding for malnourished children at the health facility and community levels in the promotion of Community Management of Malnutrition.

3.4 Health Policy Objective 4 (HO4): Intensify prevention and control of communicable and non-communicable diseases and promote healthy lifestyles

Health objective 4 supports the achievement of MDG 4 and 6, and addresses the increasing burden of non-communicable diseases. The major strategies to be employed are the following:

III. Improve prevention, detection and case management of communicable diseases
IV. Improve prevention, detection and management of non-communicable diseases

Strategy I: Improve prevention, detection and case management of communicable diseases

Vector control will be scaled-up to achieve universal access to long-lasting insecticide treated nets and materials (one net per two persons). Indoor residual spraying is being scaled up in line with evidence and the available resources, while vector control measures for other selected tropical diseases will also be maintained. Finally, together with other MDAs, the influence and appropriate response to climate change on disease patterns will be determined.

Planned immunization campaigns against yellow fever and polio will complement prevention activities against communicable diseases. To improve case detection and accurate diagnosis, rapid diagnostic testing for malaria and other diseases will be institutionalised in all facilities. Microscopy diagnostic services will be strengthened in health centres, general hospitals and district hospitals to support the diagnosis of complicated cases including increasing the case detection rate for TB.

Early detection and treatment of neglected tropical diseases such as filariasis and Schistosomiasis will be improved. Integrated surveillance systems and epidemic preparedness will be strengthened to rapidly detect and manage outbreaks of cholera, meningitis, yellow fever, influenza; to address zoonotic diseases such as anthrax and rabies; and for diseases targeted for eradication (e.g. polio, guinea worm) and elimination (e.g. leprosy, yaws, measles, trachoma and onchocerciasis).

Emergency response plans will be reviewed and prepared for outbreaks of diseases with epidemic potential e.g. H1N1, CSM.

The malaria and HIV programmes will aim to attain universal access targets for Artemesinin Combination Therapy (ACT) for malaria, anti-retroviral therapy (ART) for AIDS, and directly observed treatment – short course (DOTS) for tuberculosis, together with STI treatment. The case detection rate for TB will be increased. Care and support for HIV and AIDS patients will also be expanded to cover all in need. Stronger linkages will be made between HIV/AIDS and TB control programs to reflect the importance of addressing co-infection. ACTs will be made more accessible and affordable in both private and public sectors through the Affordable Medicines for Malaria (AMFm) initiative towards the target of universal access. Malaria case fatality rates for pregnant women and children will be specifically targeted for reduction through the implementation of the national strategic plans.
All health sector activities for HIV/AIDS will be implemented in the context of the National Strategic Plan 2011-2015 developed to address the national response to HIV and particularly to reduce the number of new HIV cases.

Strategy II Improve prevention, detection and management of non-communicable diseases

Among the general population, the relationship between diet and medical conditions is complex. It is recognised that several dietary factors have been implicated in the development of coronary heart disease; other known risk factors include smoking, physical inactivity, raised blood cholesterol, raised blood pressure, obesity, diabetes and a family history of heart disease. A comprehensive national data base and register on non-communicable disease and risk factors will be developed using the WHO STEPS protocol.

Interventions to reduce the main shared, modifiable risk factors needs will be implemented. Screening and case management programmes for selected non-communicable diseases, including diabetes, hypertension, certain cancers and sickle cell anaemia will be expanded. The Ministry of Health will establish a National NCD Epidemiology Reference Group made up of experts in epidemiology and public health with the aim of supporting its work in designing monitoring tools and providing advice to the Ministry on data collection and analysis. A national register will be developed and appropriate response strategies initiated.

The Regenerative Health and Nutrition programme will be strengthened and integrated within the Health Education Programmes of the Ghana Health Service, CHAG, Ghana Education Service and private healthcare provider institutions. The programme in the Ministry of Health will be strengthened to provide technical support to these agencies and institutions. Through appropriate media, the sector will encourage traditional household food technologies, which exist to improve the bioavailability of nutrients.

Technical support will be acquired to assist the sector in the process towards creating awareness and advocating for the passage of the national tobacco control legislation. This will include the design of a strategy for implementing the

package of six proven measures linked to the relevant provisions of the WHO Framework Convention on Tobacco. A national strategy will be developed for reducing harmful use of alcohol. This will be based on a research conducted among the general population and existing best practices internationally. It will present relevant policy options, taking into account the economic, religious and cultural contexts.

A comprehensive Road Traffic Accident and Injury prevention strategy will be implemented in collaboration with the Road Safety Campaign programme and the Labour Department. The sector will advocate for the use of point system leading to license suspension for repeat road traffic offenders, the introduction of speed cameras on accident prone and trans-national main road networks; an innovative approach for identifying offenders and applying appropriate sanctions. The work place health impact assessment will be undertaken in collaboration with the Environmental Protection Agency, the Labour Department and the Trade Union Congress and Employers Association to identify work environments that are injurious to health and recommend ameliorative measures.

3.5 Health Policy Objective 5 (HO5): Strengthen Institutional Care Including Mental Health Service Delivery

Health objective 5 supports the improvement of institutional care including mental health service delivery. The major strategies to be employed are the following:

IV. Improve access to quality institutional care and emergency services
V. Improve the availability of medical products, traditional medicines, blood safety and health technologies
VI. Increase Access to Mental Health Services

Strategy I: Improve access to quality institutional care and emergency services

The current infrastructure expansion programme initiative under the Capital Investment Plan 2007-2011will be reviewed and revised to reflect current needs. Emphasis will be placed on scaling up facilities for primary health care, rehabilitating existing structures to meet required standards and providing staff accommodation in deprived districts. To increase ownership and promote cost sharing, district assemblies and funds allocated to parliamentarians will be targeted and mobilised towards infrastructure and utilities development for health within the districts.

A comprehensive quality of care enhancement strategy will be rolled out to respond to the need to provide efficient and consumer friendly services. The existing infection control measures will be strengthened. An innovation to contract out the management of hotel services in public sector regional hospitals will be initiated and scaled up if proven effective after initial review. A concept paper will be developed and a comprehensive programme initiated to ensure that every patient has access to a bed on demand. This will include the development of a network of practice in high case load areas so that appropriate referrals for continuing care can be undertaken. Specialist outreach programmes will be scaled up to deprived areas with facilities designated in zoned areas to receive referred clients from outreach visits. In collaboration with partners, an educational institution or non-government organisation, a project on health care law and ethics will be developed to train health personnel on their duty of care, human rights and obligations under the laws relevant to their professional practice.

Specialist outreach services will be used to complete access in areas without core staff. Construction of new facilities in under-served areas will continue. Together an additional 60 CHPS facilities, 5 primary level facilities and 7 hospitals and four regional hospitals to significantly close the gap in the 54 districts currently without a hospital will be constructed. In addition 3 regional hospitals will be completed, in Upper West, Ashanti and Western Regions. Rehabilitation of Bolgatanga Regional Hospital and the Tamale Teaching Hospital should be completed by 2013. Upgrading the Cape Coast Regional Hospital to a teaching hospital will begin. At least two regional medical stores will be renovated, in Volta and Ashanti Regions.

A framework for emergency response will be developed promoting local initiatives to further expand emergency transportation for pregnant women children and others as wells as supporting private sector development of A&E services at all levels.

National strategies and guidelines for response to accidents and medical emergencies will be Developed and disseminated with implementation of programmes to train all frontline accidents and emergency staff at district, regional and tertiary hospitals.

A National Ambulance Service will be established and personnel trained to enhance effective response. This should also enhance skills availability for emergency response.

Strategy II Improve the availability of medical products, traditional medicines, blood safety and health technologies

Access to medicines and the use of appropriate diagnostic technology will remain a major priority of the sector. The Strategic Plan for Pharmaceuticals will be finalised and implemented. Securing drug availability and commodity security at affordable prices will be a priority for the sector. Local production of medicines will be actively encouraged and private facilities supported to seek pre-qualification for drugs.

The Central Medical Stores will be reorganised and strengthened to improve its efficient performance. A contractual agreement will be developed between the different public and private sector agencies and the management organisation to ensure the timely supply of efficacious and affordable drugs tested and certified by the Food and Drugs Board. The Procurement and Supplies Directorate of the Ministry of Health will continue to facilitate imports and contraceptive commodities security in collaboration with other health partners as appropriate. The existing drug programmes under the HIV programme, the vaccines management system and the Affordable Medicines Facility for Malaria will continue.

The Ghana National Traditional Medicines pharmacopeia will be developed. This will be used to inform a national Traditional Medicines Approved Medicines List and Formulary and serve as the policy and regulatory framework. The approved medicines by the Food and Drugs Board in collaboration with the Centre for Scientific Research into Plant Medicine will be made available within selected facilities as a first phase roll out strategy and patients given a choice of drug regime. All relevant personnel in these facilities particularly physicians, pharmacists and nurses will be trained on the prescription and dispensing of these drugs.

A National Blood Service will be established to ensure availability of safe blood for all facilities. This notwithstanding, each facility will be encouraged to continue its blood mobilisation strategies and improve on their blood safety measures.

A conscious effort will be made to fill the existing gaps in equipments and technologies identified in the situational analysis. The target is to provide up to 60% of the needs of each region by the end of 2013. Priority will be given to the equipment needs of secondary and tertiary facilities that will enable them provide high quality care and whose cost can affect the balance sheet of facilities negatively.

Strategy III Increase Access to Mental Health Services

To give increased attention to mental health, advocacy is ongoing for the passage of the Mental Health Bill, which is awaiting Parliamentary approval. Work will then start on the drafting and advocacy for the passage of subsidiary legislation.

Health care providers will be sensitised and trained in guidelines and protocols for mental health services with the aim of making mental health services available in all health facilities.

In order to protect the rights of mental health patients, activities to improve early detection, community education on mental health, its prevention and rehabilitation, will be intensified. Emphasis will be placed on community-based mental health care, with the development and implementation of a community mental health care roll out plan for the country. The rehabilitation of patients with psychiatric disorders into communities will be emphasised and a framework will be developed to this end making use of half-way homes to decongest hospitals and allow for patients to be integrated into communities after treatment.

The psychiatric facilities in Accra, Pantang and Ankaful will be rehabilitated. The mental health in-patients feeding programme will be given special attention. Resources will be made available to increase the training of specialist psychiatrists and psychiatry nurses. The profile of Clinical Psychologists and their practice will be raised to include counselling for trauma, grief, emotional and domestic abuse victims. To avoid stigmatisation and provide easy access, Clinical Psychology practices will be established within social welfare and health promotion settings outside hospitals.

Stigma remains a major challenge for both psychiatric patients and workers in the mental health sub-sector and efforts will be made to mobilise and sensitise communities and families on mental health issues to facilitate behavioural and attitudinal changes towards these groups. Given the role played by faith-based organisations in counselling and providing relief, a strong linkage will be developed between them and qualified specialists. A national seminar on the role of churches and traditional leaders in promoting healthy mental health practices and patient management will be held.

Research into psychiatric conditions and monitoring and surveillance of these will be improved. A new research on the patterns of substance abuse particularly among the youth and working men will be conducted. In addition, the sector will develop and implement advocacy programmes for the enforcement of legislation that prevents children under 18 from possession of alcohol and consciousness altering drugs.

4 TABLE OF KEY SECTOR STRATEGIES, PRIORITIES AND ACTIVITIES 2010-2013

HO1: Bridge equity gaps in access to health care and ensure sustainable financing arrangements that protect the poor								
Strategies		**Priority action**		**Activity**	**2010**	**2011**	**2012**	**2013**
1.1	Strengthen district health system with emphasis on primary health care	1.1.1	Improve coverage of PHC services at sub-district level through community health systems	Review of the CHPS strategy		x		
				Provide accommodation, transportation and service delivery kits	x	x	x	x
				Deploy CHOs to defined zones in collaboration with Local Government	x	x	x	x
		1.1.2	Capacity development of district and sub-district teams	Train Sub-district Teams to support approved service providers in the sub-district	x	x	x	x
				Strengthen DHMTs and develop the District Health Departments to operate in accordance with LI 1961			x	x
1.2	Develop sustainable financing strategies that protect the poor and vulnerable	1.2.1	Develop comprehensive health financing framework	Develop a national health financing strategy		x	x	
				Update and institutionalize National Health Accounts		x	x	x
				Provide leadership and support for the review and passage of the NHIS bill, including definition of the "indigent"	x	x		
				Implement NHIS one lifetime contribution			x	x
				Collaborate with Ministry of Employment and Social Welfare in implementation of health-related components of National Social Protection Strategy		x	x	x
				Create Policy Analysis Unit in MOH		x		
				Identify additional funding sources for the NHIF and other social support schemes		x	x	x

HO1: Bridge *equity gaps* in access to health care and ensure sustainable financing arrangements that protect the poor								
Strategies		**Priority action**		**Activity**	**2010**	**2011**	**2012**	**2013**
1.3	Increase availability and efficiency in human resource for health	1.3.1	Revise and implement the Human Resource Strategy	Develop a new HR strategy		x		
				Review establishments, staffing norms and develop and implement deployment plan		x	x	x
				Agree and implement incentive package to public health sector workers in under-served areas	x	x	x	x
				Increase training of midwives, Medical Assistants, laboratory and imaging technicians to support district and sub-district services			x	x
				Increase availability of tutors, including support to private sector institutions training middle level cadres	x	x	x	x

HO2: Strengthen governance and improve the efficiency and effectiveness of the health system								
Strategy		**Priority action**		**Activity**	**2010**	**2011**	**2012**	**2013**
2.1	Develop capacity to enhance the performance of the national health system	2.1.1	Leadership and management development at all levels	Design and implement in-service training programme in leadership and management for all managers in the health sector		x	x	x
				Undertake comprehensive non-government and development partner projects and programme mapping			x	
				Conduct organisational assessment, develop staffing manual and redeploy staff		x	x	x
				Evaluate implementation of the common management arrangements				x

				Review and refine the system for performance contracting within the sector		x		
		2.1.2	Performance contracting	Implement the performance contracts at all levels			x	x
				Review and implement public financial management strengthening plan		x		
		2.1.3	Enforce adherence to sound public financial management practices	Dissemination and training on various Acts		x	x	
2.2	Strengthen the policy and regulatory framework governing the sector	2.2.1	Support the implementation of the revised health sector regulations	Develop respective Legislative Instruments or issue Administrative Orders, as appropriate		x	x	
				Establish relevant institutions and systems as may be required by the Acts			x	x
				Revise and implement the private sector policy		x	x	x
2.3	Strengthen inter-sectoral collaboration including public-private partnerships	2.3.1	Finalise and implement private sector policy	Establish advisory committee on PPP		x		
				Review activities of NGOs and CSOs in the health sector and make recommendations to strengthen their structures and coordination system.		x		
				Conduct training in proposal writing and project management for NGOs and CSOs to enhance their resource mobilisation.			x	
				Establish Private Health Sector Development Fund			x	
				Establish multi-sector Technical Advisory Committee to advise Minister on health and health-related issues		x		
		2.3.2	Promote inter-sectoral collaboration and coordination	Engage with Ministry of Local Government to implement composite planning and to promote safe water and environmental sanitation		x	x	

				Collaborate with Ministry of Education to integrate concepts of healthy lifestyles into school health programmes		x		
				Collaborate with National Commission on Civic Education to engage in mass public education campaigns to promote healthy lifestyles in the population		x		
				Engage with Ministry of Water Resources, Works and Housing and MMDAs to improve staff housing and other infrastructure, and to expand safe water supply		x	x	
				Develop strategies to determine and respond to the influence of climate change on disease patterns		x	x	
				Establish an annual inter-sectoral forum as part of the Health Summit		x	x	x

HO2: Improve governance of the health system								
Strategy		**Priority action**		**Activity**	**2010**	**2011**	**2012**	**2013**
2.4	Strengthen systems for improving the evidence base for policy and operations research	2.4.1	Develop a national monitoring and evaluation framework for the sector	Prepare and implement a national M& E framework for the sector		x	x	
				Establish district league table and reward system		x		
				Update the health module in GLSS and other national surveys		x	x	
				Allocate dedicated recurrent budget to health research		x	x	x
				Finalise and disseminate a national health research agenda		x		
		2.4.2	Develop, implement and coordinate a national	Develop research capacity		x	x	x

			research agenda	Support the conduct of operational research	x	x	x	x
				Partner with Ghana Medical Association to review standards and improve Ghana Medical Practitioners Register			x	
				Compile a Directory of Health Research Organisations and Experts under the purview of the Ethics Committee			x	
				Support the conduct of clinical trials	x	x	x	x
				Support the organisation of annual forum for the dissemination of research findings		x	x	x
				Integrate and harmonise the national health data platforms		x	x	
		2.4.3	Strengthen health information management	Review and implement an enhanced system for health information management at all levels		x	x	x
				Revive the National Health Information Bulletin			x	
				Implement e-Health strategy		x	x	x
				Develop capacity for data collection, analysis and use		x	x	x
HO3: Improve access to quality maternal, neonatal, child and adolescent health and nutritional services								
Strategy		**Priority actions**		**ACTIVITIES**	**2010**	**2011**	**2012**	**2013**
3.1	Reduce the major causes contributing to maternal and neonatal deaths	3.1.1	Implement the MDG Acceleration Framework Country Action Plan for improved maternal and newborn care	Increase access to modern FP services		x	x	x
				Increase coverage of skilled delivery		x	x	x
				Finalise and implement recommendations of the report on EmONC assessment		x	x	x
				Strengthen implementation of Life Saving Skills at district and sub-district level and build Regional Resource Teams		x	x	x
				Evaluate the impact of HIRD		x		

				Raise awareness on socio-cultural barriers to access to maternal and newborn care		x	x	x
				Improve access to safe blood for expectant mothers and newborns		x	x	x
				Increase numbers of midwives trained and expand training in midwifery to CHO	x	x	x	x
				Enhance training schools' curriculum to produce cadres of staff with skills mix in the areas of midwifery, obstetric care, child health and health promotion		x		
HO3: Improve access to quality maternal, neonatal, child and adolescent services								
Strategy		**Priority actions**		**ACTIVITIES**	**2010**	**2011**	**2012**	**2013**
3.2	Reduce the major causes contributing to child morbidity and deaths	3.2.1	Implement the Child Health Policy and Strategy	Increase the uptake of EPI services	x	x	x	x
				Introduce new childhood vaccines			x	
				Train relevant Community Health Workers (CHWs) on integrated Community Case Management of Diarrhoea/Pneumonia/Malaria		x	x	x
				Review the integrated Community case management of malaria, pneumonia and diarrhoeal diseases				x
				Scale up school health programmes		x	x	x
				Implement priority activities under adolescent health strategy	x	x	x	x
				Conduct research into adolescent needs and risks in Ghana			x	
3.3	Improve adolescent health	3.3.1	Implement adolescent health policy and strategy	Develop national nutritional policy and strategy		x		
				Review and implement the national Codex Alimentarius			x	
3.4	Improve nutritional status of women and children	3.4.1	Develop and implement National Nutrition Policy and Strategy	Scale-up essential nutrition actions for women and children	x	x	x	x

HO4: Intensify prevention and control of communicable and non-communicable diseases and promote healthy lifestyles								
Strategy		**Priority Action**		**Activity**	**2010**	**2011**	**2012**	**2013**
4.1	Improve prevention, detection and case management of communicable diseases.	4.1.1	Prevention and control of communicable diseases	Scale up vector control, indoor residual spraying and achieve universal accesss to ITNs	x	x	x	x
				Implement supplementary immunization activities for polio and yellow fever	x	x	x	x
				Review and strengthen national communicable disease surveillance systems and practices			x	
				Implement national strategic plans to reduce new HIV cases	x	x	x	x
				Pursue universal access for ACTs, ARTs and DOTS	x	x	x	x
		4.1.2	Prevention, detection and management of HIV/AIDS, TB and Malaria	Implement national strategic plans to increase TB case detection and cure rate	x	x	x	x
				Implement national strategic plans to reduce malaria case fatality among pregnant women and children	x	x	x	x
				Maintain status and validate elimination of guinea worm and polio	x	x	x	x
				Increase activities for the control and elimination of onchocerciasis, lymphatic filariasis, yaws and leprosy	x	x	x	x
		4.1.3	Prevention, detection and management of diseases of epidemic potential and those targeted for eradication	Review and make ready emergency response plans for diseases of epidemic potential [eg CSM, H1N1]	x		x	

HO4: Intensify, prevention and control of communicable and non-communicable diseases and promote healthy lifestyles								
Strategy		**Priority Action**		**Activity**	**2010**	**2011**	**2012**	**2013**
4.2	Improve prevention, detection and management of non communicable diseases	4.2.1	Implement Regenerative Health and Nutrition Programme	Promote healthy lifestyle awareness among the general population	x	x	x	x
				Promote traditional food technologies to improve bioavailability of micronutrients			x	x
				Advocate for the passage of the National Tobacco Control Legislation		x	x	
				Develop national strategy to reduce use of alcohol			x	
				Implement Road Traffic Accident and Injury prevention strategy		x	x	
		4.2.2	Scale up detection and management of non-communicable diseases	Conduct a workplace health impact assessment			x	
				Establish National NCD Epidemiology Reference Group			x	
				Expand screening programmes for selected non-communicable diseases: hypertension, diabetes, sickle cell and selected cancers.	x	x	x	x
				Increase effective clinical management of NCDs		x	x	x
HO5 Strengthen institutional care, including mental health service delivery								
Strategy		**Priority actions**		**ACTIVITIES**	**2010**	**2011**	**2012**	**2013**
5.1	Improve access to quality institutional care and emergency services	5.1.1	Implement quality of care enhancement strategy	Review and develop standard protocols and guidelines for institutional care incl. referrals		x		
				Pilot and scale up contracting out of hotel services in hospitals			x	x
				Create access to services by expanding specialist outreach programmes as necessary		x	x	x
			Ensure the availability of equipment and infrastructure required for adherence to	Disseminate and train on use of standards and protocols in respective institutions			x	
				Rehabilitate, renovate or build required new infrastructure	x	x	x	x

		5.1.2	standards, guidelines and protocols	Develop new Capital Investment Plan, to include infrastructure, equipment, transport and ICT		x		
				Develop and implement medical equipment replacement plan		x		
		5.1.3	Develop framework for emergency response	Promote local initiatives to further expand emergency transport for pregnant women, children and others	x	x	x	x
				Support private sector development of A&E services at all levels			x	x
		5.1.4	Strengthen capacity of Accident & Emergency depts of health facilities	Develop and disseminate national strategies and guidelines for response to accidents and medical emergencies		x		
				Train emergency medical teams for district, regional and tertiary hospitals	x	x	x	x
HO5 Strengthen institutional care, including mental health service delivery								
Strategy		**Priority actions**		**ACTIVITIES**	**2010**	**2011**	**2012**	**2013**
5.1	Improve access to quality institutional care and emergency services	5.1.5	Establish a National Ambulance Service	Construct or allocate office accommodation		x		
				Expand network of ambulance stations		x	x	x
				Provide ambulances and other transport and communication equipment		x	x	x
				Procure and install equipment	x	x	x	x
				Recruit and train more Emergency Medical Technicians (EMT)		x	x	x
				Upgrade the skills of existing EMTs from basic to Advanced		x	x	x
				Develop organisational structure and establishment				
				Recruit and train staff for the Service			x	x

5.2	Improve the availability of medical products, traditional medicines, blood safety and health technologies	5.2.1	Establish National Blood Service	Identify, renovate or build and equip blood service centres across the country			x	x
				Develop and disseminate guidelines on blood products and transfusion services		x		
				Train relevant health workers on use of guidelines			x	
HO5 Strengthen institutional care, including mental health service delivery								
Strategy		**Priority actions**		**ACTIVITIES**	**2010**	**2011**	**2012**	**2013**
5.2	Improve the availability of medical products, traditional medicines, blood safety and health technologies	5.2.2	Finalise and implement guidelines for health technologies for medical products including traditional medicines	Fill existing gaps in equipments and technologies with priority to secondary and tertiary facilities		x	x	x
				Develop capacity for improved management of medical supplies and reduction of waste			x	
				Review and expand standards and guidelines for the supply and regulation of traditional medicines and drug products		x		
				Hold round table meeting to update pharmaceutical sector policy note		x		
				Advocate for the passage of the LI under the Mental Health Bill		x		
		5.2.3	Strengthen pharmaceutical services	Implement the Mental Health Act		x	x	x
5.3	Increase Access to Mental Health Services	5.3.1	Ensure the passage and operationalisation of the Mental Health Act	Disseminate and train health care providers on the guidelines and protocols for mental health services		x	x	x
				Establish community and facility-based mental health services		x	x	
		5.3.2	Establish mental health services in all health	Decongest and rehabilitate infrastructure in existing hospitals and improve institutional care			x	x

			facilities	Develop and implement framework for the rehabilitation of the mentally challenged			x	x
				Increase public awareness and mobilise communities in support of mental health patients		x		
		5.3.3	Increase awareness, reduce stigma and promote rehabilitation	Intensify research, surveillance, monitoring and evaluation of psychiatric conditions		x	x	x
				Develop communication support materials and implement a comprehensive campaign		x	x	x
		5.3.4	Improve research and surveillance of psychiatric conditions	Undertake comprehensive psychiatric conditions mapping in high risk communities and populations				x

HO2: Improve governance of the health system								
Strategy		**Priority action**		**Activity**	**2010**	**2011**	**2012**	**2013**
2.1	Develop capacity to enhance the performance of the national health system	2.1.1	Leadership and management development at all levels	Design and implement in-service training programme in leadership and management for all managers in the health sector		x	x	x
				Introduce an effective internal communication system within MOH and among health sector players		x		
				Evaluate implementation of the common management arrangements				x
		2.1.2	Performance contracting	Review and refine the system for performance contracting within the sector		x		
				Implement the performance contracts at all levels			x	x
		2.1.3	Enforce adherence to sound public financial management practices	Review and implement public financial management strengthening plan		x		
2.2	Strengthen the regulatory framework governing the sector	2.2.1	Support the implementation of the revised health sector regulations	Dissemination of various Acts		x	x	
				Develop respective Legislative Instruments or issue Administrative Orders, as appropriate		x	x	
				Establish relevant institutions and systems as may be required by the Acts			x	x

HO2: Improve governance of the health system								
Strategy		**Priority action**		**Activity**	**2010**	**2011**	**2012**	**2013**
2.3	Strengthen inter-sectoral collaboration and public-private partnerships	2.3.1	Finalise and implement private sector policy	Revise and implement the private sector policy		x	x	x
				Establish advisory committee on PPP		x		
				Establish Private Health Sector Development Fund			x	
		2.3.2	Promote inter-sectoral coordination	Establish multi-sector Technical Advisory Committee to advise Minister on health and health-related issues		x		
				Engage with Ministry of Local Government to implement composite planning and to promote safe water and environmental sanitation		x	x	
				Collaborate with Ministry of Employment and Social Welfare in implementation of health-related components of National Social Protection Strategy		x	x	x
				Collaborate with Ministry of Education to integrate concepts of healthy lifestyles into school health programmes		x		
				Collaborate with National Commission on Civic Education to engage in mass public education campaigns to promote healthy lifestyles in the population		x		
				Engage with Ministry of Water Resources, Works and Housing and MMDAs to improve staff housing and other infrastructure, and to expand safe water supply		x	x	
				Develop strategies to determine and respond to the influence of climate change on disease		x	x	
				Establish an annual inter-sectoral forum as part of the Health Summit		x	x	x

HO2: Improve governance of the health system								
Strategy		**Priority action**		**Activity**	**2010**	**2011**	**2012**	**2013**
2.4	Strengthen systems for improving the evidence base for policy and operations research	2.4.1	Develop a national monitoring and evaluation framework for the sector	Prepare and implement a national M& E framework for the sector		x	x	x
				Establish district league table and reward system		x		
				Update the health module in GLSS and other national surveys		x	x	
		2.4.2	Develop, implement and coordinate a national research agenda	Allocate dedicated recurrent budget to health research		x	x	x
				Finalise and disseminate a national health research agenda		x		
				Develop research capacity		x	x	x
				Support the conduct of operational research	x	x	x	x
				Support the conduct of clinical trials	x	x	x	x
		2.4.3	Strengthen health information management	Integrate and harmonise the national health data platforms		x	x	
				Implement the DHIMS II		x	x	x
				Implement e-Health strategy		x	x	x
				Develop capacity for data collection, analysis and use		x	x	x

HO3: Improve access to quality maternal, neonatal, child and adolescent services								
Strategy		**Priority actions**		**ACTIVITIES**	**2010**	**2011**	**2012**	**2013**
3.1	Reduce the major causes contributing to maternal and neonatal deaths	3.1.1	Implement the MDG Acceleration Framework Country Action Plan for improved maternal and newborn care	Increase access to modern FP services		x	x	x
				Increase coverage of skilled delivery		x	x	x
				Finalise and implement recommendations of the report on EmONC assessment		x	x	x
				Strengthen implementation of Life Saving Skills at district and sub-district level and build Regional Resource Teams		x	x	x
				Evaluate the impact of HIRD		x		
				Raise awareness on socio-cultural barriers to access to maternal and newborn care		x	x	x
				Improve access to safe blood for expectant mothers and newborns		x	x	x
				Increase numbers of midwives trained and expand training in midwifery to CHO	x	x	x	x
				Enhance training schools' curriculum to produce cadres of staff with skills mix in the areas of midwifery, obstetric care, child health and health promotion		x		

HO3: Improve access to quality maternal, neonatal, child and adolescent services								
Strategy		**Priority actions**		**ACTIVITIES**	**2010**	**2011**	**2012**	**2013**
3.2	Reduce the major causes contributing to child morbidity and deaths	3.2.1	Implement the Child Health Policy and Strategy	Increase the uptake of EPI services	x	x	x	x
				Introduce new childhood vaccines			x	
				Train relevant Community Health Workers (CHWs) on integrated Community Case Management of Diarrhoea/Pneumonia/Malaria		x	x	x
				Scale up school health programmes		x	x	x
3.3	Improve adolescent health	3.3.1	Implement adolescent health policy and strategy	Implement priority activities under adolescent health strategy	x	x	x	x
3.4	Improve nutritional status of women and children	3.4.1	Develop and implement National Nutrition Policy and Strategy	Develop National Nutritional policy and strategy		x		
				Develop national Codex Alimentarius			x	
				Scale-up essential nutrition actions for women and children	x	x	x	x

HO4: Intensify, prevention and control of communicable and noncommunicable diseases and promote healthy lifestyles								
Strategy		**Priority Action**		**Activity**	**2010**	**2011**	**2012**	**2013**
4.1	Improve upon prevention, detection and case management of communicable diseases.	4.1.1	Prevention and control of communicable diseases	Implement supplementary immunization activities for polio and yellow fever	x	x	x	x
				Review and strengthen national communicable disease surveillance systems and practices			x	
		4.1.2	Prevention, detection and management of HIV/AIDS, TB and Malaria	Implement national strategic plans to reduce new HIV cases	x	x	x	x
				Implement national strategic plans to increase TB case detection and cure rate	x	x	x	x
				Implement national strategic plans to reduce malaria case fatality among pregnant women and children	x	x	x	x
		4.1.3	Prevention, detection and management of diseases of epidemic potential and those targeted for eradication	Maintain status and validate elimination of guinea worm and polio	x	x	x	x
				Increase activities for the control and elimination of onchocerciasis, lymphatic filariasis, yaws and leprosy	x	x	x	x
				Review and make ready emergency response plans for diseases of epidemic potential [eg CSM, H1N1]	x		x	

HO4: Intensify, prevention and control of communicable and noncommunicable diseases and promote healthy lifestyles								
Strategy		**Priority Action**		**Activity**	**2010**	**2011**	**2012**	**2013**
4.2	Improve prevention, detection and management of non communicable diseases	4.2.1	Implement Regenerative Health and Nutrition Programme	Promote healthy lifestyle awareness among the general population	x	x	x	x
				Promote traditional food technologies to improve bioavailability of micronutrients			x	x
				Conduct research into the harmful use of alcohol			x	
		4.2.2	Scale up detection and management of non-communicable diseases	Establish National NCD Epidemiology Reference Group		x		
				Expand screening programmes for selected non-communicable diseases: hypertension, diabetes, sickle cell and selected cancers.	x	x	x	x
				Increase effective clinical management of NCDs		x	x	x

HO5 Strengthen institutional care, including mental health service delivery								
Strategy		**Priority actions**		**ACTIVITIES**	**2010**	**2011**	**2012**	**2013**
5.1	Enforce standards, guidelines and protocols to improve the quality of institutional care	5.1.1	Ensure availability and use of standards and protocols	Review and develop standard protocols and guidelines for institutional care including		x		
				Disseminate and train on use of standards and protocols in respective institutions			x	
		5.1.2	Ensure the availability of equipment and infrastucture required for adherence to standards, guidelines and protocols	Develop new Capital Investment Plan, to include infrastructure, equipment, transport and ICT		x		
				Develop and implement medical equipment replacement plan		x		
				Rehabilitate, renovate or build required new infrastructure	x	x	x	x
5.2	Strengthen the system capacity for emergency response	5.2.1	Develop framework for emergency response	Develop and disseminate national strategies and guidelines for response to accidents and medical emergencies		x		
				Promote local initiatives to further expand emergency transport for pregnant women, children and others	x	x	x	x
		5.2.2	Strengthen capacity of Accident & Emergency depts of health facilities	Train emergency medical teams for district, regional and tertiary hospitals	x	x	x	x
				Support private sector development of A&E services at all levels			x	x

HO5 Strengthen institutional care, including mental health service delivery								
Strategy		**Priority actions**		**ACTIVITIES**	**2010**	**2011**	**2012**	**2013**
5.2	Strengthen the system capacity for emergency response	5.2.3	Establish a National Ambulance Service	Construct or allocate office accommodation		x		
				Expand network of ambulance stations		x	x	x
				Provide ambulances and other transport and communication equipment		x	x	x
				Procure and install equipment	x	x	x	x
				Recruit and train more Emergency Medical Technicians (EMT)		x	x	x
				Upgrade the skills of existing EMTs from basic to Advanced		x	x	x
5.3	Expand access to safe blood and blood products	5.3.1	Establish National Blood Service	Develop organisational structure and establishment				
				Recruit and train staff for the Service			x	x
				Identify, renovate or build and equip blood service centres across the country			x	x
				Develop and disseminate guidelines on blood products and transfusion services		x		
				Train relevant health workers on use of guidelines			x	

HO5 Strengthen institutional care, including mental health service delivery								
Strategy		**Priority actions**		**ACTIVITIES**	**2010**	**2011**	**2012**	**2013**
5.4	Ensure commodity security of health technologies for medical products including traditional medicines	5.4.1	Finalise and implement guidelines for health technologies for medical products including traditional medicines	Streamline procurement of health commodities				
				Develop capacity for improved management of medical supplies and reduction of waste				
				Finalise and implement guidelines for health technologies and medical products				
				Review and expand standards and guidelines for the supply and regulation of traditional medicines and drug products		x		
		5.4.2	Strengthen pharmaceutical services	Hold round table meeting to update pharmaceutical sector policy note		x		
5.5	Increase Access to Mental Health Services	5.5.1	Ensure the passage and operationalisation of the Mental Health Act	Advocate for the passage of the LI under the Mental Health Bill		x		
				Implement the Mental Health Act		x	x	x
		5.5.2	Establish mental health services in all health facilities	Establish community and facility-based mental health services		x	x	
				Disseminate and train health care providers on the guidelines and protocols for mental health services		x	x	x
				Develop and implement framework for the rehabilitation of the mentally challenged			x	x
				Increase public awareness and mobilise communities in support of mental health patients		x		
				Intensify research, surveillance, monitoring and evaluation of psychiatric conditions		x	x	x

5 BUDGETING AND COSTING

5.1 Approach

A mixed-methods approach was employed for the costing of the SMTDP, drawing upon both the Marginal Budgeting for Bottlenecks (MBB) tool for MDG-related services and health systems strengthening, and an activity-based costing for additional services such as mental health and pandemic preparedness. Data inputs and intermediate results were validated with MOH and GHS stakeholders through two validation workshops and two broader presentations to MOH and partners at the beginning and end of the exercise.

Three cost scenarios were prepared. The "low" scenario reflected the status quo, assuming implementation of existing strategies at the current pace of progress, with few strategic shifts or adjustments made to the health system. Under this scenario, few of the HSMTDP targets would be met. The "mid" scenario, assumed a moderate incremental increase in the availability of resources to fund priority health services, such that 70-80% of the HSMTDP's stated 2013 targets might be achieved. The "high" scenario, assumed the availability of a more generous funding package sufficient to implement the entire plan and achieve 100% of the targets. This section presents a summary of the final preferred scenario, which was selected for its greater realism, feasibility, and its expected impact particularly on the health-related MDGs. The proposed level of infrastructure development, taking currently funded projects only, and the unit costs are presented in Table 6 below

Table 6 Infrastructure investments: number and unit costs

Facility type	Proposed number	Unit cost (US$)
CHPS	2,400 functional o/w 60 with compounds	$55,000 civil works + $6,000 equipment
Health centres/polyclinics	5	$350,000 + $80,000 equipment
District hospitals	7	$15m civil works + $7m equipment
Regional hospitals	4	$25m civil works + $10m equipment

5.2 Results of costing

Based on an exchange rate of US$1: GH¢1.457 (at end June 2010), the results of the costing exercise suggest that the total resources required over the four years will be GH¢6.5bn. This translates to roughly GH¢ 67 per capita each year over the HSMTDP period[1]. This is broken down in Table 7 by year and by chart of accounts classification. The table shows a largely even distribution of costs between personnel emoluments, service and investment costs over the period.

Table 7 Projected cost of HSMTDP by year and Item, GH¢ m

	2010	2011	2012	2013	Total	%
Item 1 Personnel Emoluments	429.20	468.82	509.44	550.64	**1,958.10**	*30%*
Item 2 Administrative Expenses	74.24	99.84	137.51	179.38	**490.98**	*8%*
Item 3 Services Expenses	482.32	507.26	534.28	562.95	**2,086.80**	*32%*
Item 4 Investment Expenses	381.21	379.07	576.04	637.25	**1,973.57**	*30%*
Total	**1,366.98**	**1,454.98**	**1,757.27**	**1,930.22**	**6,509.46**	

[1] Based on provisional estimates of the 2010 population at 24.2m; using the revised inter-censal population growth rate of 2.4% per annum, the estimated annual cost rises from GH¢56 in 2010 to GH¢ 78 in 2013.

Efforts were made to assign the different activities and interventions to the five policy objectives, although this proved problematic in some instances due to the overlapping nature of activities. Expert opinion and assumptions were used to compensate for this direct attribution weakness, and the summary breakdown is shown in Table 8 below.

Table 8 Estimated SMTDP costs by Objective, GH¢ m

	2010	2011	2012	2013	Total	%
Health objective 1	115.30	127.40	132.79	151.26	**526.75**	*8%*
Health objective 2	245.89	257.96	270.03	282.10	**1,055.96**	*16%*
Health objective 3	457.07	480.31	504.24	528.85	**1,970.47**	*30%*
Health objective 4	333.05	357.00	380.94	404.89	**1,475.88**	*23%*
Health objective 5	215.68	232.32	469.28	563.12	**1,480.40**	*23%*
TOTAL	**1,366.98**	**1,454.99**	**1,757.27**	**1,930.22**	**6,509.46**	

Table 8 shows that HO3, which seeks to improve access to key maternal, neonatal, child and adolescent health services, is associated with the largest share of the costs (30%). This is followed by both HO4 which aims to redirect government efforts towards intensification of prevention and control of non-communicable and communicable diseases and promote healthy lifestyles, and HO5 which targets improved institutional care and mental health service delivery (23% each). It should be noted that primary level capital investments have been shared across policy objectives 1, 3 and 4 since they are a means to achieving improved outputs and outcomes in these areas.

5.3 Indicative resource envelope

Parallel to the costing exercise, a fiscal space analysis was conducted to determine the country's financial capacity and the ability of the Government to finance the SMTDP. MOFEP and IMF macroeconomic projections, projected DP commitments and government health expenditure projections, covering both discretionary funding and the statutory National Health Insurance Fund, were used to develop three scenarios: progressive, in which the share of government spending rises by 1% a year; Abuja, in which the share rises to 15% from 2011; and constrained, in which the share is more or less constant until 2013. The constrained scenario being more realistic, this has been used in this document. This was then added to projections from development partners to obtain total expected public health spending.

Under this scenario, public health spending is estimated to rise from GH¢ 1,488 million in 2010 to GH¢ 1,833 million in 2013, as shown in Table 9 below.

Table 9 Progressive fiscal space projections

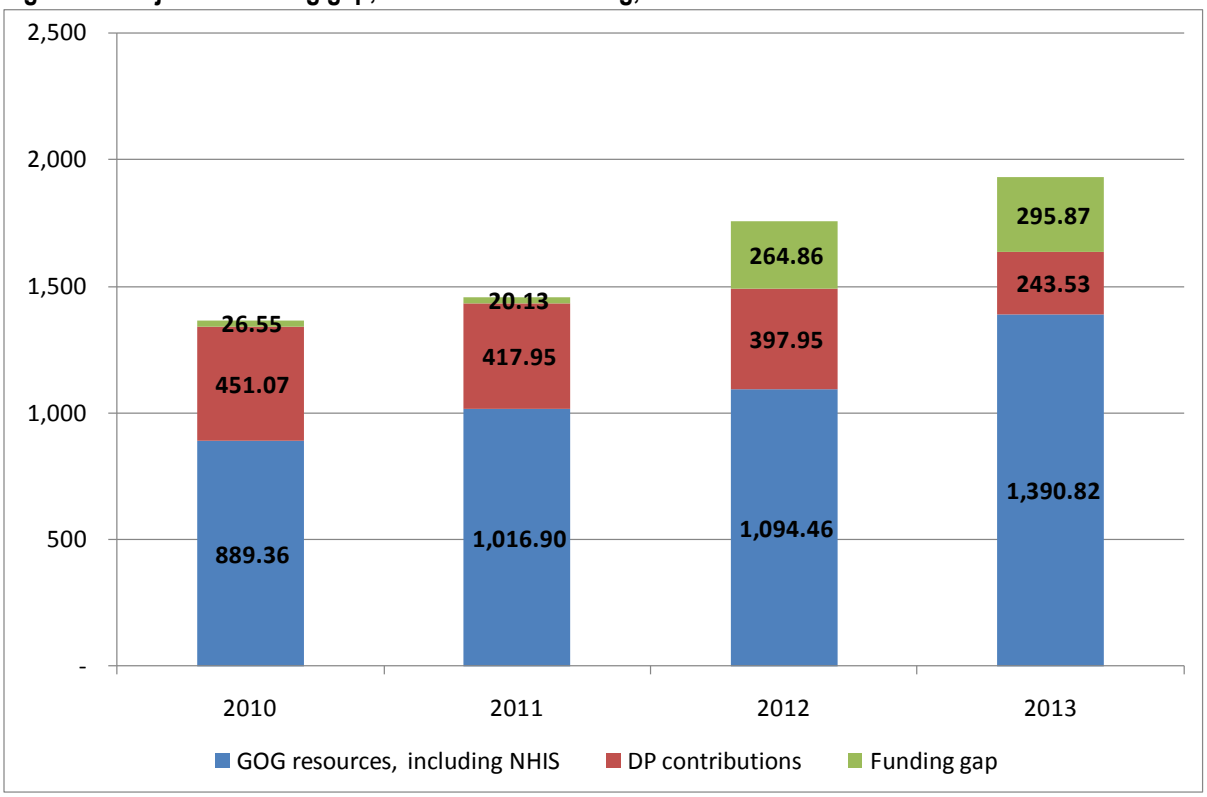
	2010	2011	2012	2013
Government expenditure	9,530.33	10,704.20	11,520.65	13,245.92
PHE (%)	9.3%	9.5%	9.5%	10.5%
PHE excl. SBS	889.36	1,016.90	1,094.46	1,390.82
Donor contributions	451.07	417.95	397.95	243.53
Total PHE	1,340.43	1,434.85	1,492.41	1,634.35

Note: Projected DP contributions are tentative

The figures in Table 9 represent an average annual increase of 7% over the period, indicating that between 2010 and 2013 the public health sector is expected to benefit from an additional inflow of around GH¢294 million.

Comparison of the projected funding with the estimated costs reveals a small deficit of 1-2% in the first two years, with the funding gap rising to around 15% of the expected costs in 2012 and 2013, as shown in Figure 10. It should, however, be borne in mind that the outer year projections for DP funding are low due to the short timeframe of external assistance, and there are a number of new loans currently in the pipeline which should help offset any reduction in grant aid due to Ghana's change in status to lower middle income.

Figure 10 Projected funding gap, constrained financing, GH¢ m



5.4 Expected Impact

On the assumption that any funding gap is filled, the HSMTDP is expected to contribute towards a 30.8% reduction in under-five mortality and a 30.5% reduction in maternal mortality. Impact on selected other key indicators is shown in Figure 11 below.

Figure 11 Expected impact on selected indicators

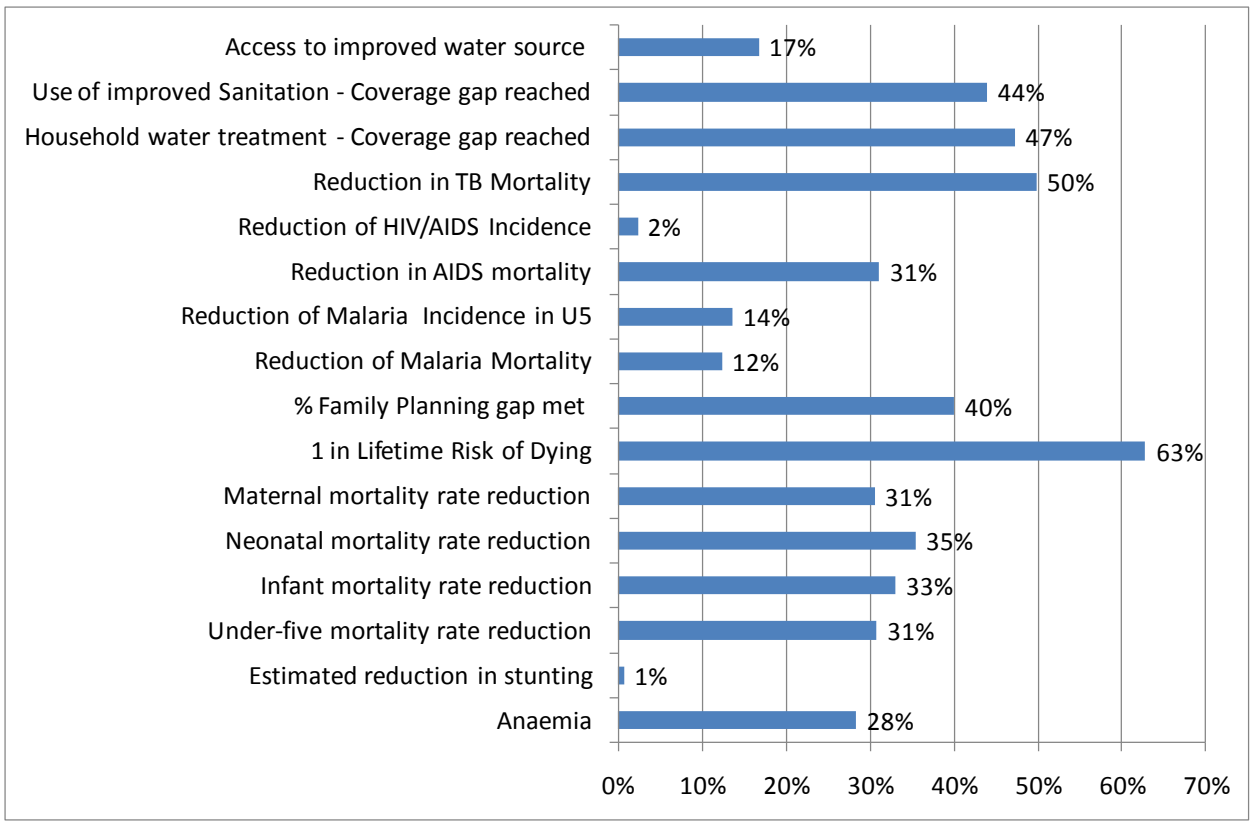


Figure 11 indicates that with the investments outlined in this plan, reductions of between 31% and 35% would be achieved in infant, neonatal, under-five and mortality rates. Relative reductions in under-five malaria incidence and in malaria mortality are predicted, at 14% and 12 % respectively, while mortality from AIDS and tuberculosis would show a greater decline. In terms of expanding access to important preventive and public health interventions, forty percent of the family planning gap could be closed, and even higher reductions in the treated water and sanitation coverage gaps.

6 MONITORING AND EVALUATION

The Ministry of Health has responsibility for monitoring and evaluating activities of the health sector. Over the years, a system for monitoring and evaluation has evolved and been institutionalised to track implementation, performance, and effects of health policies and strategies.

6.1 Routine monitoring

Progress in achieving the Sector Medium Term Strategic Objectives will be assessed against the extent to which key results are being achieved. A core set of sector-wide indicators and targets will be used to monitor the performance of the health sector. This is included as Annex '1'. The indicators are structured around the objectives of the strategic framework. To ensure continuation of the holistic assessment, most of the earlier indicators have been retained.

Progress made in achieving specific targets will form the basis for refining the annual programme and investments identified in the programme of work. Monitoring of strategic plan implementation will be done on a continual basis, and will involve a systematic process of collecting, analyzing and disseminating data to show improvements in programme management and to guide resource allocation. The monitoring and evaluation exercise will be integral to the management process of the health sector and will support learning and decision-making. Such monitoring will be closely linked to the implementation of the annual programme of work. It will involve quarterly collection and assessment of the performance of the different components of the programme of work. Specifically it will aim at determining whether activities are being implemented as planned, milestones are being achieved and outputs are being delivered. Monitoring will also involve tracking progress towards goals and objectives.

The indicators have been selected to reflect the existing data collection mechanisms within the health sector. In this regard, the Demographic and Health Survey (DHS), Multiple Indicator Cluster Survey (MICS), and the routine reporting system of the health sector will be a key means of tracking these projections. The projections are also based on analysis of past performances of the health sector, the expected inflow of resources and opportunities for change within the health sector. They also represent the need to attain both global and domestic targets for health development. There are areas where information is not readily available and therefore making precise projections has been difficult. However, steps will be taken to establish a baseline to allow for much more precise projections to be made in the course of implementation of the programme.

The governing Councils and Boards of the various Agencies will be primarily responsible for monitoring the performance of the various agencies and accounting for the use of resources and achieving the stated performance. In addition to fulfilling its obligation as required by the head of civil of service, the MOH will collate, analyse and disseminate data of sector wide performance as defined in the strategic plan. In addition to the quarterly monitoring and reporting system, the Ministry, DPs and Agencies will institute systems of joint monitoring visits to provide technical support to Agencies, and BMCs. These support visits will be structured and targeted primarily at assisting the health sector to improve performance in areas where performance is less than optimal.

6.2 Annual reviews

The annual review of the programme of work will continue to take place at all levels of the health system, from BMC through to sectorwide. Independent Annual reviews and evaluations will be conducted by external teams. In depth reviews of key areas will be conducted on a selective basis as part of the annual review process. The in-depth reviews will be in response to individual terms of reference related to specific issues, concerns and themes related to one or more component of the programme of work. The reviews will involve in-depth analysis of the context and variables affecting performance. It will aim at assisting the sector to make judgment on the relevance, efficiency, effectiveness, adequacy, sustainability and impact of components of the (or the whole) programme of work.

As part of the annual review, a Holistic Assessment is undertaken of the sector. This is an attempt to condense sector performance into a single indicator, and is one of the targets used in the annual Performance Assessment Framework for Multi-Donor Budget Support. Using a traffic light approach, the Holistic Assessment records whether progress against the Sector-Wide Indicators and Milestones (see below) has been positive, stagnant or negative. Due to the multiplicity of factors which might affect such performance, the overall result is subject to agreement as part of the sector dialogue.

6.3 Milestones

In addition to the sector-wide indicators, a number of milestones have been agreed as a means of monitoring sector progress in key areas. These are also considered in the annual Holistic Assessment exercise, and are presented in Table 10 below.

Table 10 Milestones for the HSMTDP

	2010	2011	2012	2013
HO1: Bridge equity gaps in access to health care and ensure sustainable financing arrangements that protect the poor	Roadmap for implementation of a common targeting approach for improved identification of the poor developed with MOH support	Revised staffing norms and deployment plan developed and implementation begun	Review of CHPS strategy undertaken with stakeholders, and re-zoning of CHPS completed	Financing strategy developed for the sector to ensure effective resource mobilisation
HO2: Strengthen governance and improve efficiency and effectiveness of the health system	Revised Health Bills submitted to Parliament	Leadership and management in-service training initiated	System for performance contracting introduced	Composite planning undertaken in 50% of districts
				2 questions included in DHS on client satisfaction and knowledge of patient charter
HO3: Improve access to quality maternal, neonatal, child and adolescent health and nutrition services	Midwifery certificate course for CHOs reactivated	50% of district hospitals equipped with Comprehensive EmOC equipment	Pneumococcal and rotavirus vaccines successfully introduced	90% of district hospitals and 70% of health centres equipped with C/BEmOC equipment respectively
				Adolescent health corners established in 30 hospitals
HO4: Intensify prevention and control of communicable and non-communicable diseases and promote healthy lifestyles	National cancer plan developed	Universal coverage of ITN/Ms achieved	Healthy lifestyles integrated into basic school and teacher training college curricula	Emergency response strategy for diseases of epidemic potential reviewed
		Elimination status of Guinea Worm and polio maintained	50% reduction in Yaws prevalence achieved	Elimination status of guinea worm and polio maintained
HO5: Strengthen institutional care, including mental health service delivery	Referral policy and guidelines developed	Community mental health strategy developed	Functional ambulance stations in 60% of district capitals	2 additional half-way homes established for re-integration of former psychiatric patients

7 COMMUNICATION STRATEGY

With the development of the Ghana Shared Growth and Development Agenda and commitments to attaining the Millennium Development Goals, the Health Sector Medium Term Development Plan (HSMTDP) 2010 – 2013 is focused on responding to the salient issues related to health development. The plan reflects the government's development agenda for the medium term and aligns previous policies with the national objective of attaining middle income status by 2020.The actions are designed to have a direct impact on attaining MDGs 1b, 4, 5 and 6 and to catalyzing responses in other sectors whose actions are essential in attaining goals.

7.2 Focus of the communication plan

The efficient delivery of the HSMTDP requires a clear understanding on the part of all staff of the organization, the sector collaborators and partners and all stakeholders including the beneficiaries of the programmes. The **objective** of this communication plan is "*to disseminate and create awareness on the HSMTDP among key stakeholders and generate feedback to promote ownership and attainment of the goals, objectives and targets of the strategy*".

In communicating the Health Sector Medium Term Development Plan, this communication strategy attempts to put together a coherent plan of action. The strategy will take three factors into account simultaneously:

1. Clear articulation of the goals, objectives and targets to be achieved by the various constituencies and partners;
2. Promoting understanding of the possible operational constraints and imperatives and what is required to innovatively address or mitigate any adverse effects
3. Establishing pertinent conditions in the environment that exist about the health sector and shaping the perceptions in favour of the sector

The information and feedback generated from the communication activities should bring the perspectives of the stakeholders into the annual planning and decision-making. This will enable programmes implemented to be appropriately delivered in a structured way that fits the target audience needs.

7.3 Audiences

The main audience to be targeted for this activity will include all the management and staff of the Ministry of Health and its agencies; health development partners, service providers in the private, non-government and civil society sector including organized labour unions, community leaders, district assemblies and other ministries, departments and agencies whose activities directly contribute to the attainment of the sector goals and objectives. Through an interactive dialogue, the various roles and responsibilities will be articulated and agreed. Cross cutting themes, areas of collaboration and joint action will be identified. The communication process will also be used to refine joint monitoring and evaluation processes.

7.4 Channels and tools of communication

Different channels of communication will be employed. These will include seminars, workshops, durbars, media engagement and broadcast activities. The HSMTDP will be translated into two page briefs and simple flyers to support the communication process. Frequent press releases and press pull-outs will also be used to inform the public on progress being made on specific areas of greatest impact. The HSMTDP, its review and progress reports will also be published on the internet so it is easily accessible to both the national and international community. Table 11 below maps the various stakeholders planned activities and proposed budget.

Table 11 Communication activities 2011-2012

Stakeholders	Content	Channel	2011	2012	2013	Lead Agency/ Person
Health sector senior management at all levels	The health sector goals and objectives and their role as stewards for implementation and attainment of the priority activities and targets	Seminar at the national, regional and district level	Jan - March	April, Nov	April, Nov	Chief Director, MoH
Media	Key priorities and the expected output of the health sector	• Press conference • Press release • Feature articles • Pull-out centre spread • Website of MoH and its agencies	January	January	January	Public Relations Unit of the MoH
Health Partners	Goals, objectives, targets and progress in implementation	• Partners meeting	Jan, April, Nov	April, Nov	April, Nov	PPME Division, MoH
NGOs and private sector including service providers, pharmaceutical and chemical product sellers, spa, health and wellness shops	Goals, objectives, priorities, targets and progress in implementation and their responsibilities for achieving them	Seminar at the national, regional and district level ; Brochures	Jan, April, Nov	Jan, April, Nov	Jan, April, Nov	PPME Division and PR Unit MoH with support agencies
MDAs: Women and children affairs; finance; information; education; local	Goals, objectives, priorities, targets and progress in implementation and their responsibilities for achieving	Seminars; Policy brief; brochures	May	May	May	PPME Division and PR Unit MoH with support agencies

Stakeholders	Content	Channel	2011	2012	2013	Lead Agency/ Person
government; NADMO; food and agriculture; department of social welfare; works, water and housing; EPA;	them					
Civil society and community members	Goals, objectives, priorities, targets and progress in implementation and their responsibilities for supporting implementation and monitoring impact at the community level	Durbars and Community center meetings; flyers and briefs	Sept	Sept	Sept	PPME Division and PR Unit MoH with support agencies
General public	Goals, objectives, priorities, targets and progress in implementation and their responsibilities for supporting implementation and monitoring impact at the community level	Footage and media scroll bars; web-site of MoH and its agencies; Public announcements including use of information vans; flyers	Jan-Dec	Jan-Dec	Jan-Dec	PPME Division and PR Unit MoH with support agencies

8 BIBLIOGRAPHY

Health System Building Block	Reference documents
Leadership and governance	1. MoH, National Health Policy, 2007 2. MoH. Health Sector Gender Policy, 2009 3. MoH, Independent Reviews of the health sector programme of work 2007, 2008 and 2009
Health service delivery	4. MOH & UN, Millennium Development Goals Acceleration framework, Country Action Plan, 2010 5. GHS, Regional Plans for Rolling Out CHPS – PPME 6. Ghana Country Coordinating Mechanism for Global Fund Grants, CCM Strategic Plan 2010-2015 7. WHO/APOC 2010. Proceedings from the 33rd Joint Action Forum meeting, Abuja December 2010 8. Ghana Demographic and Health Survey 2003, 2008; Ghana Statistical Sevices
Human resources	9. IOB 2010 Facilitating resourcefulness: evaluation of Dutch Support to capacity development; draft December 22 10. MoH, Human Resource Policy and Strategies for the Health Sector, 2007-2011
Health financing	11. MoH, Public Financial Management Strengthening Issues Paper, December 2008 12. MoH, PFM Strengthening action framework, 2009 13. NHIS, Draft policy and legislative proposals for reform of the National Health Insurance Schemes, October 2009 14. Seddoh A, Adjei S, Akpabli E, Nazzar A, Satara F, and Bentum B (2010) Commentary and observations on the National Health Insurance Scheme; CHeSS: Accra draft December 15. World Bank, Investing in Health in Ghana: A Review of Health Financing and the National Health Insurance Scheme, May 2009 (draft)
Health information	16. MoH/HMN, Health Information Management Strategic Plan 2007 to 2011 (draft) 17. Ghana Aids Commission, NSP, 2011-2015
Health technologies	18. MoH, Progress Report on Implementation of 2007 Capital Investment Plan 19. MoH, 2009 Performance/Annual Report – Capital Investment Management Unit, PPME 20. MoH, 2009 Capital Investment Plan – Capital Investment Management Unit, PPME 21. Joint Review of Emergency Obstetric Equipment, 2009 22. The Pharmaceutical Sector in Ghana Policy note MOH and WB, December 2008 23. Commodity Security Study, 2009; 24. Draft Pharmaceutical Sector Strategy, 2010-2013 25. Ghana Aids Commission, NSP, 2011-2015
Partnership development	26. Common Management Arrangements, May 2010
Research for health	27. MoH, Health Research Agenda, 2007 (draft) 28. Centre for Health and Social Service, Dr. Sam Adjei et al. Literature review of the key issues and suggested areas for further research in Ghana, 2010 (draft)

ANNEX A: HEALTH SECTOR CORE SET OF INDICATORS

	Indicators	Baseline 2008	Targets 2010 - 2013				Data sources	Measurement	Monitoring Frequency
			2010	2011	2012	2013			
Health Policy Objective 1 **Bridge equity gaps in access to health care and nutrition services and ensure sustainable financing arrangements that protect the poor**									
1	% children 0-6 months exclusively breastfed	62.8	N/A	N/A	70	70	DHS / MICS-Survey	% infants who received only breast milk and vitamins, mineral supplements, or medicine in the 24 prior to the interview	5 years / 3 years
2	Equity Index: Poverty (U5 Mortality Rate)	1: 2.18	N/A	N/A	1 : 1.5	1 : 1.5	DHS / MICS	Ratio of lowest to highest quintiles for U5MR	5 years / 3 years
3	Equity Index: Geography (services - supervised deliveries)	1 : 1.97	1 : 1.9	1 : 1.8	1 : 1.7	1 : 1.6	RCH Annual Report-Routine	% Deliveries attended by a trained health worker, ratio of lowest to highest region (TBAs not included)	Annual
4	Equity Index: Geography (resources – Nurses : Population)	establish new baseline	Reduce by 0.2	Reduce by 0.2	Reduce by 0.2	Reduce by 0.2	Payroll data	Nurse: population ratios for highest and lowest regions	Annual
5	Equity Index: NHIS Gender (Female/Male Card Holder Ratio)	1 : 0.92	1 : 0.92	1 : 0.92	1 : 0.92	1 : 0.92	NHIS	NHIS cardholders above 18 years, (ratio of Female / Male)	Annual
6	Equity Index: NHIS Poverty (Ratio lowest quintile to whole population who holds NHIS cards)		N/A	N/A	N/A		DHS / MICS / GLSS	NHIS cardholders; ratio of lowest to average population socio-economic groups	5 years/3 years
7	Outpatients attendance per capita (OPD)	0.77	0.82	0.85	0.88	1.0	CHIM-Routine	Total OPD encounters / population	Annual
8	Access to Health facility (Geographic)	N/A	N/A	N/A	N/A	N/A	DHS / GLSS	% population live within 8km of a health centre (level B facility or higher)	Periodic
9	Doctor : population ratio	1:13,449	1:11,500	1:10,500	1:9,700	1:9,500	IPPD	No. doctors / population	Annual

	Indicators	Baseline 2008	Targets 2010 - 2013				Data sources	Measurement	Monitoring Frequency
			2010	2011	2012	2013			
10	Nurse : population ratio	1 : 1,353	1 : 1,100	1 : 1000	1 : 900	1 : 800	IPPD	No. nurses / population	Annual
Health Policy Objective 2 Strengthen governance and improve efficiency and effectiveness in the health system									
1	% total MTEF allocation to health		14.9	11.5	15	≥15	≥15	Budget statement, MOFEP	Total MTEF expenditure is defined as total GOG allocation to health
2	% non-wage GOG recurrent budget allocated to District level and below		49	50	50	50	50	MOH budget	% Items 2 and 3 budget allocated to the district level and below
3	Per capita expenditure on health		23 (US$)	26 (US$)	28 (US$)	30 (US$)	31 (US$)	MOH Financial report,	Health expenditure / population
4	Budget execution rate (Item 3 as proxy)		97%	≥95	≥95	≥95	≥95	Financial Report	Total disbursement / total Budget
5	% of annual budget allocations to items 2 and 3 (GOG and SBS) disbursed to BMCs by end of June		23	40	42	50	50	MOH Financial Report	Disbursement of item 2 and 3 for GOG and SBS at end of June
6	% of population with valid NHIS membership card		45	60.2	65	70.3	75	NHIA Annual Report	No. people with NHIS membership/ Annual population
7	Proportion of NHIS claims settled within 12 weeks		N/A	40%	60%	70%	80%	NHIA and GHS Annual Reports	Time of reception of claims by DMHIS to reception of reimburse-ment of claim to facility
8	% of IGF from NHIS		66.5	70	70	75	75	MOH Finance division	Total claims paid /total IGF
Health Policy Objective 3 Improve access to quality maternal, neonatal, child and adolescent health services									
1	Maternal mortality rate per 100,000 live births		451	N/A	N/A	N/A	226	Maternal Mortality survey	Deaths per 100,000 live births,
2	Total fertility rate		4.0	N/A	N/A	3.8	3.8	DHS	Average number of children per woman

	Indicators	Baseline 2008	Targets 2010 - 2013				Data sources	Measurement	Monitoring Frequency
			2010	2011	2012	2013			
3	Institutional Maternal Mortality rate per 100,000 live births		196	185	170	160	150	CHIM- Routine data collection	Maternal deaths recorded in health fac. /100,000 live births
4	% of pregnant women attending at least 4 Antenatal visits		62.4	70.0	74.6	80.1	85.7	CHIM- Routine data collection	
5	Infant Mortality Rate (IMR) per 1,000 live births		50	N/A	N/A	<30	<30	DHS/MICS- Survey	The number of deaths of infants below one year of age (between 0 and 364 days after birth) per 1,000 live births during a given period of time
6	Under 5 Mortality Rate (U5MR) per 1,000 live births		80	N/A	N/A	<50	<50	DHS/MICS- Survey	The number of deaths of children below 5 years of age, expressed per 1,000 live births during a given period of time
7	% deliveries attended by a trained health worker		39.4	50.3	55.6	60.2	65	DHS/CHIM-Routine and Surveys	Number of deliveries supervised by a trained health worker/ total expected number of deliveries (TBAs should not be included)
8	Under 5 prevalence of low weight for age		13.9%	N/A	N/A	8.0%	8.0%	DHS/MICS- Survey	% of children who are below -2 standard deviation units (SD) from the median NCHS/ CDC/ WHO International reference population.

	Indicators	Baseline 2008	Targets 2010 - 2013				Data sources	Measurement	Monitoring Frequency
			2010	2011	2012	2013			
Health Policy Objective 4 Intensify prevention and control of communicable and non-communicable diseases and promote lifestyles									
1	HIV+ prevalence among pregnant women 15 – 24 years		2.2	<1.9	<1.8	<1.7	<1.6	NACP - Sentinel surveillance sites	% of pregnant women aged 15-24 years who are tested HIV+ at NACP sentinel sites
2	% of U5s sleeping under ITN		40.5	50	65	70	75	NMCP / MICS / DHS- Survey	% children 0-59 months who slept under an ITN during the previous night
3	% of children fully immunized by age one - Penta 3		86.6	87.9	89	91.4	93.5	EPI / DHS- Routine and Survey	No. children 12-23 months who received Penta 3 vaccination / no. children aged 12-23 months (Use periodic to verify)
4	HIV+ clients receiving ARV therapy [5]		23,614	51,814	65,914	80,014	94,114	NACP- Routine	Number of people with HIV infection receiving ARV combination treatment:
5	Incidence of Guinea Worm		501	<100	<70	<50	0	Guinea worm eradication programme - Routine	Number of new guinea worm cases registered during the year
6	% of households with improved sanitary facilities		11.3	N/A	N/A	21.3	21.3	MICS-Survey	% population or households who use improved sanitation facilities, MICS
7	% of households with access to improved source of drinking water		77.3	N/A	N/A	80	80	MICS-Survey	% of population or households using safe drinking water

	Indicators	Baseline 2008	Targets 2010 - 2013				Data sources	Measurement	Monitoring Frequency
			2010	2011	2012	2013			
8	Obesity in adult population (women aged 15-49 years)		30%	N/A	N/A	N/A	28%	DHS-Survey	% of population who are clinically obese (check if all women)
9	TB treatment success rate		85	87	90	90	90	NTP-Routine	Percentage of patients who are proven to be cured using smear microscopy at the end of treatment
Health Policy Objective 5 Strengthen institutional care, including mental health service delivery									
1	Psychiatric patient treatment and rehabilitation rate		Baseline to be established	10% over base-line	15% over baseline	25% over baseline	30% over baseline	Clinical data analysis and routine reporting	Percentage of Psychiatric Patients rehabilitated and integrated into the society in a year
2	Equity Index: Ratio of mental health nurses to patient population		Baseline to be established	5% over baseline	10% over baseline	25% over baseline	30% over baseline	HR data analysis and field validation then routine reporting	The total number of Nurses / total patient population
3	Number of community psychiatry nurses trained and deployed		Baseline to be established	5% over base-line	10% over baseline	25% over baseline	30% over baseline	HR data analysis and field validation then routine reporting	Number of nurses successfully trained and deployed to deprived areas
4	% tracer psychotropic drug availability in hospitals		Baseline to be established	70%	70%	75%	80%	Facility level drug inventory analysis and routine reporting	All hospitals to health centre level have basic psychiatric drugs that promote community psychiatry
5	Institutional Infant mortality rate		Baseline to be established					Routine facility level reporting	Number of infant deaths occurring in all health facilities per 1,000 live births

	Indicators	Baseline 2008	Targets 2010 - 2013				Data sources	Measurement	Monitoring Frequency
			2010	2011	2012	2013			
6	% of critical equipment functioning in hospitals		Baseline to be established	80%	80%	80%	85%	Facility level equipment assessment and routine reporting	% of X-ray and other core equipment functioning in hospitals using man working days
7	% Tracer drug availability in hospitals		68%	80%	85%	90%	90%	Pharmaceutical data assessment and Routine facility level reporting	Hospitals meet minimum stock levels of accepted essential drugs list
8	% of hospitals assessed for quality assurance and control		Baseline to be established	70%	80%	90%	100%	Annual clinical surveys	Hospitals assessed with the QA tools and meeting minimum standards
9	Institutional under-five mortality rate								

ANNEX B: POCC TABLE

ISSUES	POTENTIAL	OPPORTUNITIES	CONSTRAINTS	CHALLENGES
Inequitable access to health services between urban and rural dwellers and between the rich and poor	• Removing completely the financial barrier at point of service delivery through insurance and other mechanisms • Expanding public financed health infrastructure and outreach services at all levels • Increased private sector participation in health service provision and human resource training • Increasing coverage and efficiency of the NHIS	• Expanding primary health care services including scaling up CHPS through District Assemblies and private sector participation • Increasing human resource production capability with private sector participation • Oil/gas revenues and drive to meet the Abuja target of 15% government allocation to health	• In adequate resources for rapid expansion of CHPS • Weak HR policy and training facilities to meet production and distribution targets • Resource cuts and limited avenues for resource mobilisation to increase financing • Absence of private sector growth strategy and concessionary investment loans for private health sector growth in deprived areas	• Poor economic development infrastructure • Unaligned and unpredictable DP/government funding • Politically-driven health infrastructure development • Difficulty in deploying/ attracting personnel to deprived areas • Socio-cultural barriers affecting health seeking behaviour
Weak stewardship and coordination mechanisms	• Vestiges of SWAp present with commitment of various partners to the principles of the Paris Declaration and the Accra Agenda for Action • Increased understanding of the roles and responsibilities of the various agencies and institutions within the public sector with a commitment to let the MoH lead • Culture of multi-sector coordination and linkages growing • ICT and e-health use to increase efficiency	• Changing global aid architecture and expanding portfolio of major players under country led systems • Commitments to review major regulatory and institutional management Acts, Regulations and Legislative Instrument to respond to changing environment • Government/ DP willingness to support institutional strengthening and capacity building activities	• Inadequate leadership to provide direction and oversight to the health sector • Insufficient policy analysis, strategic planning, supervision, monitoring and evaluation capacity of MoH • Increasing project type funding and fragmentation in project implementation perpetuated by DPs • Antiquated laws/ limited capacity of key institutions to implement their mandate • limited evidence for policy and strategic planning	• Unavailability of skilled personnel to be appointed into key health sector senior management positions • Slow acceptance to changes in roles and responsibilities occurring in the health sector • DP continuing and increasing preference for project type funding • District Assemblies/GHS/DHA slow response in engaging each other for effective health planning
Inadequate access to maternal, child	• Drive to attain MDGs provide framework for increased emphasis. Ghana on track	• Several strategies and approaches being deployed simultaneously:	• Weak institutional stewardship for maternal and child health • Inadequate human resource,	• Limited resources for funding maternal, child and adolescent health services

ISSUES	POTENTIAL	OPPORTUNITIES	CONSTRAINTS	CHALLENGES
and adolescent health services including nutrition	with MDG 1b and 4 • Known and proven interventions available with affordable technology to support • Strong government and development partners commitments to attain MDG 5	Free maternal care services; Accelerated child survival programs; integrated maternal and child health campaigns; CHPS; High Impact Rapid Delivery; Child Health Policy; Improved EmOC equipment provision; Family planning; MDG Acceleration Framework (MAF) • Expanding private sector involvement in maternal and child health service delivery • Increasing role identified for NGO and CSOs in adolescent health service provision • Provision of supplementary feeding and health education	poor staff attitude and skills mix to provide services • Inequitable availability, quality and access to services • Inefficient emergency response and referral systems • Inconsistent application of policies, standards and protocols • Poor uptake of family planning services • Weak integration of the private health sector and NGOs in attaining maternal, child and adolescent health goals and targets	• Inadequate inter-sector collaboration and economic development infrastructure to promote access to services • Insufficient country specific evidence to shape policy and strategy development • Inadequate use of technology to promote access to essential maternal and child health information • Diversification of food intake amongst poor households (food insecurity).
Double burden of communicable and non-communicable	• Adequately developed service delivery backbone to accelerate the attainment of MDG 6 with support of government and development partners • Significant progress attained against diseases targeted for elimination • Integrated communicable diseases surveillance and epidemic alert system established • Integrated primary health care services delivered at various levels with improved access to clients following introduction of NHIS	• Continuing availability of dedicated funds from development partners particularly Global Fund and GAVI to support service delivery • Introduction and adoption of affordable new vaccines, diagnostics, technologies and medicines to tackle specific conditions and ailments • Mainstreaming of the Regenerative Health programme and the introduction of the Better Ghana Agenda • Increased coverage of the NHIS and efficient management of the claims system	• Low case detection rate for specific conditions and diseases • Absence of a comprehensive data-base and national framework for tackling non-communicable diseases • Inconsistent flow of budgetary resources from both government and development partners • Inadequate project proposal writing and management capacities to mobilise available resources • Limited human resources and human resource management skills at the lower level to leverage efficient service delivery • Insufficient understanding and inconsistent application of	• Rapidly changing sector priorities and political/DP agenda for the health sector • Inadequate financing of the health sector • Rapid urbanisation and changing lifestyle of the population • Effect of environmental factors outside the direct purview of health that increase the burden of disease • Poor health seeking behaviour and adherence to treatment requirements among the general population • Inadequate capacity to

ISSUES	POTENTIAL	OPPORTUNITIES	CONSTRAINTS	CHALLENGES
			policies, guidelines, standards and norms • Inconsistent data and evidence for policy and planning	engage ICT companies to make their platforms available for health promotion activities
Weak management of clinical health care services including mental health services	• Availability of comprehensive capital and equipments investment plans • Growing number of both public and private health care facilities across the country • Increased investment in upgrading health facilities, technologies and equipments over the past decade • Availability of standard treatment protocols and guidelines • A growing Ambulance and Blood Safety services • Growing and distinct emphasis on comprehensive mental health care	• Expanding public and private health sector with opportunities for growth in the private sector • Standardisation of diagnostic and treatment protocols and services for both the private and public sector with the introduction of the NHIS • Increased avenues for Continuing Professional Development to enhance mid-level and specialist skills • Growing skills mix and the development of the polyvalent worker to promote decentralisation of mental health service provision at all levels of the health system	• Inadequate HR, poor staff attitude and quality of services delivered in health facilities • Insufficient understanding and application of standard treatment protocols and guidelines • Poor supervision and organisation of services including for mental health • Absence of effective policy and guidelines for integrating mental health services into main service delivery systems • Weak and underperforming emergency services and referral systems • Inability to rapidly expand infrastructure and implement equipment maintenance and replacement plan	• Inadequate funding to initiate and complete development programmes • Poor prioritisation and inefficient clinical care development due to politically-driven infrastructure development • Weak collaboration between the Ministry of Health and professional associations and regulatory bodies to promote efficiency and introduce effective sanctions for poor performing professionals • Negative public attitude towards mental health patients and their reintegration into society