Ministry of Health
Ghana

Holistic Assessment of the Health Sector Programme of Work 2013

Ghana

Final version 30th July 2014

List of abbreviations and acronyms

ART	Antiretroviral Therapy
CHAG	Christian Health Association of Ghana
CHPS	Community Health Planning and Service
CIP	Capital Investment Plan
DFID	UK Department for International Development
DHIMS	District Health Information Management System
DMHIS	District Mutual Health Insurance Scheme
EmOC	Emergency Obstetric Care
EmONC	Emergency Obstetric and Neonatal Care
EPI	Expanded Programme on Immunisation
FP	Family Planning
GHS	Ghana Health Services
GOG	Government of Ghana
HIRD	High Impact Rapid Delivery
HMIS	Health Management Information System
HR	Human Resources
HRD	Human Resource Directorate
IGF	Internally Generated Funds
IMR	Infant Mortality Rate
ITN	Insecticide Treated Net
KATH	Komfo Anokye Teaching Hospital
KBTH	Korle-Bu Teaching Hospital
MDG	Millennium Development Goal
M&E	Monitoring and Evaluation
MICS	Multiple Indicator Cluster Survey
MMR	Maternal Mortality Ratio
MoH	Ministry of Health
MTEF	Medium Term Expenditure Framework
NCD	Non-Communicable Disease
NDPC	National Development Planning Commission
NHIA	National Health Insurance Authority
NHIF	National Health Insurance Fund
NHIS	National Health Insurance Scheme
OPD	Out-Patient Department
POW	Programme of Work
PPME	Policy, Planning, Monitoring and Evaluation
SBS	Sector Budget Support
TBA	Traditional Birth Attendant
TH	Teaching Hospital
U5MR	Under-Five Mortality Rate
WHO	World Health Organisation

Acknowledgements

The holistic assessment of the health sector 2013 Programme of Work was done internally by the Ministry of Health. A team of six people from Ministry of Health and Ghana Health Service undertook the review and holistic assessment. The members of the team were Dr. Afisah Zakariah, Daniel Degbotse, Dan Osei, Dr. Anthony Ofosu, Nicholas Nyagblornu and Dr. Andreas Bjerrum.

The team would like to thank all individuals who contributed to this review and who kindly gave their time and support to the review process.

Executive summary

Performance in 2013 was mix with an overall assessment score of zero. This implies minimal or no progress made during the year. Equity gap using supervised delivery as proxy widened with Volta region consistently underperforming. Upper West Region was the star-performing region with supervised delivery coverage of 67.5%

Wide variations in the distribution of doctor exist compared with Nurses. Greater Accra Region employs more than 50% of all government-employed doctors in Ghana, although about 50% of these are house officers in training at the Korle-Bu Teaching Hospital. The nurse population ratio improved by 20% over 2012. This is closer to the WHO target of 1 nurse per 1,000 citizens.

The Ministry of Health Financial Report for the year ended 31st December 2013 reported variations in funding and spending patterns relative to the same period in 2012. The contribution from donors was GH¢342.4 million in the reporting year whilst there was GH¢266.0 million contribution in the same year of the previous year, an increase of 28.7%. Internally Generated Fund (IGF) increased by 28.7% from GH¢442.3 million in 2012 to GH¢569.19 million in 2013. Government of Ghana contribution decreased by 13.1% from GH¢1,750.0 million in 2012 to GH¢1,521.0 million in the current year

The Ministry recorded a total expenditure of GH¢ 2,709.4 million for the year under review. Out of this amount, 57.3% was for Employee Compensation as against 63.1% for the same year of 2012. Expenditure incurred on Goods and Services was 31.1% as compared to 34.8% in 2012 whilst that incurred on Assets was 11.6% compared to 2.2% in 2012.

Active membership of The National Health Insurance scheme was 36.8% in 2013, an increase of 10% from 2012 to 2013. The bulk of public health care services rendered are financed through the NHIS. About 81.9% of all internally generated funds of health facilities are from the NHIS. Over 80% of total outpatients were insured while only 36% of the population were active NHIS members, an indication of higher utilization by active members.

Capitation pilot undertaken in the Ashanti region was evaluated. The results indicated a 10% increase in NHIA active membership after an initial drop of 20% between 2011 and 2012, and a reduction in OPD per capita for insured clients and a reduction in claims under G-DRG. About 89% of clients rated services provided by providers as satisfactory. Due to the successful pilot in the Ashanti, three regions (Upper West Region, Upper East Region and the Volta Region) have been earmarked for scale-up of capitation as a provider payment mechanism as part of overall strategy to gradually scale up capitation to all the regions.

FP acceptor rate increased by 4.5% from 24.9% in 2012 to 26.1% in 2013. In the same period, Couple Year Protection (CYP) increased from 1,222,920 to 1,592,981. Northern and Ashanti Region continue to have the lowest performance. Challenges exist in data quality and reporting. The family health division of the Ghana Health Service is working to improve reporting quality and analysis by distributing a data-dictionary for MCH indicators.

Antenatal Care coverage dropped from 72.3% in 2012 to 66.3% in 2013. Eight (8) out of the 10 regions experienced decline in coverage despite improving midwife/population ratio. Dropout rate between ANC 1

and ANC 4+ is exceptionally huge. Analysis by the GHS reveals that 17% of all pregnant women register in the 3rd trimester and this influences the coverage of ANC4+. Only 45% of pregnant women make their first ANC visit in 1st trimester.

Skilled delivery coverage was 55.3% in 2013, a slight increase from 55.0% in 2012. Seven out of ten regions, however, experienced a decline in the skilled delivery rate.

EPI coverage has stagnated at around 86% on the average over the past three years. Extra efforts would be needed to increase coverage to 90%, which is the target for achieving herd immunity.

HIV/ AIDS programmed indicators generally experienced decline during the year. The target for HIV testing and counselling was 878,696 and the sector achieved 695,929 (79%) compared to 856,583 in 2012. This is a reduction of almost 20%. Prophylaxis for pregnant women was targeted to be 17,639 while the result in 2013 was 7,266 compared to 7,781 in 2012. Coverage for testing infants born from infected mother was 32%. There were logistical and financial challenges in 2013 with respect to delivery of ARVs. The number of HIV patients receiving ARV therapy continued to increase in 2013. The number came to 75,762 but did not reach the goal of 94,114.

No case of Guinea worm was reported during the year 2013. As part of Ghana's effort to ensure certification of no Guinea Worm, a reward system of GH¢200 has been institutionalized to motivate reporting of any hanging worm.

The target for reported TB cases in 2013 was 19,386. The sector achieved 15,473 (80%) by December 31st 2013. TB treatment success rate for the 2012 cohort (reported in 2013) improved to 86.2%, which is slightly above the 2011 cohort. This exceeds the World Health Organisation's target of 85%.

The total number of infant deaths recorded at facilities in Ghana increased from 8,077 to 8,561. Northern Region recorded the highest institutional infant deaths per 1,000 institutional live births of 21.9/1,000 live births.

The total number of maternal deaths increased from 899 in 2012 to 1,016 in 2013, but since the number of skilled deliveries experienced a similar increase, the institutional maternal mortality ratio was unchanged. GHS and the Teaching hospitals plan collaborate on improving the network for referring women in labour. This is expected to facilitate referrals between levels within GHS and between GHS and teaching hospitals. Ashanti Region will pilot the improved network.

1. Introduction

The year 2013 represented the last year of the implementation of the current Health Sector Medium Term Development Plan (2010-2013). The review has placed emphasis on the performance of the sector according to identified health objectives as outlined in the Four-Year Sector Medium Term Development Plan and the derived Annual Programme of Work for 2013. The review assessed the overall sector performance for the year 2013 using the agreed Holistic Assessment tool. The Holistic Assessment tool was adopted in 2008 and has been used to assess the sector performance since then.

Since no population surveys were conducted in 2013, the analysis of indicators and trends are based on routine data alone.

The report is organized into eight chapters. The first chapter provides the background to this report. Chapter 2 deals with the health sector performance using the holistic assessment tool. Third chapter discusses the trends of sector wide indicators. Chapter four provides an assessment of regions of excellence and regions requiring attention. Fifth chapter looks at the implementation status of the programme of work 2013. Chapter six summarises the recommendations by the review team. Chapter seven is a brief report of the agencies performance. The conclusion of the holistic assessment is presented in chapter eight. Annexes are provided with further details of the basis of the analysis.

2. Assessment of the Health Sector Performance in 2013 using the Holistic Assessment Tool

The purpose of the holistic assessment is to form a basis for a balanced discussion between the Ministry of Health, its agencies and development partners to reach a common conclusion of the sector's performance. The outcome of the initial assessment is a sector score of zero, which is interpreted as sustained performance. For the detailed analysis of the indicators and the holistic assessment calculations, please refer to (Annex 2: Holistic Assessment Tool and Analysis).

Health Objective 1	1
Health Objective 2	0
Health Objective 3	-1
Health Objective 4	+1
Health Objective 5	-1
Sector score	**0**

Table 1: Sector Score 2013

Table 1 shows the overall scores for the five Health Objectives in the HSMTDP 2010-2013. Table 2 provides a detailed overview of the indicators and trends from 2007 to 2013.

		2007	2008	2009	2010	2011	2012 POW 2012	Target	Performance	Source
Health Objective 1: Bridge equity gaps in health care and nutrition services and ensure sustainable financing arrangements that protect the poor										
1	% children 0-6 months exclusive breastfed	-	62.8%	-	-	-	45.7%	-	-	
2	Equity: Poverty (U5MR)	-	1.72	-	-	-	2.04	-	-	
3	Equity: Geography - Services (supervised deliveries)	2.47	2.17	1.49	1.64	1.64	1.53	1:1.60	1.56	DHIMS II
4	Equity: Geography - Resources (nurse: population)	2.26	2.03	1.84	1.99	1.73	1.86	1:1.90	1.99	MOH
5	Equity: NHIS – Gender	-	1.27	-	-	-	1.23	-	-	
6	Equity: NHIS – Poverty	-	0.82 (F)	-	-	-	0.69 (F)	-	-	
7	Outpatients attendance per capita (OPD)	0.69	0.77	0.81	0.92	1.05	1.17	1.0	1.16	DHIMS II
8	% population living within 8 km of health infrastructure	-	-	-	-	-	-	-	-	-
9	Doctor: population ratio	1:13,683	1:13,499	1:11,649	1:11,698	1:10,217	1:11,515	1:9,500	1:10,170	MOH
10	Nurse: population ratio	1:1,537	1:1,353	1:1,494	1:1,516	1:1,262	1:1,362	1:800	1:1,084	MOH
Health Objective 2: Strengthen governance and improve efficiency and effectiveness in the health system										
1	% total MTEF allocation on health	14.6%	14.9%	14.6%	15.1%	15.8%	15.4%	≥15.0%	15.2%	MOH
2	% non-wage GOG recurrent budget to district level and below	49.0%	49.0%	62.0%	46.8%	55.3%	38.5%	50%	-	
3	Per capita expenditure on health	23.0	23.2	25.6	28.6	35.0	50.7	≥31 USD	42.0	MOH
4	Budget execution rate (Item 3 as proxy)	110.0%	115.0%	80.4%	94.0%	82.1%	86.8%	≥95%	54.9%	MOH
5	% of annual budget allocations disbursed to BMC by end of year	-	23.0%	38.9%	30.8%	89.8%	-	50%	-	-
6	% of population with valid NHIS membership card	-	-	-	33.1%	32.8%	33.3%	75%	36.8%	NHIA
7	Proportion of claims settled within 12 weeks	-	-	-	-	-	-	80%	-	-
8	% IGF from NHIS	N/A	66.5%	83.5%	79.4%	85.0%	-	75%	81.9%	MOH/GHS
Health Objective 3: Improve access to quality maternal, neonatal, child and adolescent health services										
1	Maternal Mortality Ratio (MMR) per 100,000 live births	-	451	-	-	-			-	
2	Total Fertility Rate	-	4.0	-	-	-	4.3		-	
3	Contraceptive Prevalence Rate		16.6%				23.4%		-	
4	FP acceptor rate	-	-	-	23.7%	25.2%	24.9%	No target	26.1%	DHIMS II
5	% of pregnant women attending at least 4 antenatal visits	62.8%	60.9%	72.4%	66.6%	70.7%	72.3%	85.7%	66.3%	DHIMS II
6	Infant Mortality Rate (IMR) per 1,000 live births	-	50	-	-	-	53		-	
7	Under 5 Mortality Rate (U5MR) per 1,000 live births	-	80	-	-	-	82		-	
8	% deliveries attended by a trained health worker	-	26.9%	34.8%	40.8%	49.1%	55.0%	65.0%	55.3%	DHIMS II
9	Under 5 prevalence of low weight for age	-	13.9%	-	-	-	13.4%			
Health Objective 4: Intensify and control of communicable and non-communicable diseases and promote a healthy lifestyle										
1	HIV prevalence among pregnant women 15-24 years	2.6	1.9	2.1	1.5	1.7	1.3%	<1.6%	1.2%	GHS NACP
2	% of U5s sleeping under ITN	-	28.2%	-	-	-	41.5%	-	-	
3	% of children fully immunized by age one - Penta 3	87.8%	86.6%	89.3%	85.9%	86.5%	87.9%	93.5%	86.0%	DHIMS II
4	HIV+ clients ARV treatment	13,429	23,614	33,745	40,575	59,007	69,870	94,114	75,762	GHS-NACP
5	Incidence of Guinea Worm	3,358	501	242	8	0	0	0	0	DHIMS II
6	% households with improved sanitary facilities	-	12.4%	-	-	-	15.0%		-	
7	% households with access to improved source of drinking water	-	83.8%	-	-	-	79.3%		-	
8	Obesity in population (women aged 15-49 years)	-	9.3%	-	-	-	-		-	
9	TB treatment success rate	74.5%	84.6%	85.4%	87.0%	85.3%	86.2%	90%	88.6%	GHS-NTP
Health Objective 5: Strengthen institutional care, including health service delivery										
1	Psychiatric patient treatment and rehabilitation rate	-	-	-	-	-	84.8%	No target	-	
2	Equity index: Ratio of mental health nurses to patient population	-	-	-	-	-	1:63	30% > base line	-	
3	Number of community psychiatric nurses trained and deployed	-	-	-	-	-	400	30% > base line	-	
4	% tracer psychotropic drug availability in hospitals	-	-	-	68%	64%	85.0%	80%	-	
5	Institutional infant mortality rate	-	7.0	17	5.8	4.4	13.8	No target	13.0	GHS
6	Basket equipment functioning in hospitals	-	-	-	-	-	-	85%	86.8%	Chief Phar.
7	% tracer drugs availability in hospitals	-	-	-	86.4%	94.1%	85.7%	90%	-	
8	% of hospitals assessed for quality assurance and control	-	-	-	-	-	-	100%	-	
9	Institutional under-five mortality rate	-	9.0	25.2	9.3	9.2	20.1	No target	17.9	DHIMS II
10	Institutional MMR	187	230	200	164	174	152	150	155	DHIMS II

Table 2: Sector wide indicators 2007-2013, greyed out indicators are not measured on annual basis.

3. Assessment of indicator trends

3.1 HO 1: Bridge equity gaps in health care and ensure sustainable financing arrangements that protect the poor

Equity

The indicator framework for the programme of work includes several equity indicators. Geographical equity is measured as the ratio between best and worst performing regions with respect to skilled deliveries and nurse to population ratio.

In 2013, the equity indicator for skilled deliveries experienced a marginally wider gap from 1:1.53 in 2012 to 1:1.56 in 2013. The national performance for skilled delivery improved slightly, but a regional break down reveals that coverage decreased across 7 out of the 10 regions during the period under review. Upper East Region recorded the highest coverage with 67.5% in 2013. Over the past four years, Volta Region has consistently remained the least performing region for skilled deliveries. The region increased performance to 45.0% in 2012 but began to decline again to 43.4% in 2013. Volta Region has persistently performed below the national average despite the fact that the average regional human resource availability (Midwives to WIFA population) is close to the national average.

The review team recommends conducting an in-depth study to identify factors influencing this performance.

While both the best and worst performing regions were improving their nurse to population ratio, the best region improved at a higher rate. Therefore, the equity gap is widening.

The staffing situation in Upper East Region has seen dramatic improvements since 2007, when the region had the country's lowest nurse to population ratio. With an increase in Upper East Region of almost 500 nurses (50% increase) from 2012 to 2013, it regained the position as the region with highest nurse to population rate. In 2013, the region had one nurse per 715 persons, which is well above the WHO target of 1 nurse per 1,000. Despite the increasing equity gap between best and worst performing regions, the distribution of nurses seems relatively equitable compared to the distribution of doctors **Error! Reference source not found.**.

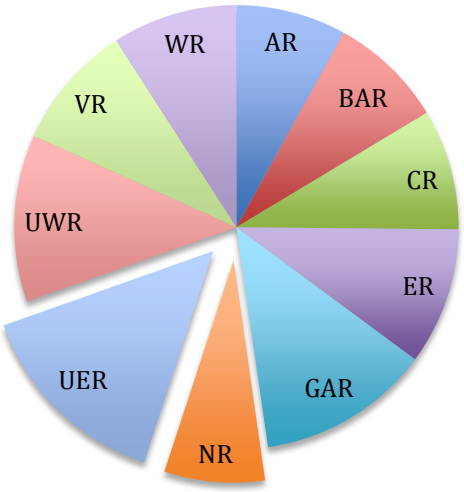


Figure 1: Nurse to population ratio by region (2013), source IPPD and DHIMS II

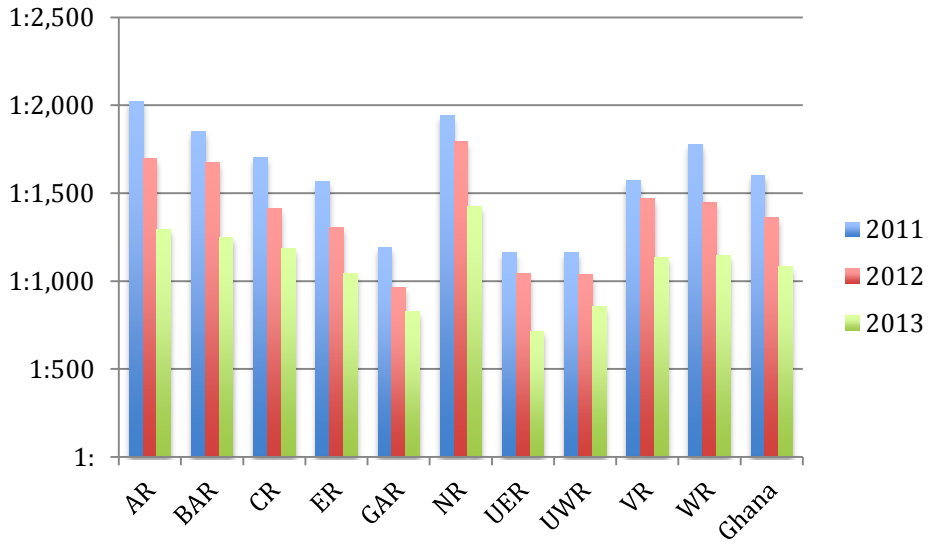


Figure 2: Nurse to population ratio by region – lower is better (2011-2013), source: IPPD and DHIMS II

Total no. of nurses	AR	BAR	CR	ER	GAR	NR	UER	UWR	VR	WR	Ghana
2009	2,325	1,214	1,373	1,994	3,698	1,191	892	586	1,533	1,422	16,228
2010	2,397	1,207	1,370	1,914	3,846	1,194	904	583	1,477	1,376	16,268
2011	2,427	1,278	1,335	1,718	3,468	1,314	912	617	1,383	1,364	15,816
2012	2,968	1,447	1,657	2,106	4,438	1,466	1,026	704	1,514	1,707	19,033
2013	3,996	1,987	2,036	2,693	5,320	1,899	1,516	869	2,010	2,207	24,533

Table 1: Total number of nurses by region (2009-2013), source: IPPD and DHIMS II

OPD

The average number of OPD visits per capita was 1.16 in 2013, which is a slight reduction from 1.17 in 2013. The figure is above the POW target of 1.0.

After several years of increased number of OPD visits per capita since the introduction of NHIS, the national trend seems to have stabilised in 2013. The national average, however, large regional variations exist. The OPD per capita in Ashanti Region continued last year's drop from 1.17 in 2011 to 0.96 in 2012 and 0.91 in 2013. This trend may be the result of introduction of capitation payment by NHIS in Ashanti Region in 2012. While decreasing trends were also observed in Eastern and Greater Accra Regions, the review team was not presented with any explanation for these trends. OPD per capita in Upper East Region continued to increase, and the region was the first to reach an average of above 2 OPD visits per capita. Despite continued increase, Northern Region remains the lowest performing region with only 0.78 OPD visits per capita.

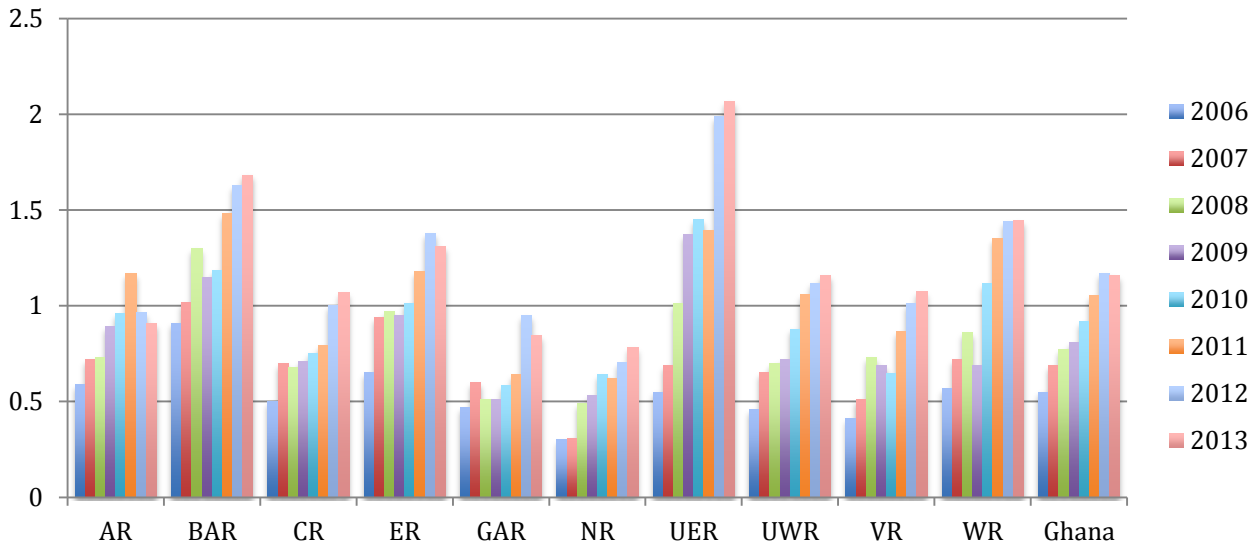


Figure 3: OPD per capita by region (2006-2013), source: DHIMS II

Human Resources for Health

In 2013, there was an increase of 363 doctors, and the total number of doctors on MOH payroll increased from 2,252 in 2012 to 2,615 in 2013. Consequently, the doctor to population ratio improved from 1 doctor per 11,515 in 2012 to 1 doctor per 10,170 in 2013.

There is a continuous improvement in the doctor to population ratio due to the increasing output from the four medical schools (UGMS, KNUST – SMS, UDS and UCC). Moreover, 78 foreign trained doctors joined the service during the year. Though there seem to be general improvement of availability of doctors in the system, a substantial number are in the Greater Accra and Ashanti Regions making the distribution skewed away from the deprived areas (Figure 4). Greater Accra Region employs more than 50% of all government-employed doctors in Ghana, but more than 50% of these are house officers in training. Of the remaining 669 fully qualified doctors (excluding house officers) in Greater Accra Region, 294 doctors work at tertiary level (285 at Korle-Bu Teaching Hospital and 9 at tertiary psychiatric facilities) and 69 are working at GHS and MOH headquarters. Another 26 doctors work in administrative positions at the lower levels of the GHS. The proportion of doctors working in administrative positions therefore stands at 14% (Figure 5).

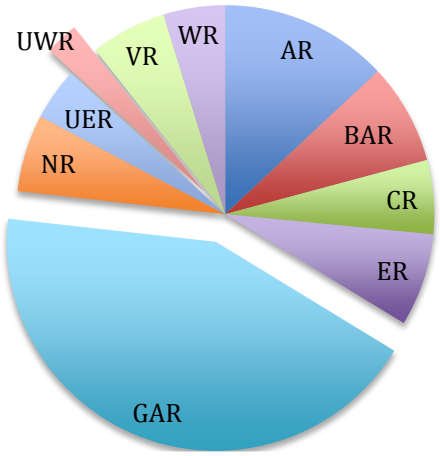


Figure 4: Doctor to population ratio (2013), source: IPPD

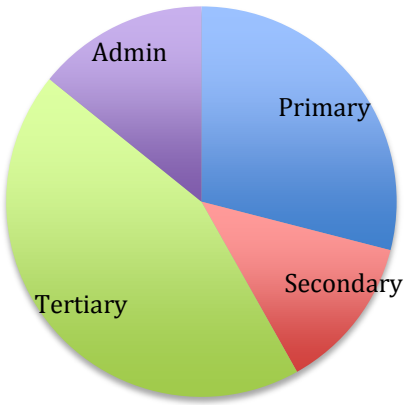


Figure 5: Distribution of doctors in GAR by administrative level (2013), source: IPPD

The nurse population ratio improved by 20% over 2012 but did not meet the POW 2013 target of one nurse to 800 citizens. The national average of nurse to population ratio, however, almost reached the WHO target of 1 nurse per 1,000 citizens.

The rapid improvement of the number of nurses in the system is as a result of increasing intake into existing nursing training schools and improvement in infrastructure of the training schools. While all regions experienced increased numbers of nurses, the increment was largest in Ashanti and Greater Accra Regions with 1,028 and 882 additional nurses, respectively. Relatively, the largest increase was in Upper East Region with 50% more nurses in 2013 compared to 2012. One of the reasons for this increase is the enforcement of the guidelines for regional retention. Regions with a tertiary facility can retain up to 90% of all newly trained staff, while regions without tertiary facilities can retain 70%.

The overall picture of the staffing situation is reflecting a considerable increase in production of health professionals, especially nurses including community health nurses (Figure 6).

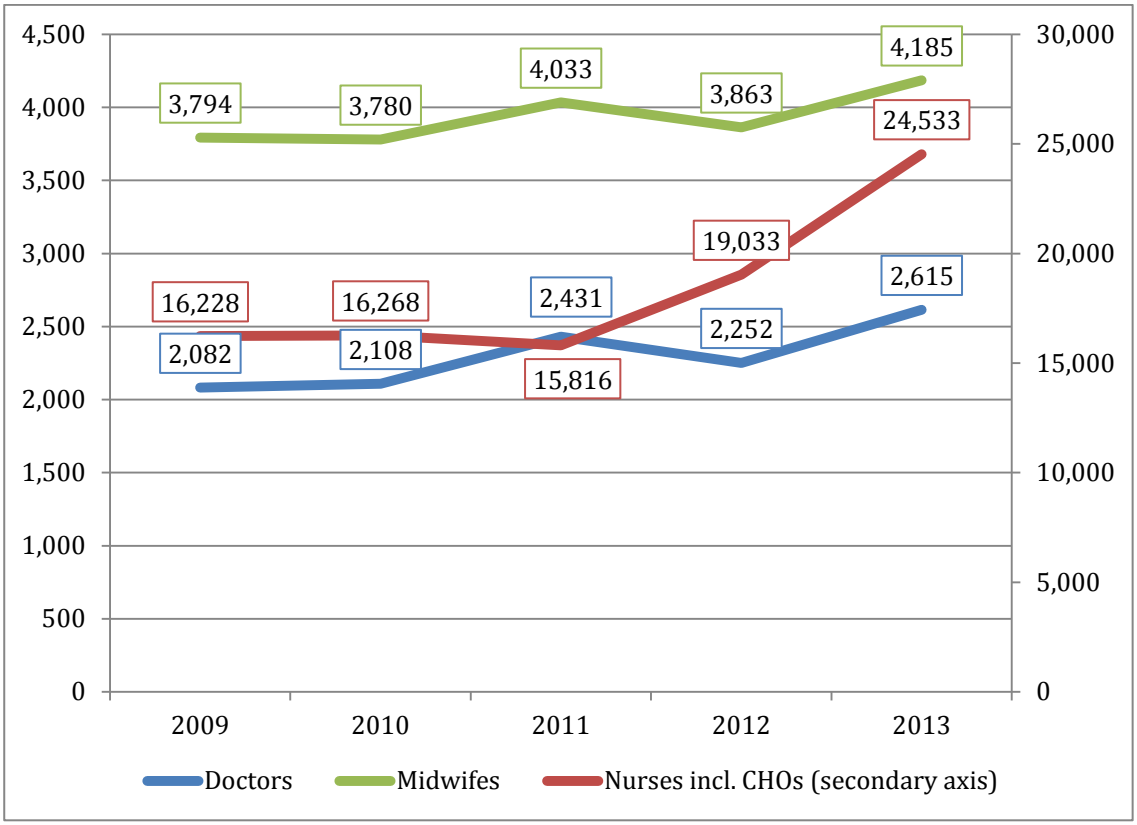


Figure 6: Trend in total numbers of nurses, doctors and midwifes (2009-2013), source: IPPD

The review team recommends an analysis of the sectors work force requirements, based on the newly developed staffing norm and the budget forecast, and a strategic plan for HR development for the sector.

3.2 HO 2: Strengthen governance and improve efficiency and effectiveness of the health system

Ministry of Health Financial Report for 2013

The Ministry of Health Financial Report for the year ended 31st December 2013 reported variations in funding and spending patterns relative to the same period in 2012. The contribution from donors was GH¢342.4 million in the reporting year whilst there was GH¢266.0 million contribution in the same year of the previous year, an increase of 28.7%. Internally Generated Fund (IGF) increased by 28.7% from GH¢442.3 million in 2012 to GH¢569.19 million in 2013. Government of Ghana contribution decreased by 13.1% from GH¢1,750.0 million in 2012 to GH¢1,521.0 million in the current year.

Source of Funds	2012 (Dec.)		2013 (as at Dec. 2013)		
	Amount (GHC Mn)	%	Amount (GHC Mn)	US Dollar (Mn)	Percent
GOG	1,750.0	70.6	1,521.0	800.6	56.0
IGF	442.3	17.8	569.2	299.6	20.9
Program - Donor	156.8	6.3	252.3	132.8	9.3

Budget Support	109.2	4.4	90.1	47.4	3.3
NHIA	15.1	0.6	6.3	3.3	0.2
F/Credits	6.4	0.3	279.0	146.9	10.3
HIPC /fund	0.0	0.0			
Others	0.0	0.0			
TOTAL	2,479.8	100.0	2,718.0	1,430.5	100.0

Table 2: Gross Revenue Distribution by Source

In terms of percentage contributions by the various sources to the sector, GOG and IGF contributed 76.9% in the year as compared with 88.4% in the same year of 2012. Donor contribution was 12.6% of Gross Revenue as against 10.7% of the previous year.

With regards to Earmarked Funds, the Ministry has made its best efforts to include directly distributed funds from multi-lateral donors to the extent of the information made available by the donors. Non-compliance with MOH guidelines on the transfer of funds to BMCs beyond Headquarters only serves to limit the Ministry's overall ability to account for and manage the flow of those funds. Reported figures in this statement for earmarked funds however covers, the figures available to the Ministry.

In terms of donor reporting of Direct Payments, the Ministry will continue to liaise with its Development Partners to enable us increasingly capture expenditures from donor direct payments in the financial report.

With this background, the Ministry herewith presents its Financial Report for the year ended 31st December 2013. Total Gross Revenue, recorded by the Ministry was GH¢2,718.0 million, the sources of which have been broken down in Table 2 above, and represented by the pie chart below.

The Expenditure patterns are also presented below, graphically and analytically according to Items and Sources as in Figures and Table 3 below.

For the Year Ended 31st Dec., 2013 (GH¢ 'million)								
	Amount in millions of GHC							
	GOG	IGF	B/SPT	MOH PROG	NHIA	F/CRED	TOTAL	%
Employee Compensations	1,518.5	34.8	0.0		0.0	0.0	1,553.3	57.3
Goods and Services	4.7	523.7	63.9	242.5	6.9	0.0	841.7	31.1
Assets	3.5	10.9	21.0	0.0	0.0	279.0	314.4	11.6
	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
TOTAL	1,526.7	569.4	84.9	242.5	6.9	279.0	2,709.4	100.0

Table 3: Expenditure Distribution by Items

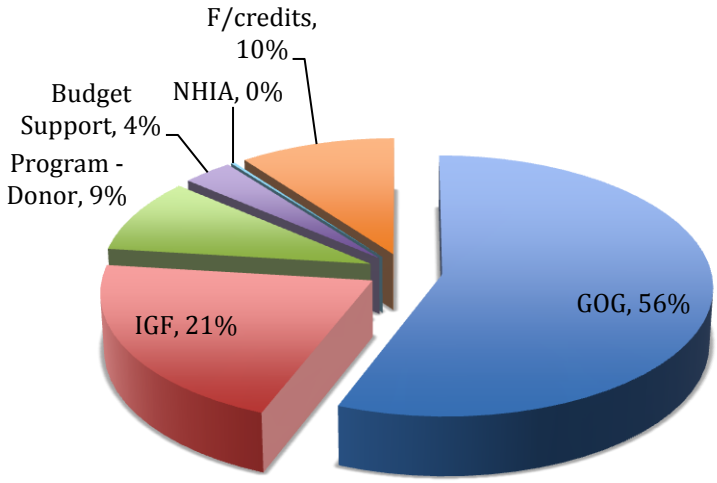


Figure 7: % Gross Revenue Distribution by Source

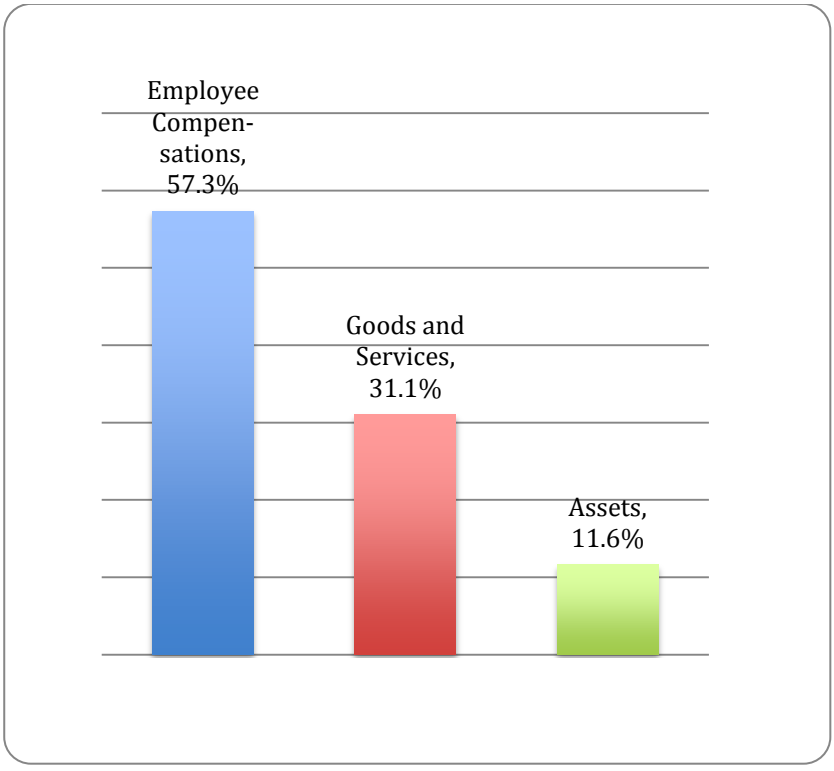


Figure 8: % Distribution of Total Expenditure by Item

The Ministry recorded a total expenditure of GH¢ 2,709.4 million for the year under review (Table 3). Out of this amount, 57.3% was for Employee Compensation as against 63.1% for the same year of 2012.

Expenditure incurred on Goods and Services was 31.1% as compared to 34.8% in 2012 whilst that incurred on Assets was 11.6% compared to 2.2% in 2012.

Figure 9 below shows comparative pattern of expenditure between 2012 and 2013 in absolute terms. Employee Compensation decreased considerably from GH¢ 1,654.6m in 2012 to GH¢ 1,553.3m in 2013.

Figure 9: Comparative Expenditure Distribution 2012 and 2013

At the end of 31st December 2013, total cash balances were GH¢171.4 million as against GH¢142.2 million at the end of 31st December 2012. These amounts represent balances standing in the books of the various health facilities nationwide and MOH/GHS Headquarters.

Debtors have increased from GH¢172.1m in December 2012 to GH¢262.2m in December 2013, an increase of 52.4%. A large proportion of the debts are IGF related, emanating from non-payment of service bills by the NHIA. Most of the debts are owed to the Hospitals; institutions which are no more benefiting from GOG and Sector Budget Support/Health Fund but are now depending solely on IGF for the operation of the Goods and Services budgets.

All readers of this are encouraged to refer to the accompanying Notes to the Financial Statements and Supporting Schedules for further clarification on specific items contained herein.

Financing Health

The proportion of government MTEF allocated to the health sector remained above the Abuja target of 15% despite a minimal reduction of 0.2 percentage points from 2012 to 2013.

This shows that the government of Ghana continues its commitment to financing health in the country. The majority of government funds, however, are allocated for compensation of employees.

The per capita expenditure on health was 41.2 USD in 2013. This is a decline of almost 10 USD from 2012 but well above the target of 31 USD per capita.

The single spine salary policy (SSSP) was introduced in 2012 leading to increased salaries for government workers. In 2012, the government paid SSSP arrears dated back to 2010 pushing the per capita expenditure to an exceptionally higher level for that year. The 2013 figure is lower than 2012 because no salary arrears were paid.

Budget execution

Budget execution rate for goods and services dropped by 32.2 percentage points from 86.8% in 2012 to 54.9% in 2013. The budget execution rate for goods and service is below the target of ≥95%.

The low budget implementation rate for goods and services may be the result of vying GOG funds from goods and services to pay salaries. Budget execution for compensation of employees was 300%, though the total budget for the health sector experienced no upward revision during 2013. If contributions from IGF, NHIF and SIP are deducted from the total amount, then what is left for public health services and administration is minimal. If we further remove donor funding from the total goods and services then practically there will be nothing left for public health services.

NHIS

Active membership was 36.8% in 2013, which is an increase of 10% from 2012 to 2013.The NHIS active membership rate has been rather stable around 35% of the population during the period of this HSMTDP 2010-2014. The ambition of the government is to provide universal health care coverage and NHIS is an important strategy for attaining this goal.

The proportion of IGF from NHIS was 81.9%, which is above the target of 75% indicating that the majority of services rendered are financed through the NHIS.

Since the introduction of NHIS, the OPD per capita rate has doubled and in 2013 over 80% of total outpatients were insured while only 36% of the population were active NHIS members. This indicates that NHIS members use services more than those without active membership. The sector does not currently have a good picture of the main drivers of the increased uptake of services, and there can be several explanations for the observed trend.

- Could this be a reflection of frivolous use of services by NHIS members (moral hazard), i.e. few insured patients consuming a lot of health service?
- Could it be a reflection of high NHIS membership rate among those in need of services, i.e. persons only register when they fall sick and refrain from renewing membership the following year if they are cured (adverse selection)?
- Could it be due to the policy of free enrolment of the poor, pregnant and children, who are expected to have higher need for health services (risk selection)?

Moral hazard, adverse selection and risk selection all provide financial risks to NHIS, and the review team recommends that these issues are further analysed and addressed.

Expenditure on compensation in 2013

An analysis of data from the IPDD indicates that 99% of total GOG resources went into the payment of salaries. Payment of trainee allowances constitutes almost 8% (GH¢109,594,122) of total salary paid to health personnel. In 2011, a decision was taken to wean trainees off allowances to create some fiscal space to support service provision. Payment for nurses constitutes almost 48% of total followed by doctors with 14%.

DECEMBER 2013 PAYROLL COST BY CATEGORY						
CATEGORY	No.	Monthly payroll cost	Market premium	Total monthly pc	Annual payroll cost	% of total APC
DOCTORS	2,615	5,747,554	10,926,288	16,673,842	200,086,104	14.4
NURSES	3,7325	35,505,590	19,782,281	55,287,871	663,454,453	47.7
PHARMACISTS	580	842,099	536,945	1,379,044	16,548,528	1.2
BIOMEDICAL SCIENTISTS	653	868,935	515,161	1,384,096	16,609,150	1.2
RADIOGRAPHERS	84	112,073	66,664	178,738	2,144,850	0.2
MANAGEMENT (DIR,DEP DIR,ETC	188	511,033	613,240	1,124,273	13,491,278	1.0
ADMINISTRATION & HRM	616	961,246	221,826	1,183,072	14,196,864	1.0
TRAINEES	18,525	9,132,843	0	9,132,843	109,594,122	7.9
OTHERS	30,508	21,080,682	8,438,020	29,518,702	354,224,425	25.5
TOTAL	**91,094**	**74,762,056**	**41,100,425**	**115,862,481**	**1,390,349,777**	100.0

Table 4: Analysis of compensation of employees 2013, source IPPD

NHIS Capitation Pilot

Background and Design

In response to continued rising costs, cumbersome claims processing procedures and delays in provider payment among others the NHIA piloted capitation as a payment method for outpatient primary care meant to overcome some of the challenges regarding costs escalation, timely payment of claims etc. The G-DRG, which is a payment method for inpatient, emergencies (outside PPP), and Specialist Outpatient and other services, was run alongside the capitation pilot.

Ashanti region was chosen for the pilot since according to NHIA the region accounts for almost 20% of the population of the country with wide variation in socio-demographic and socio-economic conditions ranging from the highly sophisticated urban metropolis of Kumasi to parts of the rural, hard to reach and under-served Afram plains.

The original package proposed for capitation accounted for 70% of total claim costs. Following concessions by the NHIA, which saw the removal of medicines and maternal services, the bundle of services that now remain under capitation constitute only 22% of total claim costs. Medicines account for over 50% of NHIS claims cost.

There is a proposal, which has been accepted by the NHIA to provide for clients to be able to change their PPPs every six months. The modalities are yet to be worked out.

Another proposal is to increase per-capita grant for private providers to GHc12, it would mean about 400% increase and private providers in Ashanti Region alone would consume about 54% of total projected OPD claims budget

Objectives of the Capitation Pilot

The objectives identified for the capitation payment system were to:

- Improve cost containment
- Simplify claims processing and address difficulties in forecasting and budgeting
- Share financial risk between schemes, providers and subscribers, introduce managed competition for providers and choice for patients compatible with portability
- Improve efficiency / effectiveness of health services through more rational resource use

Modifications to package and roll out

Interest groups expressed various concerns as the pilot progressed, and their views influenced the modification of the capitation package. Medicines and Maternal services were removed from the capitation basket. Public forums were held to educate providers on this issue and per capita rates were reviewed based on available data

Findings of Pilot

- *NHIA* Active membership increased by 9% compared to drops by 20% between 2011 and 2012**.**
- OPD per capita for insured clients fell from **2.83** in 2011 to **2.42** in 2012, compared to the national rate was **2.74.**
- From clients' perspective, 36.2% of clients who visited a health facility for health care rated the services they received as very good, whilst 53% rated good. About 7.4% rated satisfactory whilst 3.4% rated bad.
- Claims under G-DRG were reduced by 30%, falling from an average of 557,163 claims per month in 2011 to about 387,821 per month in 2012
- The per capita claims cost fell from **GHc 93.71** in 2011 to **GHc85.30** in 2012, a net change in per capita claim cost of **GHc8.41.** However, after controlling for compounding factors using the difference in difference method, the net change in per capita claim cost was **GHc 11.26**, meaning a net decrease in cost.
- Facilities that are better equipped reported gains in income in 2012 over 2011. Comparatively, small facilities (maternity homes, CHPS compounds) risk of closing down
- With the exception of one month, the NHIA successfully transferred capitation payments in advance to providers in the first week of each month

Scale-up of Capitation

Three regions (Upper West Region, Upper East Region and the Volta Region) have been earmarked for scale-up of capitation as a provider payment mechanism as part of overall strategy to gradually scale up capitation to all the regions. However the success of the scale up would depend on:

- A communication program that is effective and well-funded
- Clear understanding of the concept among clients and the general public

- Smooth PPP enrolment that reduces client frustrations to the barest minimum
- Effective monitoring should be in place from the start - claims data need to be analyzed for M&E purposes
- Quality service availability is an essential part of any provider payment system

Claims Payment

Status
During the year 2013, the average claims payment period, that is, average number of days between claims submission and payment, was 122 days.

The NHIA has made payments to majority of providers up to the month of September 2013. Payments have also been made to 8 regions for October 2013.

Outstanding
There are few outstanding claims relating to August 2013 still to be paid that were due to late submissions of claims. Claims for 2 regions for October and the entire claims for November and December 2013 are outstanding for all providers.

This report provides more details about NHIS performance in 2013 in chapter 7.1 on page 42.

3.3 HO3: Improve access to quality maternal, neonatal, child and adolescent health and nutrition services

Family Planning

FP acceptor rate increased by 4.5% from 24.9% in 2012 to 26.1% in 2013. In the same period, Couple Year Protection (CYP) increased from 1,222,920 to 1,592,981. Northern and Ashanti Region continue to have the lowest performance. The uptake of long-term methods has increased over the past years. Since some long-term methods only require the user to attend a clinic every 3-4 years, increasing uptake of long-term methods will reduce the number of annual acceptors. GHS is in the process of redefining the calculation of FP acceptor rate to adjust for this trend. Moreover, GHS family health division is working to improve reporting quality and analysis by distributing a data-dictionary for MCH indicators.

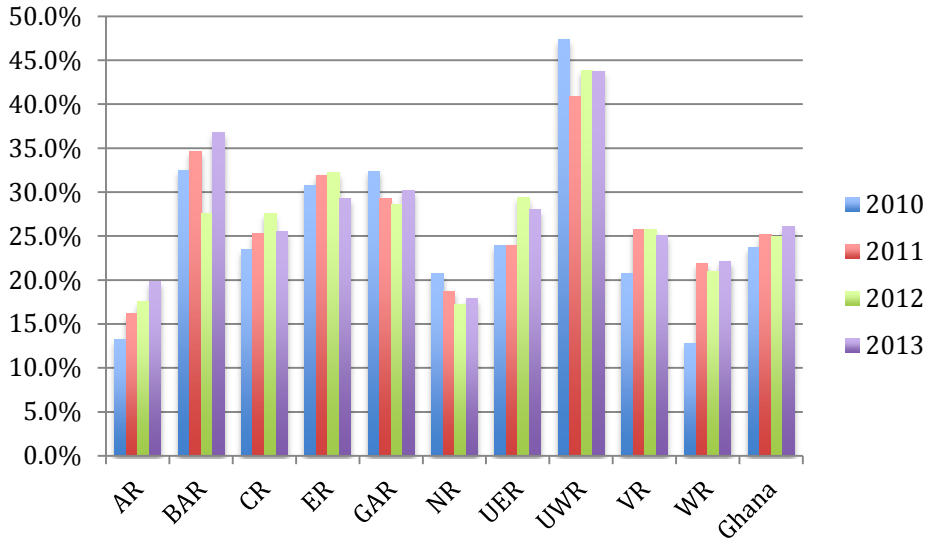


Figure 10: Family Planning Acceptor Rate by region (2010-2013), source DHIMS II

The national FP acceptor rate has steadily increased over the past years. Highest performance is observed in Upper West Region with coverage almost 45% of WIFA. The lowest performance is observed in Northern Region, possibly due to traditional opposition to family planning combined with large access barriers, both geographical and financial. Again, East Maprusi District reported acceptor rate of 40% during the period under review. GHS will explore the success stories and best practices in East Maprusi and replicate them in other Districts.

The performance of Ashanti Region was also surprisingly low, and determinants for poor performance are expected to be different from Northern Region since Ashanti Region generally has both better geographical and financial access to health services. One explanation for the poor performance could be the shift towards long-term methods in this region (as explained above).Another explanation of the poor performance in general and for Ashanti Region in particular, may be a result of perverse incentives to under report FP services rendered; FP service providers are required to account for money received from providing FP commodities. Under-reporting leaves room for channelling some money received from FP clients out of the accounts. A third explanation is a shift from public to private providers of family planning. Family planning services delivered by the private sector and CSOs are poorly captured in the public health information system.

The review team recommends that GHS should explore the reasons for the poor performance in Northern and Ashanti Regions, identify the worst performing districts and scale up interventions in these districts.

Antenatal Care

The proportion of pregnant women going for four or more ANC visits dropped from 72.3% in 2012 to 66.3% in 2013. The performance is below the target of 85.7%.

ANC 4+ coverage has been sporadic over the years and experienced a considerable drop this year. The factors contributing to this drop are not clear. There have been significant challenges with data quality for this indicator. Some providers counted the 4th visit but also 5th, 6th, 7th etc. This led to inflation of the 4+

ANC indicator. In 2013, the problem seems to have been solved, and this may to some extend explain the declining trend. Looking at the trend, 8 out of the 10 regions experienced decline in coverage despite improving midwife/population ratio.

Analysis by the GHS reveals that 17% of all pregnant women register in the 3rd trimester. These women will not have time for four ANC visits before delivery. Only 45% of pregnant women make their first ANC visit in 1st trimester. With the revision of the CHPS policy, there will be increased focus on home-visits, which is expected to increase the proportion of pregnant women registering early for ANC.

The review team recommends analysing distributional, supervisory and logistics issues in an attempt to improve uptake of antenatal care services.

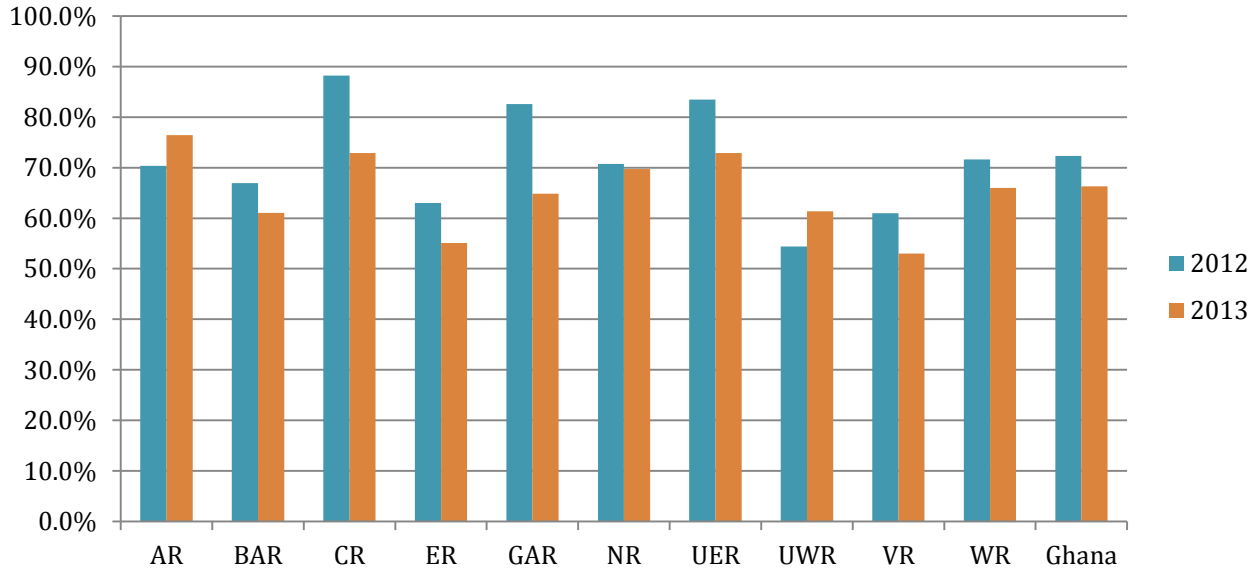


Figure 11: ANC 4+ performance by region (2012-2013). Source: DHIMS II

Skilled delivery

After several years of impressive increases in skilled delivery rate, the performance stabilised between 2012 and 2013 with only a marginal increase to 55.3%. The figures for previous years were revised in 2013 due to issues with double counting of deliveries in teaching hospitals. Though Korle-Bu and Komfo Anokye Teaching Hospitals are not reporting through DHIMS, they do provide data on maternal health to the sub-metro authorities where they are located and this reflects in the GHS aggregate data. This anomaly was detected in the latter part of 2013.

Despite overall improvements in midwife to WIFA rate, seven out of ten regions experienced a decline in the skilled delivery rate. Volta Region continued to have the lowest performance at 43.4%. Upper East was performing best at 67.5% closely followed by Brong-Ahafo Region with 65%. Interestingly, the midwife to WIFA ratio in Brong-Ahafo is comparable to the ratio of Volta Region with 1:1,554 and 1:1,601, respectively. Some regions performed above average level of skilled delivery despite poor staffing situation e.g. Brong-Ahafo and Central Region, while other regions have poor level of skilled delivery despite being above average staffing situation e.g. Eastern and Volte Regions (Figure 13).

Interrogation of the data revealed that there is variance between providers on reporting of deliveries by CHOs. Some providers report these as skilled deliveries while others do not.

The review team recommends that GHS and MOH clarify the definition of skilled delivery and establish whether a CHO-delivery shall be classified as a "skilled-delivery".

The review team recommends that GHS and MOH clarify the role of CHOs with respect to performing planned deliveries and agree on formal training of CHOs in obstetric care and requirements for clinical attachment to obstetric wards.

When the relation between ANC +1, ANC 4+ and skilled delivery performance is compared across the regions, it shows that the gap between ANC 4+ and skilled delivery in some regions is considerably smaller than other regions (Figure 12). This indicates that some regions are better at ensuring that women attending ANC clinics choose to deliver in the facilities under skilled supervision.

Based on these observed differences, the review team recommends a fact-finding mission to selected regions (Volta, Ashanti, Central and Northern Regions) to better understand the determinants for poor performance.

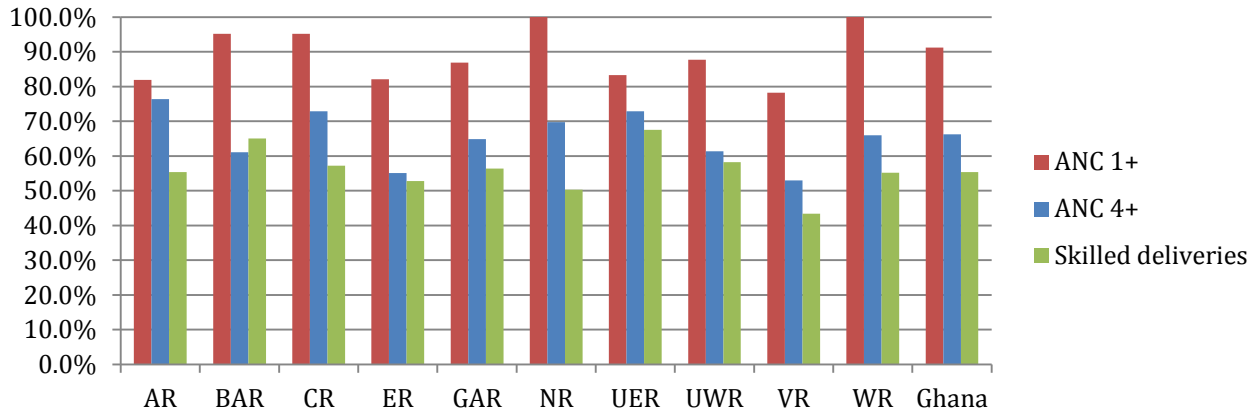


Figure 12: Relation between ANC 1+, ANC 4+ and Skilled Delivery performance (2013). Source: DHIMS II

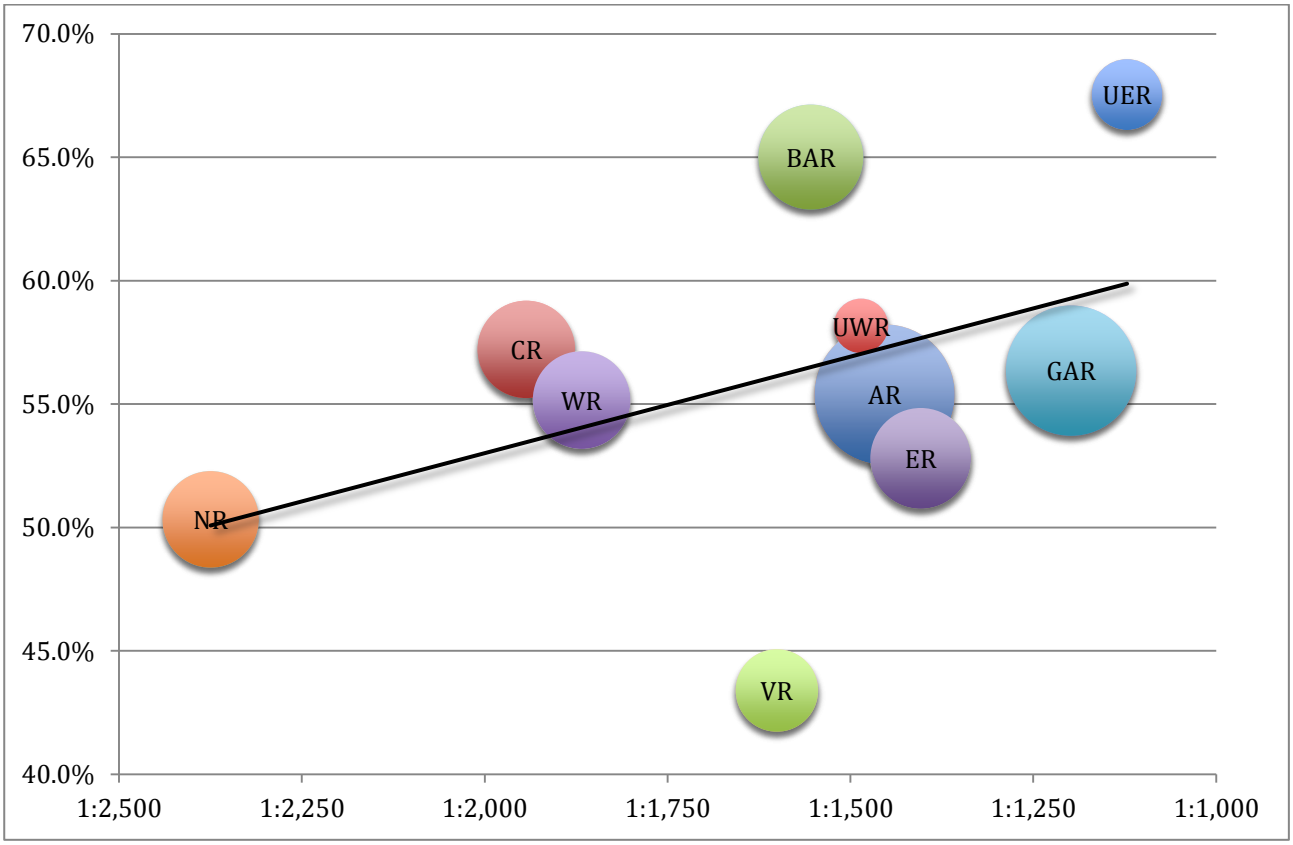


Figure 13: Skilled delivery against midwife to WIFA ratio by region. Bubble size represents number of deliveries. Source: DHIMS II and IPPD

3.4 HO4:Intensify prevention and control of communicable and non-communicable diseases and promote a health lifestyle

Extended Programme of Immunization (EPI)

The coverage for Penta-3 has been stable between 85% and 90% since 2007. In 2013 the coverage dropped slightly from 87.9% last year to 86.0%. Seven of the ten regions experienced a drop in coverage in 2013 and three regions have coverage below 80%.

In 2013, three new vaccines were introduced into the EPI. This may have created additional burden coupled with the decreasing financial support to the districts and thus might have influenced performance. The Penta 3 coverage over the years has remained stagnant at around 86% and has not reached set target. This may make children susceptible to disease outbreaks due to our inability to achieve the herd immunity. Efforts should be made to identify and mitigate the challenges to raise the coverage to 90%. Improved strategies could include tracking of all children through a social network that requires all institutions that comes into contact with children to report on their immunization status.

The stable coverage can also be seen as a demonstration of the strength of the EPI programme. The effect of low and erratic flow of funds to the district level, which is an issue of great concern, appears not to have

had much impact on delivery of immunization service. A lot more effort and input however will be needed to move the coverage to 90%. Weak supervision may also be a factor that will need to be addressed.

The quality of EPI data can also be questioned, especially in the larger cities. Routine EPI coverage in Greater Accra and Ashanti Regions were low while the survey findings (MICS and DHS) put these regions on par with the other regions and at higher coverage. This could either result from data capture difficulties or inflated denominator figures.

The review team recommends disaggregating data to the district and sub-district level to identify least performing districts and sub-districts and the factors influencing their performance. A peer review system using the holistic assessment tool for instance may be appropriate

HIV

For the period under review, the health sector planned to continue the implementation of HIV/AIDS interventions, assess the HIV resource gap and drug availability/sustainability over the next five years. The objective was to:

- Provide Counselling, Testing and give out HIV test results
- Provide HIV-infected pregnant women with HIV testing and counselling services
- Provide HIV-infected women with a course of anti-retroviral prophylaxis to reduce Mother to Child Transmission
- Infants born to HIV infected mothers to receive HIV tests within 2 months after birth

The target for testing and counselling was 878,696 and the sector achieved 695,929 (79%) compared to 856,583 in 2012. This is a reduction of almost 20%.

Prophylaxis for pregnant women was targeted to be 17,639 while the result in 2013 was 7,266 compared to 7,781 in 2012.

While most of these indicators for testing and counselling as well as ARV treatment for adults are worsening, the performance related to infants born to HIV infected mothers improved. The target for testing infants born to HIV infected mother was 11,132. While the target was not achieved with 3,546 infants tested (32%), the figure is more than doubling last year's performance.

There were logistical and financial challenges in 2013 with respect to delivery of ARVs. Ghana did not succeeded in the round 10 application to GFATM, which put a financial pressure on GOG, which in turn released 50% of its 50 mill GHS budget for ARVs.

The number of HIV patients receiving ARV therapy continued to increase in 2013. The number came to 75,762 but did not reach the goal of 94,114.

Guinea worm surveillance

The last case of guinea Worm was detected in May 2010. All the cases were reported from Savelugu-Nanton district (NR). No case was reported during the year 2013. As part of Ghana's effort to ensure certification of no Guinea Worm, a reward system of GH¢200 has been institutionalized to motivate reporting of any hanging worm. This is part of the overall strategy to improve surveillance and reporting.

As part of the Stop Transmission of Guinea Worm (STOG) exercise in Eastern and Western regions, assessment of awareness of the general population was done. One hundred and twenty persons per district totalling 2520 were randomly selected from 21 districts and assessed in the Eastern region while 555 persons were assessed in the Western Region.

Reporting of rumour is an important indicator in assessing surveillance activities and also awareness of the Guinea Worm Cash Reward.

Region	Number of persons surveyed	% of surveyed that can recognize GW Disease	% of surveyed that know reward system	% of surveyed that know the correct amount of the reward system
WR	555	452(81%)	282(51%)	173(31%)
ER	2,520	1,890(75%)	1,167(46%)	525(21%)

Table 5: Results of Assessment of Guinea Worm Reward System in Eastern and Western Regions, 2013

Tuberculosis

The target for reported TB cases in 2013 was 19,386. The sector achieved 15,473 (80%) by December 31st 2013. TB treatment success rate for the 2012 cohort (reported in 2013) improved to 86.2%, which is slightly above the 2011 cohort, but the increase was less than 5% margin. This however exceeds the World Health Organisation's target of 85%. The increase and high performance may be attributed to improvement in follow-up of treatment upon discharge, and some regions are recording zero defaulter rate.

3.5 HO5: Strengthen institutional care including mental health service delivery

Infant and Child mortality

Institutional infant mortality improved from 13.8 deaths per 1,000 institutional live births in 2012 to 13.0 in 2013. The total number of infant deaths recorded at facilities in Ghana increased from 8,077 to 8,561, but in the same period, the number of live births increased leading to an overall improvement of this indicator. The highest iIMR was recorded in Northern Region with 21.9 institutional infant deaths per 1,000 institutional live births. Ashanti was the best performing region with less than half the rate of Northern Region at 6.5 per 1,000 live births.

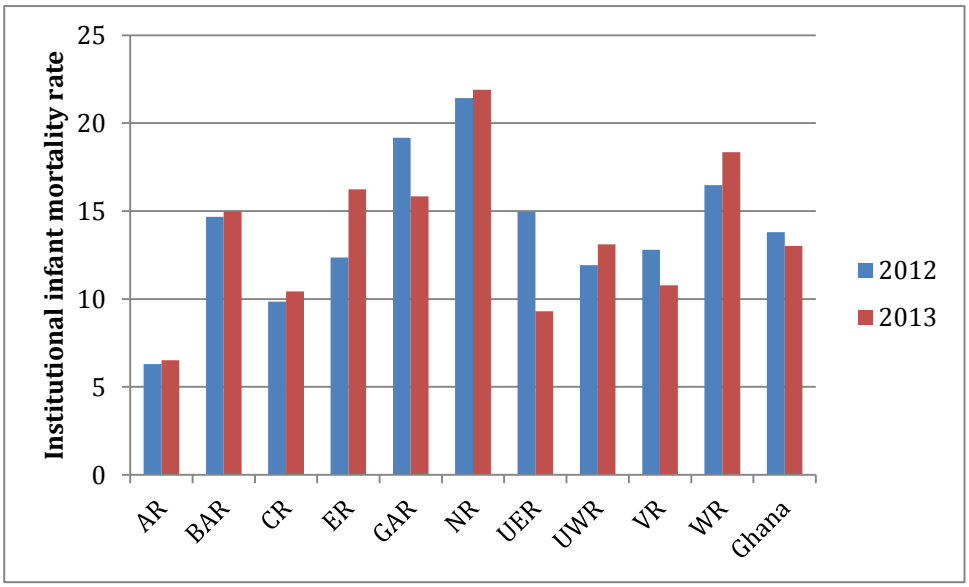


Figure 14: Institutional Infant Mortality Rate (2012-2013). Source: DHIMS II

Institutional under-five mortality improved from 20.1 per 1,000 institutional live births in 2012 to 17.9 in 2013. This indicator was recalculated for 2012 and 2013 due to improved data source in DHIMS II. The total number of children under five years was almost constant between 2012 and 2013 at approximately 11,750. As mentioned previously, the number of institutional live births increased in the same period leading to an improvement of this indicator. There are large regional differences with the highest iU5MR in Northern Region (40.8) and the lowest in Ashanti Region (9.3). This is a result of relatively many under-five deaths in Northern Region and a relatively low number of institutional live births. It is worth noting, that iU5MR in the other two northern regions is considerably lower than for Northern Region. The number of institutional child deaths in Upper East Region reduced from 1,309 in 2012 to 456 in 2013.

Maternal Mortality

While the total number of maternal deaths increased from 899 in 2012 to 1,016 in 2013, the institutional Maternal Mortality Ratio remained stable at just over 150 maternal deaths per 100,000 live births. Since the total number of women delivering in facilities is increasing, it is also expected to see an increase in the total number of maternal deaths everything being equal. Moreover, if the increase in institutional deliveries was a result of improved access to emergency obstetric care, e.g. access to ambulance or other emergency services, one would expect to see a more high-risk profile of the women delivering in facilities. This indicator is therefore difficult to use to measure clinical quality of maternal services. Another weakness of the indicator is that maternal deaths are reported from the facility, where the death occurred, not where the woman lived. This may obscure important determinant for maternal mortality that are specific for the particular community, may it be cultural, logistically, financial or other.

The review team recommends that MOH and GHS should collaborate to improve the reporting system so maternal deaths can be geographically mapped to the community the woman came from.

GHS and teaching hospitals will collaborate on improving the network for referring women in labour. This is expected to facilitate referrals between levels within GHS and between GHS and teaching hospitals. Ashanti Region will pilot the improved network.

Figure 15 shows the relation between midwife staffing strength (midwife to WIFA ratio) and institutional maternal mortality ratio. Regions with good staffing strength (e.g. UER and AR) tend to have lower iMMR, while regions with poor staffing strength (e.g. NR) have higher iMMR. There are three outliers with relatively high iMMR compared to their staffing strength, namely Greater Accra, Upper West and Eastern Region. These are three very different regions with different types of challenges. While Greater Accra is densely populated with good geographical access but relatively limited public facilities, Upper West region has poor geographic access.

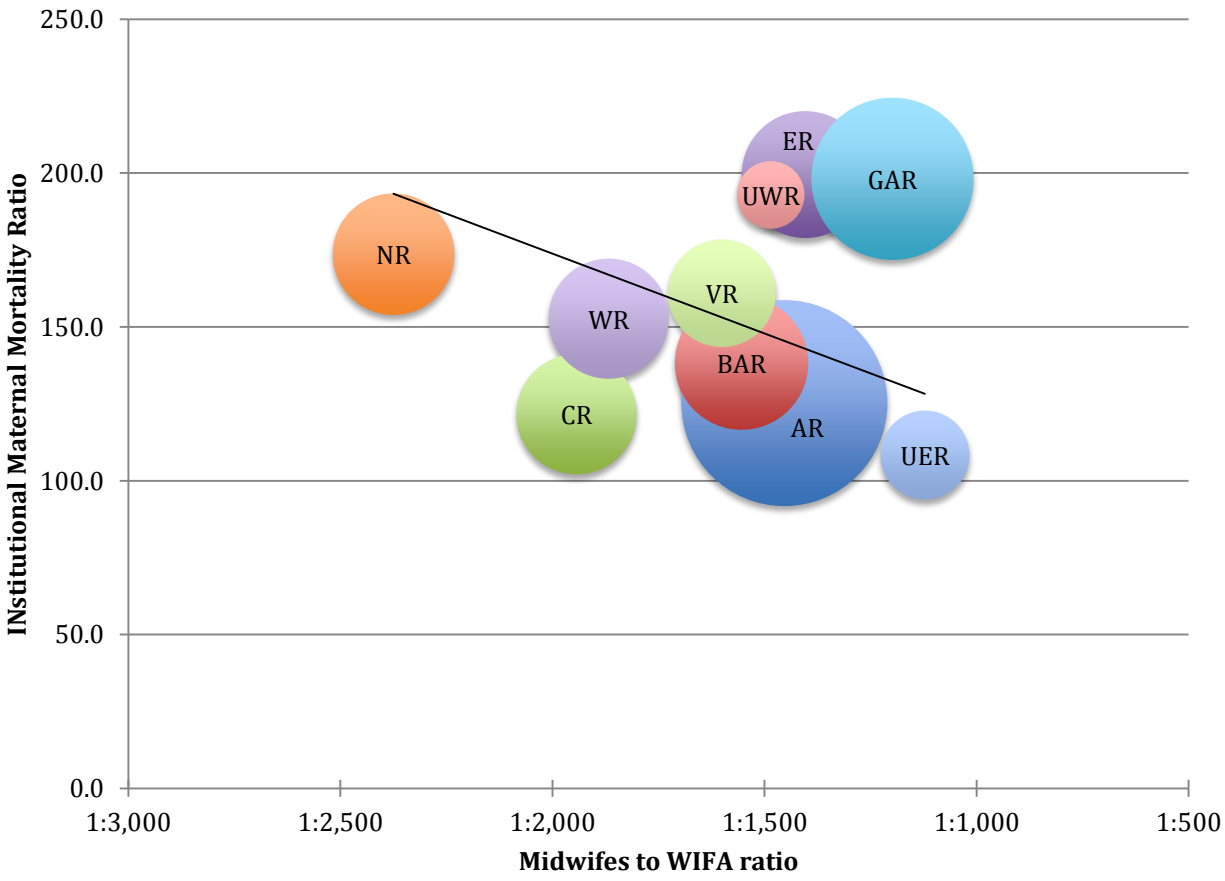


Figure 15: Relationship between Midwife staffing strength and institutional maternal mortality (2013). Sizes of bubbles represent number of live births. Source: IPPD and DHIMS II.

iMMR	AR	BAR	CR	ER	GAR	NR	UER	UWR	VR	WR	GHS total
2010	151.6	141.9	149.0	191.6	207.1	139.7	137.9	157.7	219.4	137.0	164.1
2011	197.4	127.4	123.8	207.3	242.4	170.8	127.4	159.6	200.6	101.0	174.4
2012	76.9	166.8	113.2	172.9	205.3	211.7	135.8	145.9	173.8	131.8	151.8
2013	125.3	138.3	121.6	199.5	198.1	173.7	108.4	192.9	161.0	152.7	154.6

Table 6: Institutional Maternal Mortality by region (2010-2013). Source: DHIMS II.

3.6 Health Information Systems and data quality

The sector has observed tremendous improvements in data quality and reliability over the past years. With the implementation of DHIMS II, all public service providers are now entering health information directly into the DHIMS. This information is immediately accessible to managers at all levels, which cuts processes that previously delayed reporting. With a unified reporting system, information consistency and reliability has also improved. This increases the quality and relevance of year-on-year comparisons.

Despite these improvements, the review team observed issues with DHIMS II and the information management in the sector as a whole that need to be tackled.

- *Teaching hospitals should come onto the DHIMS*
- *Reporting from the private sector providers should be improved*
- *Options should be explored for bringing other non-service providing agencies onto the DHIMS*
- *Systems should be put in place to distinguish zero-reporting (e.g. reporting of zero cases of disease x) from non-reporting*

The continuous development of DHIMS II and the implementation of the sector's M&E framework is expected to remedy these issues.

4. Regions of excellence and regions requiring attention

In the review of POW 2011, the review team introduced a simplified holistic assessment based on regional performance of selected indicators to identify the region of excellence and the region requiring attention. The scoring of each indicator follows the rules of the holistic assessment adapted to regional analysis.

It is important to note that the regional performance assessment is only indicative since it is based on a limited number of service delivery indicators, which may not reflect the true performance of the individual regions.

	Total Score	Penta 3	ANC 4+	Skilled delivery	FP acceptor rate	OPD/capita	iMMR	iIMR
Western	3	0	-1	0	1	1	1	1
Upper East	3	0	-1	1	0	1	1	1
Northern	3	1	0	1	0	1	1	-1
Upper West	2	1	1	1	0	1	-1	-1
Brong-Ahafo	1	-1	-1	1	1	1	1	-1
Greater Accra	1	0	0	0	1	-1	0	1
Ashanti	0	0	1	1	1	-1	-1	-1
Central	0	0	-1	0	**-1**	**1**	1	0
Volta	0	0	-1	0	0	1	0	0
Eastern	-4	-1	-1	0	-1	1	-1	-1

Table 3: Holistic assessment of regional performance in 2013

	Total Score	Penta 3	ANC 4+	Skilled delivery	FP acceptor rate	OPD/capita	iMMR	iIMR
Western	3	0	-1	0	1	1	1	1
Upper East	3	0	-1	1	0	1	1	1
Northern	3	1	0	1	0	1	1	-1
Upper West	2	1	1	1	0	1	-1	-1
Brong-Ahafo	1	-1	-1	1	1	1	1	-1
Greater Accra	1	0	0	0	1	-1	0	1
Ashanti	0	0	1	1	1	-1	-1	-1
Central	0	0	-1	0	**-1**	**1**	1	0
Volta	0	0	-1	0	0	1	0	0
Eastern	-4	-1	-1	0	-1	1	-1	-1

Table 3 shows the result of the regional assessment. In the regional analysis of POW 2012, all regions came out with a positive score. In the current review three regions have a score of zero and one region has a negative score, which indicates a relative deterioration since 2012 for these selected service delivery indicators.

Three regions have improved performance relative to 2012 - Western, Upper East and Northern Region. While Northern Region continue to have below average performance on most of the service delivery indicators, the region must be acknowledged for its tremendous improvement in 2013 over 2012.

Eastern Region experienced a worrying trend in performance between 2012 and 2013. Except from OPD per capita all other indicators were stagnant or worsening.

The analysis suggests that Eastern Region may require special attention in 2014, and the review team recommends technical support to this region in order to identify the causes of the worsening performance.

5. Implementation status of the POW 2013

5.1 HO 1: Bridge equity gaps in access to health care and nutrition services, and ensure sustainable financing arrangements that protects the poor

Strengthen district health systems with emphasis on primary health care

Functional CHPS zones increase from 2,226 to 2,316 far short of the 3,000-target envisaged. The definition of functional CHPS is not firm, and according to GHS the number of CHPS zones with a functional CHO may be substantially higher. GHS will firm up the definition as part of the revision of the CHPS policy.

The CHPS policy has been revised. A strategic plan has also been developed to implement the policy. The plan and strategy, however, have not yet been disseminated broadly. There is an increasing requirement for clear direction for CHPS, especially in the definition of the CHOs' core activities as well as their deployment into communities. While new policy will increase the priority of home-visits and strengthen the role of CHPS in maternal health, the role of CHOs in relation to skilled deliveries remains undecided.

Training manuals for the community level were developed and printed. The training of sub-district teams as trainers to support CHPS service providers has been organized in all districts in Volta Region and 9 districts in Central Region. Although Community health management teams were established in all districts in Volta region and 9 districts in the central Region, the coverage was too small to make any meaningful impact on service delivery at the community level. This coupled with our inability to negotiate suitable accommodation for CHOs with the help of the assemblies represents a draw back in our attempt to deploy community health staff to where they are needed. Despite this drawback, some progress was made and efforts should be made to strengthen community level service delivery by bringing on board all relevant stakeholders.

One thousand five hundred (1,500) service delivery kits were procured under the nutrition and malaria programme for distribution to the CHPS zones.

The 2013 programme of work provides for the training of community level volunteers and health promotion assistants. Although this activity was not done, it is important to recognise the need for better coordination and training of community volunteers to ensure optimum benefit from their activities.

Increase availability and efficiency of human resource for health

Staffing norms tools have been developed and tested. Human resource deployment plan will be based on the staffing norm. Its development is therefore yet to commence. Though the technical work on the staffing norm is complete, stakeholder consultations are yet to begin. Stakeholder consultation will be held in the first part of 2014. The preparation of the staffing norm has therefore not completed approval processes.

Another output under this sub-objective was the introduction of deprived area incentives for 10 districts. This policy has become obsolete due to the single spine pay policy, which included rural incentives for all categories of workers including health staff. The single spine pay secretariat demands that all MDAs aligned their pay policies to single spine pay policy.

5.2 HO2: Strengthen governance and improve the efficiency and effectiveness of the health system

Strengthen the regulatory and inter-sector collaboration for governing the health sector

Analysis of the POW 2013 activities revealed that many planned activities were not carried out. This indicates that the MOHs role of coordinating the sector using the POW as a tool is inadequate. The annual POWs have not been published before the beginning of the year, making it difficult for agencies to comply with the plan.

As part of the HSMTDP II 2014-2017, the MOH will provide the overall guidance while agencies are required to develop their own detailed implementation plans. This is expected to increase the agencies' ownership of their plans and equip MOH with better tools for demanding accountability and exert its stewardship role.

The processes for developing most of the L.I.s were initiated at the latter part of 2013. The Public Health Act 851, for instance is made up of nine (9) different constituents. The constituents needed to be dealt with separately by different group of professionals. Consultations on way forward have been completed and a group has started work on the Framework Convention for Tobacco Control. A zero draft has been completed. The governing body for the mental health service was inaugurated during the year and started work. The delay in completing the L.I.s has affected the establishment of the various governing boards.

Strengthen DHMTs and orient the district health Directorates to operate in accordance with LI 1961

Orientation on LI 1961

Under this objective, the Ministry was to review and amend the Ghana Health Service and Teaching Hospitals Act 525 of 1996 to reflect the ceding of the oversight responsibility for service delivery to district assemblies. This activity has become out-dated because of the consultative work on decentralization. It will be considered by a team of legislative drafters who will consider a new institutional framework for the sector vis-à-vis the amendment agenda.

The L.I. 1961(Local Government Departments if District Assemblies Instrument) is to be amended as part of a local government legislative consolidation exercise. The orientation planned for the 50 health management teams is therefore on hold. Stakeholder consultative meetings were however held as part of a process to collate views to review and consolidate various local governance laws. A draft bill has been prepared as a result. The consultations were held under the auspices of the IMCC and LGSS.

Decentralisation Process

The decentralization process has been initiated. A proposed institutional framework has been submitted to the inter-ministerial coordinating committee. The ministry is waiting for further direction. The Ministry through the Ghana Health Service was to train district staff in composite planning and budgeting, however, this activity could not take place due to inadequate funding.

MOU with the private Health Sector Council and Coalition of NGOs

The planned Private Health Sector Council has not been set up. The private health sector alliance, which is an umbrella organisation for the private sector, is undergoing re-organisation. A new constitution has just been drafted for the group awaiting approval after which consultations will start for the possible inauguration of the council. The signing of the MOU between the Ministry of Health and the council was

postponed till the re-organisation of the private sector groups is finalised. Provision however was made in the new private sector policy for an advisory body, which is yet to be inaugurated. Consultations are going on to review and sign MOU between MOH and the Coalition of NGOs. This MOU is expected to be signed during the second quarter of 2014.

Integrated Disease Surveillance and Response

The Minister of Health inaugurated a national advisory committee on International Health Regulation (IHR). All stakeholders including MOFA, particularly the veterinary section, attended. During the meeting the Terms of Reference was spelled out to members and communication links was established with all stakeholders. Update on disease occurrence is provided on weekly bases to all members. As part of Integrated Disease Surveillance and Response (IDSR) strengthening, 2013 guidelines was revised to take on board all diseases; both communicable and non communicable, specified by the IHR. To provide training and develop capacity of health professionals on case detection of epidemic prone diseases, ten regional surveillance teams and 114 district teams were trained on second edition of Integrated Disease Surveillance and Response.

School Heath Programme

As part of the Ministry's engagement to scale-up the school health programme in basic and secondary schools, a ration tool designed for school feeding in collaboration with Ghana School Feeding Programme. Manual on healthy eating for schools was developed in collaboration with Ghana School Feeding Programme. The planned training for 200 Lead School Health Education Programme (SHEP) coordinators could not take place due to funding problems.

2.2 Strengthen systems for improving the evidence base for policy and operations research

Health Policy

The planned development of a national health policy could not take place due to logistics challenges. On the other hand, Terms of Reference for the review of exiting policy have developed. The policy team is waiting for the release of funding. A draft Health Sector Medium Term Development Plan is ready. It is being fine tuned for submission to the health sector working group meeting for adoption.

Demographic and Health Survey

The conduct of the Ghana Demographic and Health Survey was supposed to take place at latter part of 2013. This was however postponed due funding difficulties and timing for some of the modules. A series of meeting were held with the Ghana Statistical Service and it was agreed in principle to include questions on client satisfaction survey. The Ministry therefore sent questionnaires to the GGS for consideration and inclusion into the GDHS.

Support for conducting clinical trials

Eight operational researches were done and 7 other studies are in the various stages of proposal development during the period under review. In addition, clinical trials are on-going in all the three research centres and 110 research staff had CPD on proposal developments and ethical scientific reviews.

5.3 HO3: Improve access to quality maternal, neonatal, child and adolescent health and nutrition services

Access to Family Planning

The 2013 POW under this objective sought to increase access to and use of modern contraceptives, antenatal and post-natal care and improve access to adolescent health services in health facilities. Family Planning acceptor rate increased from 24.9% in 2012 to 26.1% in 2013, ANC 4+ dropped to 66.3% while 64.9% of post-natal coverage was achieved in during the same period.

Skilled Delivery Coverage

The Health Sector in 2013 has increase coverage (from 55.0% to 55.3%) for skilled delivery probably as the result of the implementation of the MDG Accelerated Framework (MAF), which started in earnest in later part of the year under review. Various activities were carried out based on specific institutional and district plans. Procurement of specific equipment to increase access and quality of EmONC has delayed because of the international nature of the bidding process.

Read more details about progress related to maternal and child health indicators in chapter 3 above.

Life Saving Skills

To strengthen the implementation of Life Saving Skills at district and sub-district level, Regional Training of Trainers was done in Brong-Ahafo, Ashanti and Eastern Regions. This was done to ensure that all regions have established teams of trainers. Almost all regions have conducted Life saving Skills (LSS) downstream training for their regions and as a result 487 midwives were trained nationwide in LSS as at June 2013.

During the period under review, steps were taken to increase numbers of midwives trained, secure learning materials and expand training to private training institutions. One midwifery degree programme was established at the Kwame Nkrumah University of Science and technology (KNUST).

Access to safe blood for expectant mothers and new-borns

To improve access to safe blood for expectant mothers and new-borns, the sector planned to strengthen Area Blood Centres and Blood banks by improving infrastructure and equipment. The National Blood Service (NBS) also planned to provide Technical Assistance support for the construction and equipping of the Southern and Central Area Blood Centres in Accra and Kumasi respectively.

Accra: NBS Headquarters and Southern Area Blood Centre

The Ministry of Health's Project Implementation Unit (PIU) and NBS worked with the Architectural Consultants to supervise the completion of the new headquarters and southern Area Blood Centre which is 99% now complete. Equipment specifications were determined, tendering process completed and contract awarded; contracts to supply the equipment were signed between Ministry of Health and the respective companies.

The NBS headquarters and Southern Area Blood Centre, was expected to be operational by end of January 2014.This will greatly improve blood procurement and delivery in the southern zone and National Coordination of Implementation of Blood Safety activities in the whole country. Plans are underway to

expand operations of the catchment area from the current Greater Accra area and cover the entire southern zone of the country.

The Nordic Development Fund (NDF) is providing technical assistance for completion of the outstanding activities, streamlining and improving the function of the entire NBS. This was successfully implemented by Technical Assistance consultants.

Under the CDC/PEPFAR Task order contract, Technical Assistant consultants from Safe Blood for Africa Foundation (SBfAF) paid a number of visited during the course of the year to assist in the modernization and streamlining processes regarding all the components of the blood value chain.

Kumasi: Central Area Blood Centre

Design for Kumasi Area Blood Centre for the Middle Zone was completed and is available. Equipment specifications were determined and processes for procurement of some equipment for blood donor services activities was done. Procurement process would commence as soon as a "No-objection" is received. Funding for construction of civil works and equipment for Kumasi ABC is being sourced by MOH PIU from MOFEP.

Tamale: Northern Area Blood Centre

The plan for the Northern Area Blood Centre was to provide technical assistance in the design of civil works and equipment specifications. In this regard, funds for civil works and equipment for Tamale ABC for the Northern Zone is being sourced by the MOH's PIU. The process of procurement for some equipment for blood donor services activities was done. Procurement process will commence as soon as a "No-objection" is received. Again, the NBS collaborated with GHS (Family Health Directorate) to provide specifications for cold storage equipment to be procured under the MAF project

Steps are been taken to collaborate with aid agencies to supply blood bank refrigerators and other blood banking equipment on needs-based basis to hospital Blood Banks Nationwide. During the period the Tamale Teaching Hospital blood bank was rehabilitated under the current TTH project and made functional. Thirty-five (35) new blood bank refrigerators were donated by UNFPA. A distribution list based on the MAF gap report and needs-basis was prepared for distribution to 35 hospitals across the country

Reduce the major causes contributing to child morbidity and deaths

Salt iodization coverage was 32% in 2013. The main challenge includes low production from salt producers. This is due to the scarcity of potassium iodate on the market and the reluctance of producers to incur additional cost through the purchase of the potassium iodate.

The plan to evaluate the implementation of Growth Monitoring Chart was not done, but prevalence of anaemia among children under five and pregnant women was not done. The indicator on anaemia has been included in the DHS module for the 2014 survey.

To increase access and coverage to EPI services including the newly introduced vaccines the following objectives set out to be achieve;

1. Update the programme's working document (Comprehensive Multi-Year Plan -cMYP) with new policies and innovations; and introduce Measles/Rubella (MR) vaccine.
2. Improve access to new - Human Papilloma Virus (HPV) vaccines and Innovative Technologies for vaccine preventable diseases
3. Accelerate the control and prevention of vaccine preventable diseases; and Conduct two rounds of polio vaccination nationwide (NIDs)
4. Increase and maintain routine immunization coverage for all childhood antigens to 90% and above; and Vaccinate all children under 1 year with the 11 EPI vaccines
5. Accelerate the control and prevention of vaccine preventable diseases; and conduct nationwide MR campaign
6. Promote and ensure injection safety

Progress made towards achieving the objectives outlined above

1. The Comprehensive Multi-Year Strategic Plan was updated to include Measles / Rubella (MR) new vaccine
2. MR campaign conducted nationwide. The MR Vaccine has been introduced into routine EPI vaccines to replace measles vaccine at 9 months
3. Three (3) rounds of vaccination completed in 17 districts in 3 regions:
    a. CR -7 districts
    b. NR - 8 districts
    c. GAR-2 districts
4. Two rounds of Polio nationwide NIDs conducted

The sector is yet to secure funding for an in-depth assessment to determine the prevalence of measles and yellow fever and effectiveness of interventions and also evaluate the effectiveness of the cold chain system. These two assessments were estimated to cost the sector US$200,000.

5.4 HO4: Intensify prevention and control of communicable and non-communicable diseases

Improve upon prevention, detection and case management of communicable diseases

Home based care and home management of malaria

Home base care (HBC) is a strategy geared towards communities with challenges in accessing health care. It is aimed at giving basic health care to a child as close to the home/community as possible to treat the condition before complications arise. It is also meant to get children suffering from malaria, pneumonia and diarrhoea treated as quickly as possible to prevent deaths. Home management of malaria (HMM) is one aspect of HBC.

Implementation of HMM is done in 136 districts nationwide. Most of the districts were targeted because they have a high rural component. Uptake of home management of malaria is very low. Uptake was only 9% of the stated target of approximately 1,700,000 malaria cases planned to be treated at community level. About 26,000 Community Based Agents (CBAs) were trained countrywide. However, in a recent assessment, only approximately 7,800 CBAs and 500 supervisors are active. This is due to;

- High attrition rate
- Inadequate supply of drugs
- No remuneration of CBAs
- Low motivation of supervisors who are to oversee the work of the CBAs
- Low perception of CBAs in the communities and low mass media campaign
- Presence of CBAs in communities where there is a health facility.

If however, the three factors of remuneration, continuous supply of drugs and sustained mass media campaign are addressed, uptake of the intervention may increase. As a result of the challenges enumerated, the National Malaria Control Programme (NMCP) is scaling down to communities and areas where access to health facilities is still a problem.

Community interventions are generally not well harmonized and integrated into the health system structures.

The review team recommends that all community-based interventions should centre around the CHPS structure and the CHO. Funds for volunteer programmes should likewise be channelled through the CHPS level.

The team also recommends that GHS reconsider the role of volunteers in treatment of malaria and other diseases and explore options for integrating these activities into the CHPS strategy.

Continue implementation of TB intervention including surveillance and assessment of health professional competency in TB case management

The overall objective was to procure diagnostics and develop capacity at districts to detect, manage TB and specifically:

- Detect and notify national level on smear positive TB cases
- Improve private sector involvement in detection of new smear positive TB cases
- Treat all detected TB cases according to National guidelines and attain treatment success rate of ≥88%
- Conduct test on eligible people for MDR-TB as per national guidelines and enrol all Laboratory confirmed MDR-TB cases on second line anti-TB treatment
- Scale up and strengthen Community Based TB Care (CBTC) to support TB case management
- Ensure continuing availability of TB drugs in the districts (Number & percentage of districts reporting no stock out of TB drugs on the last day of the quarter)

Polio and Neglected Tropical Diseases

Throughout 2013, some activities were carried out towards the attainment of the following priority areas: Complete the eradication certification process for guinea worm and polio, scale up elimination activities for leprosy, trachoma and yaws onchocerciasis, lymphatic filariasis and schistosomiasis and control buruli ulcer.

No cases of guinea worm and poliomyelitis were detected. AFP rate for the year was 2.71. The sector organized mass drug distribution for control of onchocerciasis and lymphatic filariasis in the endemic

communities as well as active case search and treatment of cases and contacts for Yaws and Leprosy in the endemic communities.

Improve prevention, detection and management of non-communicable diseases

Support to establishment of the NCD monitoring centre and data repository was not done during the year under review. There were intensive efforts to promote healthy lifestyle, and strengthen the prevention and management of non-communicable diseases particularly hypertension, diabetes, sickle cell disease and cancers, including Framework Convention on Tobacco Control (FCTC) implementation. Healthy lifestyle was introduced into basic schools and teacher-training curricula. 100% tobacco and alcohol advertising and public exposure requirements enforced.

About 35.7% of public hospitals in the country have functional hypertension and diabetes clinics far exceeding the 10% target for the period whilst only 2.7% of hospitals have units for cervical cancer screening. The planned community mental health strategy was finalized and disseminated. Implementation of the plan will start in earnest in 2014.

5.5 HO5: Strengthen institutional care including mental health service delivery

Under this objective a structured supportive supervision was carried out in some selected hospitals. Supportive supervision on malaria case management was done in 42 health facilities in seven (7) regions; namely: Volta, Eastern, Ashanti, Brong-Ahafo, Northern, Upper East and Upper West regions.

Customer care and quality assurance

To Strengthen quality assurance and improvement systems in health facilities, a review of the Quality Assurance manual done and a Quality Assurance and Safety book was developed. Health managers from three regions – Western, Central and Greater Accra were trained as trainers (TOTs), this has facilitated the training of staff from selected facilities in Western and Central Regions were trained to ensure that the district and sub-district facilities staff are subsequently trained. In addition, two hundred and eighty three (283) health providers from 131 health facilities across the country were trained on customer care and quality assurance. Further three hundred (300) staff of the Trust hospital, eighty (80) staff from the Adabraka Polyclinic and sixty nine (69) staff from four district in Ashanti region and four district from the Volta region were also trained on customer care and quality assurance.

GHS has developed an integrated support supervision checklist, which includes Quality Assurance. In 2013, integrated support supervision from the national level was carried out in 2 regions. In addition to this peer review of hospitals has been reintroduced and 6 regions conducted peer reviews of hospitals in their respective regions.There is on-going a large-scale quality improvement initiative underway in collaboration with Project Fives Alive, GHS and National Catholic Health Secretariat that builds capacity of frontline health facility staff in quality improvement towards reducing under five mortality. As at 2013, one hundred and forty hospital quality improvement teams had been trained and were at different stages of implementing QI projects to improve facility outcomes for children under five years

Triage and Basic Life Support

OPD and Accident and Emergency staff were reoriented on triaging and management of critical conditions. One hundred and thirty four (134) Clinicians from 17 district hospitals and clinics as well as one paediatric hospital were trained on Essential Surgical skills and management of key emergency conditions including

Triage and Basic Life Support. Sixty five (65) from the ten (10) regional hospitals and thirteen (13) district hospitals were trained to manage key surgical and medical emergencies.

6. Summary of recommendations by the review team

- *The Ghana Health Service should conduct an in-depth study to identify reasons for consistently low performance in Volta and Eastern Regions.*
- *An analysis of the sector's work force requirements, based on the newly developed staffing norm and the budget forecast, to inform staff recruitment policy.*
- *The NHIA should continually analyse, review and implement measures to reduce Moral hazard, adverse selection and risk selection.*
- *The GHS should assess reasons for the poor family planning coverage in the Northern and Ashanti Regions. The assessment aim at, identifying the worst performing districts and scale up interventions in such districts.*
- *An analysis of distributional, supervisory and logistics issues in an attempt to improve uptake of antenatal care services.*
- *The GHS and MOH should clarify the definition of skilled delivery and establish whether a CHO-delivery could be classified as a "skilled-delivery".*
- *The GHS and MOH clarify the role of CHOs with respect to performing planned deliveries and agree on formal training of CHOs in obstetric care and requirements for clinical attachment to obstetric wards.*
- *Based on these observed differences, the review team recommends a fact-finding mission to selected regions (Volta, Ashanti, Central and Northern Regions) to better understand the determinants for poor performance related to provision of maternal health services.*
- *The review team recommends disaggregating EPI data to the district and sub-district level to identify least performing districts and sub-districts and the factors influencing their performance. A peer review system using the holistic assessment tool for instance may be appropriate*
- *The review team recommends that MOH and GHS should collaborate to improve the reporting system so maternal deaths can be geographically mapped to the community the woman came from.*
- *The review team observed issues with DHIMS II and the information management in the sector as a whole that need to be tackled.*
    - *Teaching hospitals should come onto the DHIMS*
    - *Reporting from the private sector providers should be improved*
    - *Options should be explored for bringing other non-service providing agencies onto the DHIMS*
    - *Systems should be put in place to distinguish zero-reporting (e.g. reporting of zero cases of disease x) from non-reporting*
- *The regional analysis suggests that Eastern Region may require special attention in 2014, and the review team recommends technical support to this region in order to identify the causes of the worsening performance.*

- *The review team recommends that all community-based interventions should centre around the CHPS structure and the CHO. Funds for volunteer programmes should likewise be channelled through the CHPS level.*
- *The team also recommends that GHS reconsider the role of volunteers in treatment of malaria and other diseases and explore options for integrating these activities into the CHPS strategy.*

7. Agencies assessments

7.1 National Health Insurance Authority

The National health Insurance Authority set out to achieve the following;

- Increase active membership to 38% of the population be December, 2013
- Increase active membership of the poor and indigent to 30% by December 2013
- Provide support to increase access to quality basic health care for subscribers of the NHIS
- Strengthen governance systems of the NHIS and improve human resource capacity
- Improve the quality of service accessed by subscribers of the NHIS
- To improve level of provider experience within the NHIS
- To improve participation and involvement in health insurance programmes

The objectives were based on the assumptions that the Ministry of Finance shall release funds due the NHIA in full and on timely basis and policies strategies for improving the NHIS will receive required attention and approval.

The NHIA is also aware of that funds are usually in three months arrears and stakeholder engagement may take longer than anticipated. Similarly the Authority is aware that approval process for some major policy proposals could take longer than planned. These factors may affect the smooth operation of the authority.

1. Key activities planned to ensure funds are released on time include;
   - Dialoguing with the Ministry of Finance to ensure timely release of funds
   - Strengthening of control systems and increasing premium paid by the informal sector to improve premium income.
2. To increase efficiency in the financial operations of the Scheme, the scheme planned to introduce prudent fund management practices to improve investment income, and cut down on administrative cost and introduce electronic payment system to improve financial management. It also planned to begin nationwide PPP enrolment and extend capitation to other regions and establish a joint clinical and claims audit teams to undertake forensic audit to reduce fraud and abuse in the system
3. To increase active membership to 38% of national population, the following activities were planned. They include
   - To conduct regular and special registration and renewal excises to increase coverage
   - Increase enrolment for the poor and indigent including LEAP beneficiaries.
   - To register inmates of psychiatric hospitals across the country.
   - Introduce bio-metric ID card system to improve ID card management
4. A major activity carried to ensure improved access to quality and basic health care services was the revision of the benefit package, the tariffs and medicines prices.
5. To strengthen governance system and improve human resource capacity the authority planned to organize institutional reforms to reflect the new Act 852 and develop LI for the new Act 852. It will also planned to mainstream M&E system within the NHIS

6. The authority also planned to improve the quality of service accessed by members of the NHIS through the compilation of subscriber handbooks, support providers to improve service quality and implement ICT upgrade.

Achievements

The National Health insurance authority received 69% of receivable funds from government. This is an improvement of the 2012 figure of 46%. The authority submitted a concept paper on various scenarios for raising additional sources of revenue for consideration. It is yet to get a response to the proposals. Proportion of premium income rose from 3.6% of total revenue to 4% in 2013. The change did not impact on the operations of the authority. A paper on premium adjustment is under consideration. The target is to raise the premium level from GH¢7.20 to ¢48 to GH¢10.00 to GH¢40.00.

Returns on investment increased from 4.6% in 2012 to 11.4% this year. This increased the number of months of investment cover from 3 months to 4 months. Administrative expenditure was reduced from 14% to 10.7% and reduced expenditure on non-core NHIS activities. This is as a result of consolidated information system and leaner logistics and transport. Pilot electronic payment system introduced. It will be scaled up incrementally and hopefully will improve payment of claims in real time.

A Quality assurance directorate was established to help push the agenda of integrating clinical audit and credentialing function under on directorate. The objective of having more providers audited was not achieved due logistical challenges. The proportion of providers audited fell from 8% to 2.3%.

The planned roll-out of capitation in three regions could not take-off due to delayed stakeholder consultations. The plan hopefully will be rolled up in 2014. A Joint clinical and claims audit team was established, however, the output of the team was affected by logistical challenges, which are being addressed. Detailed evaluation of the capitation pilot is presented in chapter 3.2.

The proportion of active membership of the scheme was increased from 33.3% in 2012 to 36.8% in 2013. This impacted on the finances of the authority. Enrolment of the poor and indigent including LEAP (Livelihood Empowerment Against Poverty) beneficiaries increased from 393,453 to 1,124,438, an increase of about 186%. A total of 1,037 in-mates of the psychiatric hospitals were registered exceeding the target of 500.

In an effort to improve the ID card management system, the authority introduced a bio-metric ID card system on a pilot bases in two districts. This will be scaled up incrementally during 2014.

Support for health sector investment increased. About 47% of planned releases were actually released in 2012 compared with 53% in 2013. The releases are proportional to releases from the Ministry of Finance.

	2008	2009	2010	2011	2012	2013
Fund Size (GH¢)	464.01	447.17	382.06	235.65	220.21	205.8
Investment (GH¢)	-	-	-	-	184.60	159.92
Investment Cover (Months)	-	-	-	-	3	4
Investment Income (GH¢)	42.80	75.96	58.81	32.87	28.79	39.73
Investment Income as % of Total Income	11.98%	17.95%	12.15%	5.31%	3.72%	6.14%

Syndicated Bridge Finance Facility	-	-	-	-	149.40	112.50
Bridge Finance as % of Investment	-	-	-	-	80.9%	70.35%

Table 7: Trend investment portfolio of NHIA

	2012	2013
Income (actual releases)	713 Million Cedis	*498 Million Cedis
Expenditure	787 Million Cedis	735 Million Cedis

Table 8: Income& Expenditure Summary in 2012 & 2013

Challenges

Key challenges of the authority include both internal such as financial sustainability issues, identification of the poor, Identity card management and how to use ICT to improve operations.

External

Moral hazards from both demand and supply sides continue to be major challenges. Other challenges include high cost of medicines, the consumers' ability to pay premiums, quality if care at health facilities and long waiting times at the facilities.

Mitigation strategies

Introduce prudent cost containment measures and intensify clinical audits. Measures will be introduce in ensure more people are registered issued instant ID cards. Collaboration with the social welfare department of Ministry of Gender, Children and Social Protection (MGCSP) to identify the poor for exemption will be intensified whilst computerization of NHIS operations scaled up. Claims processing and payment will also be shortened through E-claims management. Audit and risk management systems will also be strengthened. Capitation will be rolled out nationwide incrementally.

7.2 Ghana Health Service

Key priorities for the service include:

- SO1: Review and accelerate scale-up of Community-based Health Planning and Services (CHPS)
- SO2: Improve leadership & management systems, especially HR & health information system to improve health outcomes
- SO3: Intensify the implementation MDG 5 Acceleration Framework and other Reproductive & Child Health Services
- SO4: Step-up disease control activities, particularly HIV & AIDS, TB, Malaria, GW & polio eradication, and IDSR
- SO5: Improve institutional care, especially management of emergencies, specialist outreach & mental health services

Achievements

As part of effort to develop leadership capacities in the service, leadership development training was carried out in UER, UWR, NR, CR, WR, and greater Accra Regions bringing coverage of health staff to be trained to 70%.

An integrated monitoring visit was conducted to the regions using a monitoring tool developed for purpose. The monitoring tool will be revised based on experience gathered on the field.

As part of efforts to strengthen health information management, forms on DHIMS 2 was rationalized to ensure a more synchronized and improved data management within the service. Regional Teams were also the forms in DHIMS2. Regional Teams were trained on the SOP for data Management.

Date	Source	Received from	Recipient	Amount (Ghc)
May-13	MAF	MoH	GHS Regions & Districts	3,903,359
May-13	MAF	MoH	GHS Headquarters	200,000
Nov-13	Danida SBS	MoH	GHS Headquarters	762,000
Nov-13	GIFMIS GoG (April & May)	MoH	GHS Headquarters	311,917
Nov-13	Danida SBS	MoH	GHS Regions	800,000
Nov-13	Danida SBS	MoH	GHS Districts	1,302,000
Nov-13	DFID	MoH	GHS Headquarters	184,000

Table 9: Ghana Health Service Disbursements in 2013

Operating Revenue	2013	2012
IGF Services	271,939,961.28	213,578,861.80
Medicines and Pharma	139,515,782.60	118,608,392.11
Total	411,455,743.88	332,187,253.91
Non-operating Revenue	2013	2012
GoG subsidy	592, 910,655.27	606,538, 861.80
Health Fund	18,585,778.95	11,646,606.37
Programmes	132,955,510.21	118,168,989.10
Refunds	0.00	0.00
Financial Credits	0.00	0.00
HIPC Funds		0.00
Other non-operating income		870,293.01
Total	**745,168,618.12**	**737,224,355.42**

Table 10: Ghana Health Service, Revenue by Source

2012 – 2013 Expenditure

GOG	2013	2012
Employee compensation	594,036,543.15	604,937,454.72
Goods & Services	703,127.44	7,003,976.12
Assets (purchases)	3,338,222.31	0.00
Total expenditure	598,077,892.90	611,941,430.84
IGF	2013	2012
Employee compensation	37,666,026.42	30,997,678.52
Goods & Services	339,998,403.33	277,754,931.68

Item 3(service)	0.00	0.00
Assets (purchases)	0.00	0.00
	377,664,429.75	308,752,610.20
Heath fund	2013	2012
Employee compensation	12, 104.00	2,104,598.05
Goods & Services	8,504,752.26	9,753,641.72
Assets (purchases)	278,264.63	283,718.98
Total	8,795,120.89	12,141,958.75
Program Expenses	2013	2012
Program expenses	129,479,480.58	120, 652,075.80

Table 11: Ghana Health Service, Expenditure 2012 and 2013

Challenges

1. Inadequate funding: New DHMTs not provided with start up funds to operate
2. Delays in NHIS reimbursements to health facilities
3. Low tariff regime for Govt health facilities to meet the cost of services
4. Difficulties in attracting health professionals outside the major cities of Accra & Kumasi
5. Competing health sector activities often disrupting service delivery due to in adequate planning
6. In adequate transport for supervision, especially the new districts
7. Staff accommodation in most districts, especially in the rural districts where there are no suitable accommodation for hiring

Mitigation strategies

1. Exploring non-traditional sources of funds for the service – e.g. Responding to calls for proposals from funding entities
2. Integrating some activities for efficiency gains
3. Costing of services & realistic tariff setting
4. MOH, GHS and Partners to share their annual work programmes with regions to enable them adjust their own programmes
5. Finalize the staffing norms and all agencies of the MOH be committed to implementing the norms.

7.3 Korle-Bu Teaching Hospital

Key priorities of the hospital during the year include Client and Patient Care, Governance issues, General Works including Equipment Management provision of outreach services within and beyond Greater Accra Region. Research and engage in institutional survey activities are also priorities of the hospital

In furthering its priorities, the hospital planned to expand the Children's Emergency Unit, establish ICUs in Surgery, Plastic Surgery, Child Health, Medicine and Obstetrics and Gynaecology. It also planned to equip the stroke unit and support the cell biology unit. Other plans of the hospital include the institution of measures to improve patient outcomes, reduce post operative and post procedural deaths.

The hospital planned to commence the conduct of Renal Transplantations during the year and continue with the internal decentralisation and restructuring exercise. Financial Management and Audit Systems of the Hospital were to be strengthened. It was anticipated that each sub BMC would conduct at least one Research

Achievements

The hospital completed the renovation of the surgical second Floor and the Third Floor of Children's Block with the support of Vodafone. The Korle-Bu advanced Medical Imaging Centre (KAMIC) and a six bed ICU facility at the medical department were completed whilst expansion of the Children's Emergency unit was commenced.

Other works completed include the installation of a New 1,000kv transformer at KAMIC, Two medical gas plants of 120m³/hr for surgical and Maternity. The stroke ward and the Psychiatry Unit's were also renovated

The hospital through the BELSTAR RETOOLING PROJECT has also completed the First Phase of Laundry and Kitchen projects and commenced the second phase. The dental unit was completed and handed over to the hospital authorities

Challenges and mitigation strategies

Challenges	Mitigation Strategies
The Hospital's relationship with the Centres of excellence not properly structured e.g. Shared utilities yet they have independent financial management systems	Engaging the centres in discussions on cost sharing/the possibility maintaining Sub BMC relationship.
Structures are very old without available blue prints(this makes maintenance difficult and expensive)	Blue prints are generated during major renovation works/Pursuing Agencies like AESL where possible.
Problems with the very old sewage system	AMA and Zoomlion have completed the blue print for contract award
Facilities over stretched because of additions in the Units and Departments; service facilities such as water and electrical systems remain constant	A consultant has been engaged to generate a master plan to enable redevelopment and efficient use of land
Limited capacity of water storage facility	Ghana Water Company contacted to advise on increasing capacity to store water for ten day during general water crisis. Purification of available borehole water
Increasing capacity and number of ICUs and the Human Resource implications; staff required to manage these units eg. critical care nurses for HDUs/Respiratory Therapists/Anaesthetists	The Human Resource requirement has been factored into the HR plan.
NHIS Reimbursement not very regular and putting a strain on service delivery	Engaging NHIA in discussions on how expedited actions can be taken regarding reimbursement
Number of staff members on IGF and financial implication on the Hospital	Replacement of Retirees with IGF Staff. Dead, dismissed, resignations compiled from the cleaning exercise.
Power panels, switch gears and other systems have not been replaced since 1920	Efforts made at doing complete replacements when these are found to be malfunctioning

Increasing demand for service and the pressure on existing facilities	Where possible Management has tried to expand existing facilities to meet increasing demand.
Strike actions by Doctors and Pharmacists impacted negatively on the Hospital in terms of reduced service to clients, the finances of the Hospital and its image	Management ensured that all emergency areas remained open during the strike actions

Service Utilisation

SERVICE INDICATOR	2011	2012	2013
OPD	321,481	363,325	342,911
IN-PATIENT	50,010	50,189	48,252
MAJOR SURGERIES	11,419		
MINOR SURGERIES	8,470		
DEATHS	5,069	3,800	3,421
Total live Births	10,503	10,103	11,647
Total Caesarean S.	4,121	4,125	4,805
Total Deliveries	10,503	10,278	11,186
Caesarean Section Rate (%)	39.2	40.1	43.0
Maternal Mortality	119	85	87
Maternal Mortality Rate	1,138/100,000	841/100,000	789/100,000
Neonatal Deaths		424	214
Infant Mortality	965	1,239	598

Revenue

TYPE	BUDGETED 2013 (GH¢)	2012 ACTUALS (GH¢)	2013 ACTUALS (GH¢)	VARIANCE (GH¢)
FEEPAYING	37,367,158.61	26,269,462.34	25,968,248.16	11,398,910.45
NHIS	14,346,071.10	10,134,926.20	12,454,916.91	1,891,154.19
OTHERS	4,006,072.74	1,578,068.66	1,543,275.50	2,462,797.24
TOTAL	55,719,302.45	37,982,457.20	39,966,440.57	15,752,861.88

Expenditure

EXPENDITURE BY ITEM	2013 BUDGET (GH¢)	2012 ACTUALS (GH¢)	2013 ACTUALS (GH¢)	VARIANCE (GH¢)
EMPLOYEES COMPENSATION	8,765,569.92	7,043,342.23	10,742,709.57	(1,977,139.65)
GOODS & SERVICES	39,941,892.73	24,736,072.37	22,497,210.51	17,444,682.22
FIXED ASSETS	7,011,839.80	2,374,207.89	4,747,476.16	2,264,363.64

TOTAL	55,719,302.45	34,153,622.49	37,987,396.24	17,731,906.21

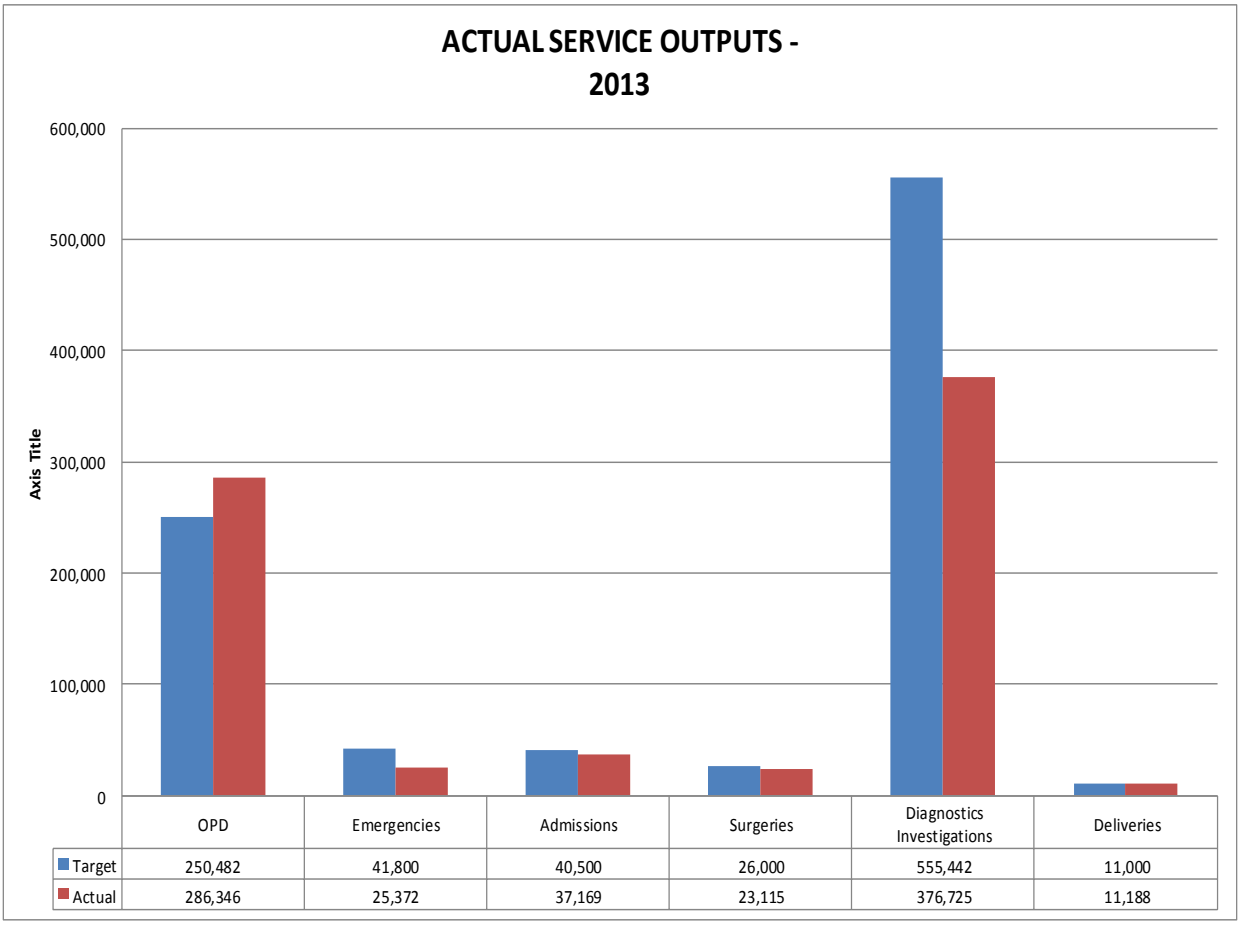
7.4 Komfo Anokye Teaching Hospital

The Komfo Anokye teaching Hospital planned to continue with strategies aimed at widening access to specialist clinical care services and sustain activities aimed at reducing mortality, especially maternal mortality, and improving general care outcomes. In this light, it planned to continue efforts aimed at providing support to district and regional hospitals in the northern sector of Ghana. The hospital also planned to complete outstanding infrastructure projects and Improve Management Information system.

Achievements

As part of strategies aimed at widening access to the specialist clinical care services an MRI Centre was set up and is fully operational. A test run was also conducted on the hospital's eye centre with OPD services provided. Equipment were acquired and installed at theatres with the support of USA benefactors whiles additional space was created for paediatric services and at the Polyclinic to provide Minor emergency procedures reducing congestion at the Emergency centre.

To sustain activities aimed at reducing mortality and improving general care outcomes, weekly maternal mortality audit meetings was initiated and monthly meetings with Regional & Metro Health Directorates were held to review results of audit. Workshops were also held for the quality assurance committees to bring them to date.



	OPD	Emergencies	Admissions	Surgeries	Diagnostics Investigations	Deliveries
Target	250,482	41,800	40,500	26,000	555,442	11,000
Actual	286,346	25,372	37,169	23,115	376,725	11,188

A client satisfaction survey was conducted during the year with a satisfaction rate of 70%. The survey identified staff attitude and inadequate seats at the main own OPD as concerns of clients. To improve the clinical skills of staff, training activities were organised for clinical staff, especially staff from O&G and Child Health whilst space was identified for the creation of ICU at the maternity area. Maternal mortality reduced from to 152 to 126. Neonatal Mortality was 19% of neonates admitted.

The KATH continue to provide support to district and regional hospitals in the northern sector of Ghana. Outreach programmes in the areas of Ophthalmology, Cleft palate, ENT, were intensified considerably with more focus on Maternal and Child Health. In an effort to improve collaboration with peripheral institutions of the Ghana Health Service, the hospital organised maternal and neonatal health conference with 27 identified peripheral facilities. Consultants and Senior Specialist were allotted specific Hospitals to provide support and periodic outreach. To improve communication, desktop phones were procured for all the 27 facilities whiles mobile phones were procured for the clinical teams to ensure they are easily accessible by the health facilities. Maternal and Neonatal Telephone hot lines were established at the O&G

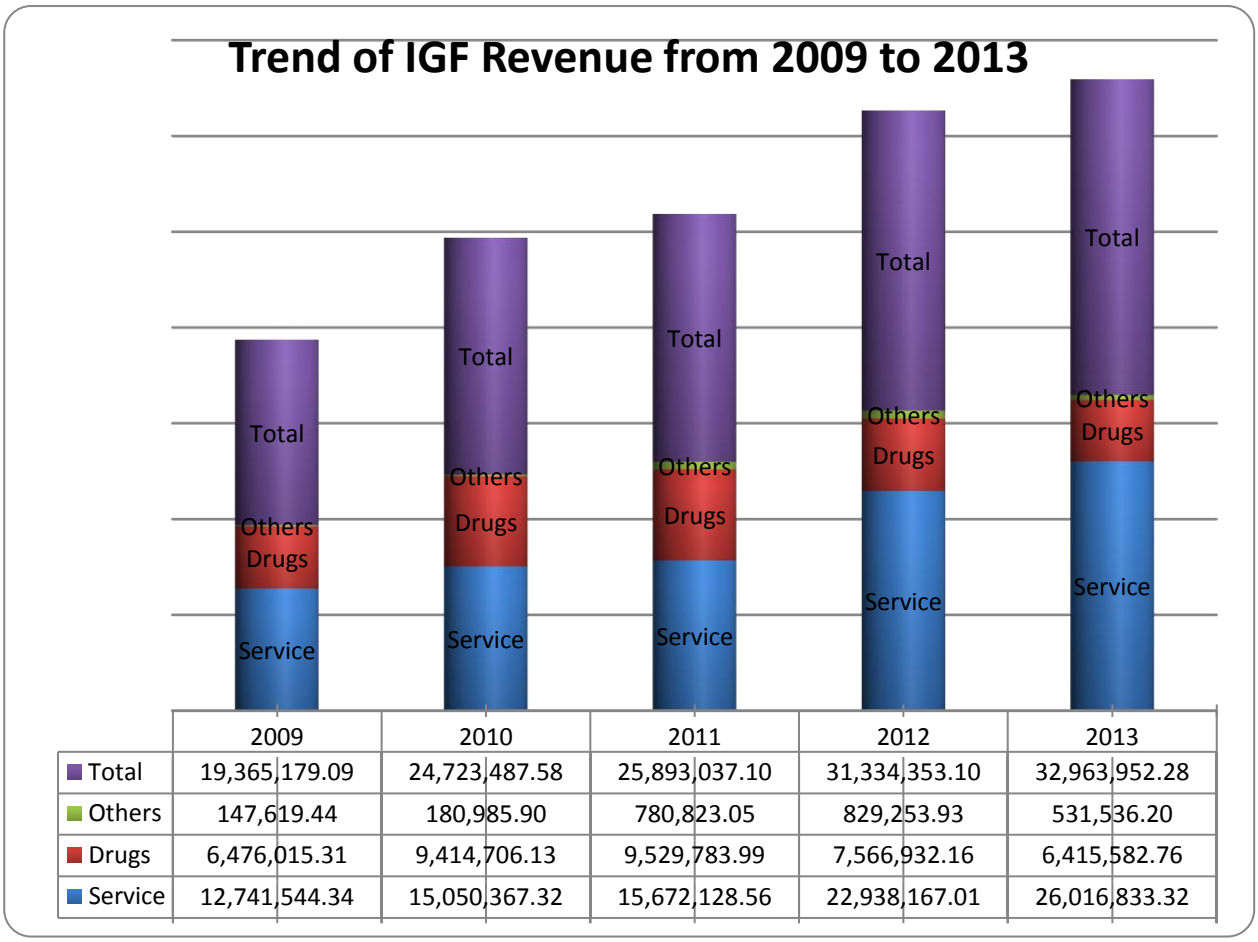
The hospital initiated a process to complete some outstanding projects. The projects are at various stages of completion as indicated in the table below

Status of hospital outstanding projects

Project	Year End 2012 Status	Year End 2013 Status
Construction of Maternity and Children block	65%	75%
Complete the construction of a new eye centre	95%	100% (Complete)
Complete the construction of the new family planning cent	80%	90%
Painting of the Old Hospital Block(A-D)	50%	100% (Complete)

In an effort to improve information management in the hospital, it started the installation of Hospital Administration Management System (HAMS) software. 50% of Phase I installations & training, which are mainly at the clinical areas were done

2013 FINANCIAL PERFORMANCE



	2009	2010	2011	2012	2013
Total	19,365,179.09	24,723,487.58	25,893,037.10	31,334,353.10	32,963,952.28
Others	147,619.44	180,985.90	780,823.05	829,253.93	531,536.20
Drugs	6,476,015.31	9,414,706.13	9,529,783.99	7,566,932.16	6,415,582.76
Service	12,741,544.34	15,050,367.32	15,672,128.56	22,938,167.01	26,016,833.32

Challenges

Challenges confronting the hospital include

- Late referrals of patients from lower level institutions
- Congestion, especially at maternal & children's wards
- Inadequate clinical staff, particularly Specialised Nurses
- Accommodation for House officers and Residency Doctors
- Delays in the payment of health insurance claims
- Non -functioning Oxygen Plant
- Deplorable condition of the old hospital block
- Ageing vehicles
- Obsolete radiology equipment at main radiology block

7.5 Tamale Teaching Hospital

STRENGHTEN AND IMPROVE GOVERNANCE AND EFFICIENCY OF TTH's MANAGEMENT SYSTEMS

STRATEGY	ACHIEVEMENT
Optimize operations of sub- BMC,s	• Sub-BMC management teams appointed, trained and functioning.
Continue upgrading of TTH's infrastructure and institutionalize PPM schedules	• Completion of phase 1 of TTH major refurbishment and upgrading of Phase 2 • Hospital currently linked to public system with fiber – optic ICT connection • Full implementation of Hospital's computerization system using the Hospital's Administration and Management Systems (HAMS)
Forge stronger collaborations and partnerships	• Visit by local and external collaborators to the Hospital.(collaborators in areas of research, faculty exchange, QA)
Strengthen financial controls/ financial management systems	• Collaboration with HFC to improve efficiency in revenue collection • Computerized revenue collection systems
Strengthen QA systems to ensure excellent service delivery	• MOU signed with Kybele international • Wake Forest Univ • Continued collaboration with 5 Alives • QA secretariat established and functioning

PROVIDE EXCELLENT QUALITY MATERNAL AND CHILD HEALTH

STRATEGY	ACHIEVEMENT
Expand MCH infrastructural and logistical needs	• 69 staff trained in proper referral system • 12 in neonatal resuscitation • 12 in Paediatric advance life support
Attract and retain specialized staff and build existing staff capacity.	• In- housing training of 728 staff • 2 staff on overseas workshops and conference
Reduce maternal and child health mortalities	• TTH's MAF Implementation Plan developed • MAF Steering Committee set up • MAF Implementation Committee set up

PROVIDE EXCELLENT TERTIARY HEALTH CARE

STRATEGY	ACHIEVEMENT

Establish additional clinical sub-specialties	Re-opening of Psychiatric unit with additional Psychiatric nurses recruited Family Medicine Sickle cell, Paediatric nutrition, Pain Mgt and Nephrology clinics established.
Acquire required equipment and logistics	Introduction of additional improved diagnostic services (Mammography, Dental X-ray) New wall-mounted diagnostics sets, BP Apparatus etc in each consulting room Regular availability of oxygen due to completion of new Oxygen Plant.
Attract and retain staff for specialized areas	Recruitment of Psychiatrist, Neurosurgeon, Obstetrician and Return of trained Emergency Nurses and other Specialized Nurses Revitalized multidisciplinary clinical and mortality meetings

IMPROVE AND COORDINATE TTH's RESEARCH /M&E ACTIVITIES

STRATEGY	ACHIEVEMENT
Accreditation for postgraduate training with GCPS **Create a strong brand/ public image for thehospital**	Accreditation acquired for Surgery, O&G and Family Medicine and awaiting accreditation for Medicine and Paediatrics Awarded the best Teaching Hospital by the MOH Best medical Outreach programs in Ghana so far.
Establish performance/need based motivational schemes	Staff housing policy developed.
Identify staff for specialized training	127 Participants given technical assistance training under the TTH-SIMED TA programme in Ultrasonography, ENT, Mammography & Quality Management
Institute regular and continuous staff development programmes	2 staff attended Overseas Workshop /Conference 728 staff trained

Strengthen TTH,s capacity for research	• Successful creation of the research department • Appointment of DD, R & 7 officers • Successful creation of the research committee . • Draft research policy developed and being discussed • Conducted research on staff satisfaction and theatre utilization • Research published in peer review journals and disseminated at Int' conferences by TTH staff.
Seek fund for research	• Proposals for funding is incorporated in the

	draft research policy
Improve collaborations/partnerships with other institutions for research and development programmes	• Assessing factors that influence Health Care Service Delivery and Consumer experience (University of Louisville)

REVENUE					
YEAR	IGF (GH₵)	DPF (GH₵)	GOG 2(GH₵)	GOG3(GH₵)	TOTAL(GH₵)
JAN - SEP 2012	4,842,052.39	945,619.29	NIL	NIL	5,787,671.68
JAN – SEP 2013	5,127,967.93	519,775.86	NIL	NIL	5,657,325.79
EXPENDITURE					
	IGF (GH₵)	DPF (GH₵)	GOG 2(GH₵)	GOG3(GH₵)	TOTAL(GH₵)
JAN - OCT 2012	2,397,450.95	730,769.72	NIL	17,114.21	3,145,334.88
JAN - OCT 2013	3,132,010.96	21,710.30	NIL	NIL	3,153,721.26

	2012 (GH₵)	**2013 (GH₵)**	**% CHANGE**
NHIS	4,019,541.82	4,298,791.48	7%
CORPORATE CLIENTS	27,938.26	44,558.35	59%
CASH CLIENTS	666,851.16	777,539.59	17%
OTHER INCOME	127,721.15	7,078.51	-94%
TOTALS	4,842,052.39	5,127,967.93	6%

NHIS STATEMENT

	2012 (GH₵)	**2013 (GH₵)**	**% CHANGE**
AMOUNT SUBMITTED	4,019,541.82	4,298,791.48	7%
AMOUNT PAID	3,898,002.94	4,348,798.06	12%
AMOUNT REJECTED	499,669.45	63,450.68	-87%

7.6 Ghana College of surgeons and physicians

Activity	**Comment**
Examinations (Membership)	Pass rate=82/105 (78.1%)
Intake interviews for 2013-14	Pass rate=221/234 94.4% Admission 143/170 (84%)*
Implementation of Guidance on Sponsorship	Commitment of agencies "not clear"
Revised training facility accreditation guidelines	Done. Proactive distribution – TTH, KATH

CPDs, Updates & Conferences	On-going – 22 so far/24
Research, Leadership & Management	In progress – 1 out of 2
ICT infrastructure for e-learning and management	Installation complete; VC units sent to TTH & KATH
Establish BLS/ACLS & ATLS Training	On-going courses
Estimation of national specialists' need and projections for next 5 years	First round of data collection

FACULTY	TOTAL PRODUCED	2013
Anaesthesia	23	3
Dental Surgery	21	5
General Surgery	90	15
Obstetrics & Gynaecology	79	10
Ophthalmology	16	3
Otorhinolaryngology	13	3
Emergency Medicine	11	5
TOTAL	253	44

FACULTY	TOTAL PRODUCED	2013
Family Medicine	27	10
Internal Medicine	35	2
Laboratory Medicine	11	2
Paediatrics & Child Health	45	11
Psychiatry	5	0
Public Health	38	12
Radiology	19	1
Radiation Oncology	3	0
TOTAL	183	38

Challenge	Mitigation Strategy
Recruitment of Staff	Pursue MoH
Sponsorship of Residents – A MAJOR THREAT	Clearer communication of MoH policy; and implementation of policy
Evaluation of training programmes – exit competencies	Institute mechanisms for assessment during and at end of training
Decentralizing Training sites – appropriate infrastructure, numbers and faculty	Communicate accreditation criteria to Agencies and Facilities; Posting of specialists and senior specialists
Attracting residents to 'deprived' faculties	Clearer definition and incentives; MoH to provide core

	funding and other packages
Determining National Specialists Needs	Encourage HRHD to facilitate and accelerate the exercise; Link to admission into residency training
Communications between stakeholders	Improve on existing mechanisms

7.7 Mental Health

The Mental Health Authority planned to Continue with the Mass repatriation and decongestion of the Accra psychiatry hospital and drill 2 bore holes to ensure regular supply of water. It also planned to refurbish two wards and paint all wards of the Accra Psychiatry hospital. Again the Accra psychiatry hospital was to be provided with new beds and a VIP female ward.

At Ankaful the Authority planed to complete the OPD block and establish a physical OPD to help general revenue for the hospital. Major repair of roofs of wards of the hospital was planned Collaboration with faith based healers was a key intervention planned for the Ankaful psychiatry hospital.

The mental Health Authority planned the to aid the Pantang Psychiatry hospital to complete rehabilitation of existing structure for Psycho OPD, review the hospital protocols, rehabilitate hospital roads and kitchen.

Apart from the hospital related priorities, the authority planned to establish psychiatry wings in five regional hospitals in collaboration with the Ghana Health Service and initiate a 50-bed unit facility at the northern sector of the country. It also planned to create a community rehabilitation centre.

Achievement

Decongestion of the Accra Psychiatry hospital is on course with inpatients now down to 480 from 860 in December 2012. One new bore hole drilled and three hundred new beds procured through Medshare, Citihope and GHS for the hospital. Four wards have been given a facelift.

The Ankaful Psychiatry hospital initiated a programme to collaborate with Faith-based healers in their catchment area. The collaborative effort is an on-going programme that encourages faith healers to consult the hospital on regular basis on care of patients in their care. The hospital has also established a physical OPD, which will help it to generate some revenue to aid in the hospital's work.

Outreach services were undertaken to the Western Region. The objective was to provide access to psychiatry services to clients who for varied reasons could not visit the hospital for care. Some repairs were carried out on the roofs of the hospital wards.

The Pantang Hospital completed the psychology OPD, completed the revision of the hospital protocols and initiated new ones. A new pick-up was also acquired to aid in the hospital's operations.

Mental Health Strategic Document for the establishment of psychiatric wings at regional and district hospitals have been completed. This will guide the establishment of the psychiatry wings in hospitals in the country and thus make psychiatry services accessible to majority of the communities. The Mental health Authority Board was inaugurated on 19thNovember, 2013 and have had 2 meetings since. Under its auspices, a first draft of the legislative instrument has been produced.

OPD attendances

	2011	2012	2013
Accra	34,801	39,536	35,898
Pantang	20,822	23,331	23,360

Top 5 psychiatric conditions at OPD Pantang

ICD-10	Condition	Total
F20-29	Schizophrenia, schizotypal & delusional disorders	12,090
F30-39	Depression and Mood Disorders	3,617
G40	Seizure Disorders	2,268
F10-19	Mental disorders due to psychoactive substance use	2,209
F0-09	Organic mental disorders, eg. Dementia	524

Accra Psych Hospital budget for 2013

	2012	2013
BMC budget	9,591,666	8,438,600
MOH approved	1,543,452	1,543,452
Gap	8,048,214	6,895,148
MOH released	1,828,160	4,216,000
IGF service	64,439	63,251
IGF drugs	51,021	45,943

Challenges

- Inadequate and irregular funding
- Low human resource capacity
- Inadequate supply of psychotropic medicines
- No career progression for mental health nurses
- No placement for new cadre of mental health workers – CMHO, CPOs

7.8 National Ambulance Service

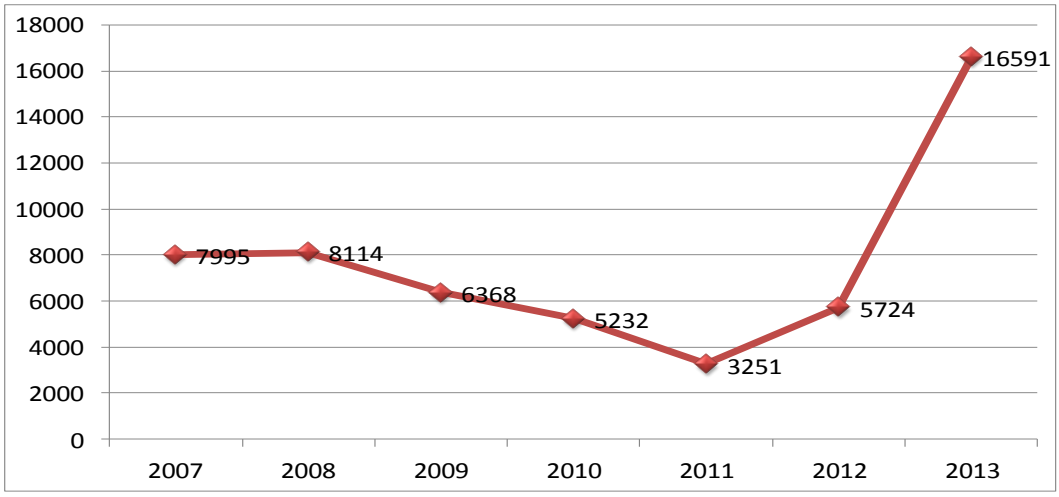
The national Ambulance Service planned to open new ambulance stations to cover80% of districts and maintain 121 existing stations. It also planned to recruit and train 600 new emergency medical technicians (EMTs), organize refresher courses for 200 existing EMTs and get the paramedical school functioning

NAS has increased the number of stations across the country to 122 by the end of 2013

REGIONS	NO. OF DIST.	DISTRICTS COVERED	NO. OF STATIONS	% COVERED
ASHANTI	30	14	16	47%
GREATER ACCRA	16	10	13	62.5%
BRONG AHAFO	27	12	12	44%
CENTRAL	20	9	9	45%

EASTERN	26	16	16	61.5%
NORTHERN	26	17	17	65%
UPPER EAST	13	7	7	53.8%
UPPER WEST	11	8	8	72%
VOLTA	25	16	16	64%
WESTERN	22	8	8	36%
TOTAL	216	117	122	54.2%

GRAPHICAL REPRESENTATION OF CASES FROM 2005-2013



CASES BY CALL LOCATION

SERVICE POINT	CASES
Inter-Hospital Transfers & Emergencies	12,223
Work place/Industrial Emergencies	178
Social events coverage	157
Domestic Emergencies	1,354
Roadside Emergencies	2,526
TOTAL	16,591

Efficiency of Operations

REGION	CASE RESPONSE	CASE HANDLING TIME	VEH. ENGAGED PERIOD
ASHANTI	0:16:46	0:17:56	2:10:26
BRONG AHAFO	0:11:13	0:20:48	3:27:46
CENTRAL	0:14:13	0:19:21	3:13:59
EASTERN	0:15:03	0:23:02	3:53:28
G. ACCRA	0:14:07	0:19:20	2:31:58

NORTHERN	0:21:56	0:14:20	2:33:34
U/ EAST	0:16:03	0:11:31	2:20:23
U/ WEST	0:21:35	0:14:27	3:08:56
U/EAST	0:26:00	0:28:00	7:33:00
VOLTA	0:21:21	0:21:06	3:50:32
AVERAGE	0:17:12	0:18:31	3:28:52

CHALLENGES

- Inadequate Budgetary Allocation
- Late Release of Funds
- Lack of Legislation
- Lack of funds to complete training school and Headquarters
- Lack of dedicated source of funding

7.9 National Blood Service

Blood Supply Situation

Blood demands currently outstrip supply. There are inadequate voluntary blood collections as a result there is over-reliance on family replacement donors Hospital-based blood collections. Most facilities fail to follow NBS standards and protocols due to inadequate trained staff, documents/forms and basic equipment and laboratory standards.

To alleviate some of these challenges, the NBS planned to put in measures to improve on voluntary blood donations and ensure the safety, adequacy, timely and accessibility of efficacious blood and blood products' supply to all who need them, especially the most vulnerable groups, without any form of discrimination.

Total collections in 2012 & 2013 (AABC)

Collection modes	2012	2013 (to end Nov.)	Increase	% increase
No. of Mobile sessions	289	362	73	25.2%
Vol. (Mobile)	9,637	13,695	4,058	
Vol. (Static)	958	634	- 324	
Total voluntary	10,595	14,329	3734	35.24%
Replacement (AABC)	14,786	15,211	425	
Replacement (satellites)	2230	3,252	1022	
Total replacement	17,016	18,463	1447	
Total donations	27,611	32,792	5181	18.8%
% vol. donations	38.4%	43.7%		5.3%

SOURCE OF FUNDING	BUDGET SUBMITTED	RECEIPT	EXPENDITURE (ACTUALS)	%
A. GOG				
Compensation of employees	830,336.45	867,233.16	867,233.16	100%

Goods and Services	270,531.00	54,299.08	(not entered account yet)	0%
Assets/Capital	-	-	-	-
B. IGF				
	1,697,319.20	1,368,979.24	1,236,503.00	90%
C. DONORS				
CDC/PEPFAR	-	-	-	-
EU T-REC	261,934.55	198,600.75	140,686.12	71%
SBS				

CHALLENGES

- Lack of effective coordination of blood services nationwide. NBS legislation to support implementation of adopted NBP essential
- Inadequate numbers & proportion of VNRBD from low risk populations
- Inadequate numbers of trained staff, and high attrition rate
- Inadequate numbers of functioning vehicles, essential equipment and logistics for basic blood safety activities nationwide
- Unreliable provision of adequate quantities of essential and standard consumables such as test kits, reagents and blood bags resulting in occasional shortages
- Lack of understanding of BTS as a therapeutic and not a diagnostic service and of the concept of blood safety at all levels.
- Inadequate funding
- Indebtedness of health facilities

7.10 Christian Health Association of Ghana (CHAG) based on draft annual report for 2013

During 2013, CHAG consolidated health services provision through its network of 173 health facilities. Whereas 2 key outcome health indices show a slightly improved trend, 3 other key outcome indicators are unstable:

Main Health Indicators: 2010 – 2013

Health Indicator	2010	2011	2012	2013	4-Year Trend
Maternal Mortality	181	254	187	177	Improving
Infant Mortality	12.4	12.9	5.9	7.9	Fluctuating
Under-5 Mortality	11.2	9.2	6.5	7.7	Fluctuating
Still Births	37	29	25	23	Improving
Crude Mortality Rate	39.7	25.7	22.4	23.1	Fluctuating

Whereas out-patient attendance showed just a slight increase compared to 2012 (1.3%), in-patient attendance further increased by 8% compared to 2012.

Provision of Maternal Health Services remained a priority area and increases were recorded in number of deliveries (1.2%) and number of CS (14.3%). Antenatal Care recorded an increase of 36.5% in registrants and 25% in attendance. Overall, provision of HIV/AIDS related health and counselling services increased

considerably compared to previous years. Whereas profile of diagnosed conditions at OPD did not change much, proportion of Non-Communicable diseases is increasing.

Despite an overall increase in staff employment with 18.9%, CHAG continued to struggle with serious shortages in clinical staff such as Medical Doctors, Medical Specialist and Pharmacists. Moreover, available staff is unevenly distributed across the network putting pressure on securing equitable and quality health services. In part, this also explains the considerable variance in performance within the Network. Pressure on the Government wage-bill resulted in reduced number of staff accepted on the government payroll than expected.

Persistent delays in NHIA claim reimbursement up to 3-6 months resulted in serious solvency constraints of all members of the network. Moreover, NHIA tariff levels for services and commodities, although slightly adjusted, remained low and did not keep up with the devaluation of the Ghana Cedi. Available funds for capital investments and maintenance remained critically insufficient and, if not addressed, will profoundly impact on service readiness of plant and equipment.

CHAG continued to engage with the Ministry of Health (MOH), the Ghana Health Service (GHS) and many other stakeholders to strengthen the health sector through policy dialogue, technical input and sharing best practices. CHAG entered into a memorandum of understanding with the GHS to improve collaboration at Regional and District levels. In order to further develop the Network and strengthen service outputs, CHAG formulated a new 3-year strategic framework (2014-2016) and maintained partnerships with various donor agencies. Some key performance indicators of the association are indicated below

OPD

	2010	2011	2012	2013
OPD (CHAG)	4,134,887	4,847,944	5,692,640	5,766,567
% CHAG contribution to OPD (National)	19%	20%	19%	19%

Inpatient

	2010	2011	2012	2013
IPD (CHAG)	338,998	394,442	397,240	428,601
% CHAG IPD Contribution (National)	37%	33%	29%	30%
IPD Insured	256,820	313,855	332,705	368,892
% IPD Insured	76%	80%	84%	86%

BUDGET PERFORMANCE 2013 (SECRETARIAT AND NETWORKS)

	Approved Budget			Actual Expenditure		
ITEM	GOG	IGF/IGR	Donor	GOG	IGF/IGR	Donor
Personnel comp.	125,088,844	40,434,454	-	140,381,748	25,880,066	-
Service	150,640	279,369,689	3,120,666	-	238,607,097	3,120,666
Assets	-	25,749,446	-	-	4,982,782	-
Total	125,239,484	345,553,589	3,120,666	140,381,748	269,763,131	3,120,666

MAIN CHALLENGES

HSS Block	Critical Challenge & Future Agenda
Leadership & Governance	• Continued training and education in leadership, governance, management and organisational and institutional development across the network; • Development of institutional arrangements for the CHAG network at the Region, District and sub district levels in the context of the imminent decentralisation policy of the Ministry of Health; • Update and improve CHAG membership criteria as well as conduct a regular CHAG membership audit; • Strengthen the governance system within the CHAG network.
Human Resources Health	• Critical shortage and un-equal distribution of key professional health staff across network; • Considerable attrition rate of professional staff; • Inadequate HR planning, management and supervision across the network; • Non-compliance with some MoH policy and procedures and use of varied HR management guidelines. • Poor to average student exam results of training schools.
Service Delivery	• Improve health planning in context of local disease burden in collaboration with local authorities, GHS and communities; • Need to promote and continuously improve patient safety and quality of care; • Documentation, exchange and application of good practices across the network.
Health Financing	• Persistent delays in NHIS claim reimbursement; • Low NHIS tariffs (medicines, specialist services, etc.); • Insufficient funds for capital investments and maintenance across the network; • Un-timely and incomplete financial reporting by CHAG members.
Health Technology	• Dilapidated health facility plant and equipment; • Limited maintenance culture, budgets and –plans; • High cost of equipment and drugs.
Health Information	• Prevailing in-adequate data management and use for decision making at the health facility level; • In-ability of DHIMS-II to provide disaggregated data on CHAG at all levels; • Late and incomplete submission of CHAG minimum data-set by members.
Community Ownership	• Continuously strengthen health facility-community engagement; • Document and disseminate good examples and lessons learnt.
Participation	• Improve collaboration between CHAG health facilities and GHS at the Region, District and sub-district levels; • Develop a strategic Public-Private-Partnership agenda; • Update and comply with Memorandum of Understanding (MOU) between CHAG and MOH; • Establish MOU between CHAG and GHS at the Regional and District level; • Secure long-term funding beyond 2016.
Health Research	• Limited systematic research of innovative work carried out within CHAG; • Lack of an operational and institutional research agenda; • Limited dissemination of research initiatives for CHAG and the health sector.

7.11 Centre for Scientific Research into Plant Medicine

- Develop at least one herbal medicine for the ff. diseases conditions: malaria, diabetes, hypertension, infections
- Improve quality and presentation of 3 herbal products
- Disseminate research findings (4 research papers and 6 technical reports) on quality, efficacy and safety of herbal medicines
- Intensify efforts at sourcing for grants to support research
- Improve and expand access to herbal medicines
- Intensify program for the conservation & cultivation of medicinal plants
- Provide technical support services to herbal medicine manufacturers and Traditional Medicine Practitioners (TMPs)
- Undertake the training of students/interns in herbal medicine development and practice(6 months internship etc.)
- Collaborate with pharmaceutical industry in the manufacture of herbal medicines
- Collaborate with TMPs In the development of their products (aimed at building confidence between researchers & TMPs
- Register some of Centre's products

7.12 Nursing and Midwifery Council

The Nursing and Medical Council plans to complete its new office complex and establish three additional Completion of new office complex Regional Offices in Western, Upper East and Upper West. (Takoradi, Bolga and Wa). It also planned to disseminate and publish findings of research into Low Performance of Students in Nursing and Midwifery Training Schools and update inspection and support supervision Manual and print initial copies. Other planned activities include accreditation of new and existing and NMTCs whose accreditation has expired, Development of assessment tools for the Paediatric Nursing programme and commencement a major review of curricula for the four basic programmes and the two auxiliary ones (RGN,RM,RMN,RCN, HAC, CHN)

Achievements

Conducted 2 licensing examinations for all nursing and midwifery disciplines. In all, a total of 10,269 candidates were examined. Work commenced on new office complex with funds from IGF of then council and 3 new Regional Offices in Takoradi, Bolga and Wa were established. The planned research into low performance of students in nursing and midwifery schools was successfully carried out. Dissemination of the report has started.

The Inspection and Support Supervision Manual was updated and in use. The Council conducted inspection and support supervisory visits to 18 training institutions and 36 hospitals as part of their mandate. Twelve new NMTCs were accredited and 8 existing schools re-accredited. Forty-four principals were taken through an academic leadership-training programme to improve on their leadership skills. Assessment tools for the Paediatric Nursing programme was developed and commenced a major review of curricula for the four basic programmes and the two auxiliary ones (RGN, RM,RMN,RCN, HAC, CHN)

Challenges

1. Inadequate office accommodation at the Head office

2. Inadequate staff: difficulty in securing financial clearance to employ
3. Perceived falling standards of Nursing and Midwifery Practice

FINANCIAL PERFORMANCE AS AT 31ST OCTOBER 2013

Source	Approved Budget	Actual Receipts	% Of Actual Receipts	Actual Expenditure	% of Actual Expenditure on Actual Receipts
GOG	2,178,027	725,186	33	725,186	100
IGF	10,715,083	6,308,996	59	7,612,957	120
Total	12,893,110	7,034,182	55	8,338,143	119

7.13 Pharmacy Council

Planned Activities

The council planned to conduct education and training for service providers and interns to assure quality of Pharmacy practice in Ghana and license pharmaceutical service providers and businesses. Other activities planned for the year include inspection and monitoring of pharmaceutical practices and standards to promote compliance and conduct public education to enhance effective regulatory activities.

Achievements

Pre-registration trainings for 375 service provider interns were conducted in June and November 2013. A General Pharmacy Practice Qualifying Exams (GPPQE) was also conducted during the year. A total of 214 candidates sat the examinations with 87% pass rate. Details of Exams conducted during the year are indicated in the table below.

Post-registration training for service providers conducted during the year include:

- 9,051 license chemical sellers (LCS) on family planning
- Continuous Education (CE) for 1360 was conducted for pharmacists. The council's target for year was 1300.
- 5,143 LCS in the Ashanti, Brong-Ahafo Western regions were accredited by the NHIA with the support of UASID.

Other achievements in the areas of licensing and registration, Inspections and Monitoring are as follows:

- The council in 2013 renewed licenses for 1,641, which is 83.1% of target and 7,488 licensed chemical sellers constituting 78.9% of target for the year. One hundred and forty three (143) new pharmacists were registered and the license of 1,582 representing (98.9%) of target were renewed. A total of 204 pharmacies and 594 LCS were licensed.
- 865 pharmacies were inspected and 5,018 LCS were inspected during the year representing 43.8% and 52.9% respectively of planned target

CHALLENGES

- Limited and skewed distribution of facilities
- Limited/ageing fleet of vehicles (expensive to maintain)
- Lack of funds and logistics to strengthen decentralized offices (Upper East, Upper West, Northern Regions)

- Inadequate staff – 31 Pharmacists including the Registrar (both in numbers and specialties)
    - Approval granted Pharmacy Council to recruit additional staff could not be done because IGF cannot support payment of their emolument

2013 Budget execution

SOURCE	APPROVED BUDGET GH¢	ACTUAL RECEIPTS GH¢	ACTUAL EXPENDITURE
GOG (Goods &Services)	87,678.00	9,915.13	9,865.00
Internally Generated Fund	1,993,657.00	1,403,950.00	1,197,216.80
TOTAL	2,081,335.00	1,413,865.13	1,207,081.80

7.14 Traditional and Alternative Medicine Council

The council planned to scale up the following;

- Accreditation, registration and licensing
- General enforcement, Special Enforcement exercises,
- Monitoring and supervision.
- Collaborate with stakeholders within the framework of PPP

It also planned to promote cooperate image through the Intensification of communication and information at health facility level and operationalise and review TAM training manuals developed by the Ministry of Health. Other activities planned include;

- Improvement of general administration and financial management system
- Enhancement of professional capacity of practitioners and existing staff

Achievements

Four (4) Special Enforcement exercises were conducted in the conducted Eastern Region, Central Region, Volta Region and Western Region. Two (2) regular enforcements conducted in the Greater Accra and Eastern Regions. The revision of the TAM bill commenced during the year.

Training was conducted as part of the continuous professional development (CPD) in the Eastern Region for indigenous practitioners, complementary health assistants and Chinese-TCM

Professional Qualifying Exams:

Training Schools:

- 2- Obuasi
- 1-Kumasi

Budget Execution

	Approved Budget		Expenditure		Execution(%)	
Source	GOG	IGF	GOG	IGF	GOG	IGF
Compensation	568,409	58,868	465,734.70	50,840.00	82	86

Goods & Service	111,155	803,087	28,649.11	431,154.16	26	54
Assets	0	217,904	0	44,133.52	0	20
TOTAL	679,564	1,079,859	494,383.81	526,127.68	73	49

7.15 Allied Health Professions Council

The council was established to regulate the training and practice of Allied Health Professions in Ghana. It was first started as the Allied Health Task Force on July 6, 2011 under a Ministerial Fiat pending the passage of the Health Professions Regulatory Bill to Law.

The Professions include Medical Imaging, Biomedical Science, Optometry and Optical Technology, Dietetics and Nutrition Science, Occupational Therapy, Audiology, Speech & Language Therapy. Others include Physiotherapy, Orthotics & Prosthesis, Medical Physics Environmental Health, Community Health (DCO, HI)

Planned activities

The council planned the following activities for 2013

- Develop standards of practice and code of conduct for Allied Health Professions
- Conduct maiden Licensure Examination for AHPs who completed their Internship in 2013
- Organize Induction Ceremony for Allied Health Graduates before the commencement of the 2013/2014 Internship Programme
- Monitor Allied Health Interns performance in all health facilities throughout the country
- Collaborate with NSS to post Allied Health Graduates for the 2013 /2014 NSS/ Internship Programme
- Conduct public education on the activities of the Council

Achievements

The AHPC approved and licensed 1,075 (47.5%) Allied Health Practitioners out of 2,267 registration applications received. Certificates and PIN Cards were issued to qualified Allied Health practitioners applications are still pending for various reasons.

Guidelines for accrediting Allied Health training programs and for the conduct of licensure examinations were developed and disseminated. Guidelines and standards for accrediting allied health training institutions/schools where also develop and disseminate.

- 12 allied health training institutions were given provisional accreditation in 2013 to run allied health programmes
- AHPC inducted a total of number 650 allied health interns (Degree Level) in 2013
- AHPC also inducted a total number of 150 allied health interns (Diploma/ Certificates Level) in 2013
- Conducted public education and sensitization on activities of AHPC
- Monitored and evaluated Allied Health Training Institutions

Challenges

- Absence of a Legislative Instrument (LI) to operationalise the Act 857
- Inadequate funding from GoG; reliance on our inadequate IGF

- Inadequate logistics (e.g. transport to undertake effective monitoring and supervision)
- Inadequate office accommodation for effective operations and administration
- Inadequate staffing to undertake numerous activities
- The status over 1,000 applicants who did not meet the AHPC criteria for registration and licensing and yet are employed by GHS, Teaching Hospitals, CHAG and private health facilities.
- Wide spread activities of quacks who are practising as Allied Health Professionals
- Health facilities and Agencies are still recruiting unqualified people without recourse to AHPC

7.16 Food and Drug Authority

Introduction

The Food and Drugs Authority (FDA) as a national regulatory body that has the responsibility for the regulatory control of the manufacturing, importation, exportation, distribution, sale and advertisement of food, drugs, cosmetics, medical devices and household chemical substances as enshrined in the Public Health Act, 2012 (ACT 851).

In 2013, the two (2) existing Divisions were restructured to Six (6) Divisions: Drug Registration and Inspectorate Division; Cosmetics, Medical Devices and Household Chemicals Division; Safety Monitoring and Clinical Trials Division; Food Inspectorate Division; Food Safety Division and Regional Monitoring and Evaluation Division. This was to enhance the regulatory function of the FDA, Ghana.

Product Registration

A total of one thousand four hundred and fifty (1,450) product applications were submitted to the Drugs Evaluation and Registration Department for registration. Eight hundred and eighty-four (884) were accepted and the products registered in the year 2013 as compared to seven hundred and seventeen (717) registered products in 2012. Most of the products were not registered in 2013 due to incomplete documentations on the part of the applicants. Again, the processes involved in testing and evaluation leads to some delays in registering the products. The table below show the category and number of application for product registration submitted to the FDA.

Table: Summary of applications received and registered. Source: Drug Evaluation and Registration Department

Product Type	Received 2013	Received 2012	Registered 2013	Registered 2012
Allopathic Drugs (Human)	1000	826	695	663
Veterinary Drugs	200	44	33	54
Local Allopathic	250	-	156	-
Total	1450	870	884	717

The FDA in 2013 also received (959) and registered (1,284) one thousand two hundred eighty-four (1,284) cosmetics and Household Chemical products were registered compared to six hundred and eighty-one (681) registered in 2012. The excess registered products were the previous year's pending applications.

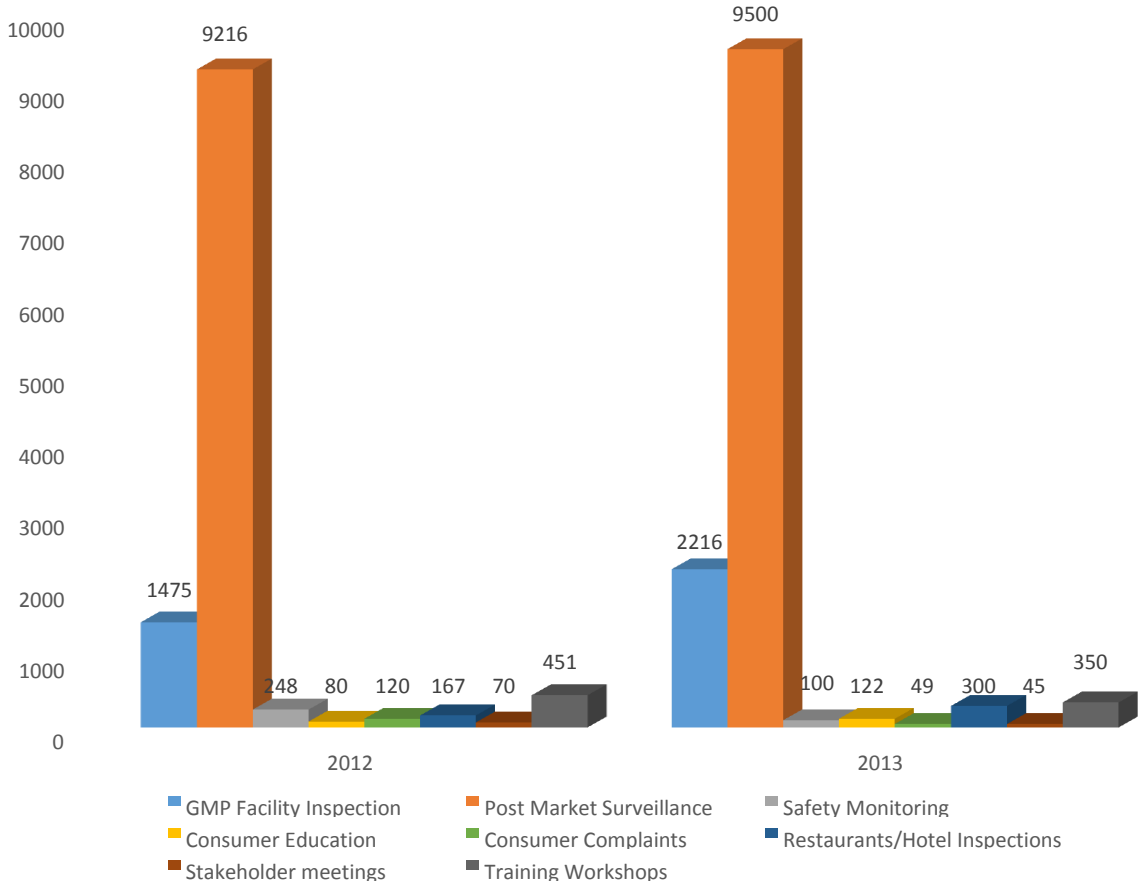
Safety Monitoring and Clinical Trials

The National Expert Committees reviewed reports received from the following safety monitoring activities; two new vaccines (Rotavirus and Pneumococcal vaccines) and Measles-Rubella as well as the final Yellow Fever meeting for classification of serious Adverse Events Following Immunization(AEFI) reports.

The authority conducted 12 out of 14 planned Good Clinical Practice (GCP) Inspections of approved on-going clinical trials were carried out.4 out 8 applications for Clinical Trial Applications were processed during the same period and has given 7 out of 8 approvals for Clinical Trial Amendments. The table summarized AEFI reports received.

Activities	2012	2013
Spontaneous ADR Reports Received	312	308
Number of spontaneous AEFI reports received	14	5
Number of AEFI reports received on Gardasil	-	8
Number of AEFI reports received on New Vaccines		22
Number of reports committed into Vigiflow	289	205

Post Market Surveillance



8. Conclusion

1. In 2013, the health sector performance was mixed with an overall assessment score of zero. This implies minimal or no progress made during the year.
2. Performance in maternal health service delivery was poor, and the number of women dying in health institutions during childbirth increased. Coverage of antenatal care dropped, skilled delivery was stagnant and the equity gap using supervised delivery as proxy widened with Volta region consistently underperforming, but family planning acceptor rate increased.
3. The number of infant deaths recorded at facilities increased. Northern Region recorded the highest institutional infant death rate with 21.9 deaths per 1,000 live births.
4. HIV prevalence improved with a drop again in 2013, but HIV/ AIDS programme indicators, e.g. testing and counselling, generally worsened during the year.
5. The sector experienced an overspending on staff compensation of over 300% while budget execution for goods and services dropped to 55% in 2013. This led to eradicate funding for service delivery.
6. With rapidly increasing staff numbers and limited funds for the sector, the staff budget is getting out of hand.
7. Distribution of doctors is strongly skewed towards Greater Accra and Ashanti Regions, where more than 70% of the country's doctors are employed.
8. Active membership of The National Health Insurance increased. Members tend to use health services more than non-members. Over 80% of total outpatients were insured.

Annex 1: Sector Wide Indicators and Targets – HSMTDP2010-2013

	Indicators	Base-line	Targets			
		2009	2010	2011	2012	2013
Health 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	70.0%	70.0%
2	Equity Index: Poverty (U5MR by highest/lowest wealth quintile)	1:2.18	N/A	N/A	1:1.5	1:1.5
3	Equity Index: Geography - Services (Supervised deliveries by region)	1:1.97	1:1.90	1:1.80	1:1.70	1:1.60
4	Equity Index: Geography - Resources (Nurses:Population by region)	1:2.03	1:2.00	1:2.00	1:1.95	1:1.90
5	Equity Index: NHIS Gender (Active members by gender)	1:0.92	-	-	-	-
6	Equity Index: NHIS Poverty (Active members by lowest quintile to whole pop)	-	N/A	N/A	N/A	-
7	Outpatients attendance per capita (OPD)	0.77	0.82	0.85	0.88	1.00
8	Access to Health facility	N/A	N/A	N/A	N/A	N/A
9	Doctor:population ratio	1:13,400	1:11,500	1:10,500	1:9,700	1:9,500
10	Nurse:population ratio	1:1,353	1:1,100	1:1,000	1:900	1:800
Health Objective 2: Strengthen governance and improve efficiency and effectiveness in the health system						
1	% total MTEF allocation to health	14.9%	11.5%	15.0%	≥15.0%	≥15.0%
2	% non-wage GOG recurrent budget allocated to District level and below	49%	50%	50%	50%	50%
3	Per capita expenditure on health	23 US$	26 US$	28 US$	30 US$	31 US$
4	Budget execution rate (Item 3 as proxy)	97%	≥95%	≥95%	≥95%	≥95%
5	% of annual budget allocations to items 2 and 3 (GOG and SBS) disbursed to BMCs by end of year	23%	40%	42%	50%	50%
6	% of population with valid NHIS membership card	45.0%	60.2%	65.0%	70.3%	75.0%
7	Proportion of NHIS claims settled within 12 weeks	N/A	40%	60%	70%	80%
8	% of IGF from NHIS	66.5%	70.0%	70.0%	75.0%	75.0%
Health 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
2	Total fertility rate	4.0	N/A	N/A	3.8	3.8
3	Institutional Maternal Mortality rate per 1000 live births	196	185	170	160	150
4	% of pregnant women attending at least 4 Antenatal visits	62.4%	70.0%	74.6%	80.1%	85.7%
5	Infant Mortality Rate (IMR) per 1,000	50	N/A	N/A	<30	<30
6	Under 5 Mortality Rate (U5MR) per 1,000	80	N/A	N/A	<50	<50
7	% deliveries attended by a trained health worker	39.4%	50.3%	55.6%	60.0%	65.0%
8	Under 5 prevalence of low weight for age	13.9%	N/A	N/A	8.0%	8.0%
Health Objective 4: Intensify prevention and control of communicable and non-communicable diseases and promote a healthy lifestyle						
1	HIV+ prevalence among pregnant women 15 – 24 years	2.2%	<1.9%	<1.8%	<1.7%	<1.6%
2	% of U5s sleeping under ITN	40.5%	50.0%	65.0%	70.0%	75.0%
3	% of children fully immunized by age one - Penta 3	86.6%	87.9%	89.0%	91.4%	93.5%
4	HIV+ clients receiving ARV therapy[5]	23,614	51,814	65,914	80,014	94,114
5	Incidence of Guinea Worm	501	<100	<70	<50	0
6	% of households with improved sanitary facilities	11.3%	N/A	N/A	21.3%	21.3%
7	% of households with access to improved source of drinking water	77.3%	N/A	N/A	80%	80%
8	Obesity in adult population (women aged 15-49 years)	30%	N/A	N/A	N/A	28%
9	TB treatment success rate	84.7%	86.0%	88.0%	89.0%	90.0%
Health Objective 5: Strengthen institutional care, including mental health service delivery						
1	Equity Index: Ratio of mental health nurses to patient population	N/A	5% >b.l.	10% >b.l.	25% >b.l.	30% >b.l.
2	Number of community psychiatry nurses trained and deployed	N/A	5% >b.l.	10% >b.l.	25% >b.l.	30% >b.l.
3	% tracer psychotropic drug availability in hospitals	N/A	70%	70%	75%	80%
4	Institutional Infant mortality rate	6.3	-	-	-	-
5	Basket equipment functioning in hospitals	N/A	80%	80%	80%	85%
7	% Tracer drug availability in hospitals	68%	80%	85%	90%	90%
8	% of hospitals assessed for quality assurance and control	N/A	70%	80%	90%	100%
9	Institutional under five mortality rate	10.2	-	-	-	-
10	Institutional Maternal Mortality rate per 1000 live births	196	185	170	160	150

Annex 2: Holistic Assessment Tool and Analysis

The holistic assessment tool was developed during the 5YPOW 2007-2011 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. Most of the indicators from the 5YPOW have been carried over to the HSMTP and used in the 2011 POW. The indicators have been clustered under Health Objectives 1 to 5.

The review team has performed the initial assessment based on the holistic assessment methodology. The purpose of the initial assessment is to form a basis for a balanced discussion between the Ministry of Health, its agencies and development partners to reach a common conclusion of the sector's performance. During this discussion, the final sector score can be modified if the initial assessment has either over- or underestimated the performance.

Methods

The assessment is based on indicators and milestones specified in the operational annual POW. More specifically, the analysis underlying the holistic assessment is based on the following elements:

1. Annual POW including budget
2. Annual Performance Review Reports and presentations from MoH and its Agencies
3. Annual MoH Financial Statement
4. National survey reports (Ghana DHS, MICS etc.)
5. Health Sector Medium Term Development Plan 2010-2013

As part of the annual health sector review process, the review team has conducted an initial assessment of milestones' realization and indicator trends. The assessment was guided by a predefined methodology that ensured full transparency of calculations.

The assessment will be presented at the April Health Summit where overall performance of the sector and possible factors, which may have influenced the performance, can be discussed.

The purpose of the initial assessment is to form a basis for a balanced discussion between the Ministry of Health, its agencies and development partners to reach a common conclusion of the sector's performance.

The initial assessment has three steps:

First, each indicator and milestone is assigned a numerical value of -1, 0 or +1 depending on realization of milestones and trend of indicators. While indicators which normally are measured on annual basis are included in each year's assessment, indicators which are not measured on annual basis (e.g. survey based information like MICS, DHS etc.) are only included in the assessment if new information is available.

Milestones are assigned the value **+1** (colour coded green) if the review team is provided with evidence from the relevant authority that documents the realization of the milestone; otherwise it is assigned the value **-1** (colour coded red).

Indicators are assigned the value **+1**(colour coded green) if

- The indicator has attained the specified annual target regardless of trend, or

- The indicator has experienced a relative improvement by more than 5% compared to the previous year's value

Indicators are assigned the value **-1**(colour coded red) if

- The indicator is below the annual target and has experienced a relative deterioration by more than 5%, or
- No data is available (only applies to annually measured indicators and not to survey indicators)

Indicators are assigned the value **0**(colour coded yellow) if

- The relative trend of the indicator compared to previous year is within a 5% range, or
- The indicator was not reported the previous year (for annually measured indicators) or the previous survey (for survey indicators)

Second, the indicators and milestones are grouped into Health Objectives as defined in the HSMTDP and the sub total of indicators and milestone values are calculated for each group. Health Objectives with a positive score are assigned a value of +1, -1 if the total score is negative and 0 if the total score is 0.

Third, after assigning a numerical score to each of the Health Objectives the scores are added to determine the sector's score. A positive sector score is interpreted as a highly performing sector, a negative score is interpreted as an underperforming sector and a score of zero is considered to be sustained performance.

Step 1: Assessment of indicators and milestones

Health Objective 1: Bridge equity gaps in health care and ensure sustainable financing arrangements that protect the poor

Milestone: Financing strategy developed for the sector to ensure effective resource mobilization

2013 Performance: Achieved
Source: MOH
Outcome: ***+1***

The financing strategy has been developed. MOH is currently working on an implementation plan for the strategy.

% children 0-6 months exclusively breastfed

2013 Performance: No new data for 2013
2013 Target: N/A
Source: N/A
Outcome: N/A

2003	2006	2008	2012
53.4%	54.0%	62.8%	45.7%

Equity – Poverty (Poorest/Richest U5 mortality rate)

Wealth Quintile	2003	2008	2012
Lowest	128	103	106
Second	105	79	85
Middle	111	102	83
Fourth	108	68	86

2013 Performance: No new data for 2013
2013 Target: N/A
Source: N/A
Outcome: N/A

Highest	88	60	52
Ratio	1.45	1.72	2.04

Equity – Geography (Supervised Deliveries)

2013 Performance: 1:1.56
2013 Target: 1:1.60
Source: DHIMS2
Outcome: ***+1***

	2010	2011	2012	**2013**
UER	53.8%	64.6%	68.6%	**67.5%**
VR	32.9%	39.9%	45.0%	**43.4%**
Ratio	1:1.64	1:1.64	1:1.53	**1:1.56**

Result: The geographic equity gap has widened marginally from 1:1.53 in 2012 to 1:1.56 in 2013. Supervised deliveries coverage has decreased across all the regions during the period under review; Upper East Region which has recorded the highest coverage since 2010 drop slightly from 68.6% (2012) to 67.5% in 2013. Over the past four years, Volta Region has consistently remained the least performing region for supervised deliveries. It increased to 45.0% in 2012 but began to decline again to 43.4% in 2013.

Discussion: Generally, the equity gap for supervised delivery has remained stable over the past few years. However, Volta Region has persistently performed below the national average despite the fact that the average regional human resource availability (Midwives to WIFA population) is close to the national average. It is worth conducting an in-depth study to find out factors influencing this performance.

SKILLED DELIVERY RATE	AR	BAR	CR	ER	GAR	NR	UER	UWR	VR	WR	Ghana
2008	37.8%	15.9%	39.4%	14.6%	33.2%	18.6%	38.8%	29.4%	17.9%	19.6%	26.9%
2009	41.3%	39.2%	55.8%	23.7%	22.3%	31.2%	48.5%	41.3%	22.7%	39.5%	34.8%
2010	43.4%	42.5%	52.4%	35.2%	37.0%	34.4%	53.8%	43.6%	32.9%	43.1%	40.8%
2011	47.8%	57.8%	55.0%	44.7%	49.6%	39.3%	64.6%	49.4%	40.8%	53.1%	49.1%
2012	50.3%	65.9%	60.1%	55.3%	57.2%	47.0%	68.6%	53.0%	44.9%	57.1%	55.0%
2013	55.4%	65.0%	57.2%	52.8%	56.4%	50.3%	67.5%	58.2%	43.4%	55.2%	55.3%

Equity – Geography (Nurses/Population ratio)

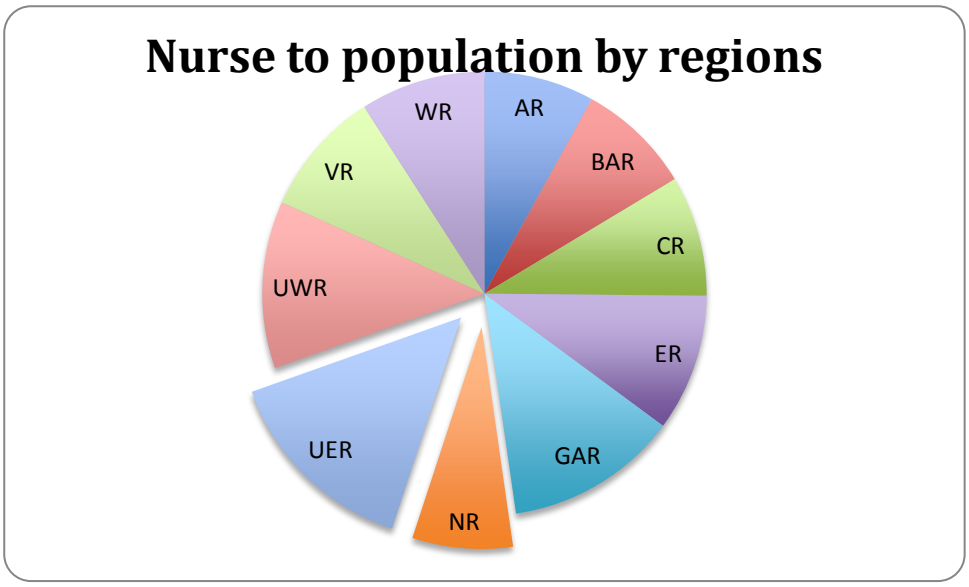
2012 Performance: 1:1.99
2012 Target: 1:1.95
Source: HR – MoH
Outcome: -1

	2009	2010	2011	2012	**2013**
GAR	-	1:1,043	1:918	1:960	-
AR	1:2,100	-	1:1,586	-	-
NR	-	1:2,077	-	1:1,791	1:1,423
UER	1:1,138	-	-	-	1:715
Ratio	1:1.84	1:1.99	1:1.73	1:1.86	**1:1.99**

Result: With an increase of almost 500 nurses (50% increase) from 2012 to 2013, Upper East Region regained the position as the region with highest nurses to population rate from Greater Accra Region. While both the best and worst performing

regions were improving performance, the best region improved at a higher rate. Therefore, the equity gap is widening.

Discussion: The staffing situation in Upper East Region has seen dramatic improvements since 2007, when the region had the country's poorest nurses to population ratio. In 2013, the region had one nurse per 715 persons, which is well above the WHO target of 1 nurse per 1,000. Despite the increasing equity gap between best and worst performing regions, the distribution of nurses seems relatively equitable compared to the distribution of doctors.



Nurses:population	AR	BAR	CR	ER	GAR	NR	UER	UWR	VR	WR	Ghana
2009	1:2,100	1:1,868	1:1,400	1:1,197	1:1,158	1:1,960	1:1,138	1:1,145	1:1,264	1:1,797	1:1,494
2010	1:1,994	1:1,915	1:1,607	1:1,376	1:1,043	1:2,077	1:1,158	1:1,204	1:1,434	1:1,727	1:1,516
2011	1:1,586	1:1,514	1:1,372	1:1,190	1:918	1:1,551	1:927	1:987	1:1,253	1:1,416	1:1,262
2012	1:1,699	1:1,671	1:1,412	1:1,303	1:960	1:1,791	1:1,045	1:1,036	1:1,470	1:1,448	1:1,362
2013	1:1,296	1:1,245	1:1,185	1:1,041	1:826	1:1,423	1:715	1:855	1:1,135	1:1,142	1:1,084

Equity – Gender (Female/Male NHIS Card Holder ratio)

2013 Performance: No new data for 2013

2013 Target: N/A

Source: N/A

Outcome: N/A

	2008	2012
Ratio	1.27	1.23

Equity – Poverty (Poorest/National NHIS Card Holder ratio – Women only)

2013 Performance: No new data for 2013
2013 Target: N/A
Source: N/A
Outcome: *N/A*

Wealth Quintile	2008	2012
Poorest	27.9%	28.7%
National	34.1%	41.6%
Ratio	0.82	0.69

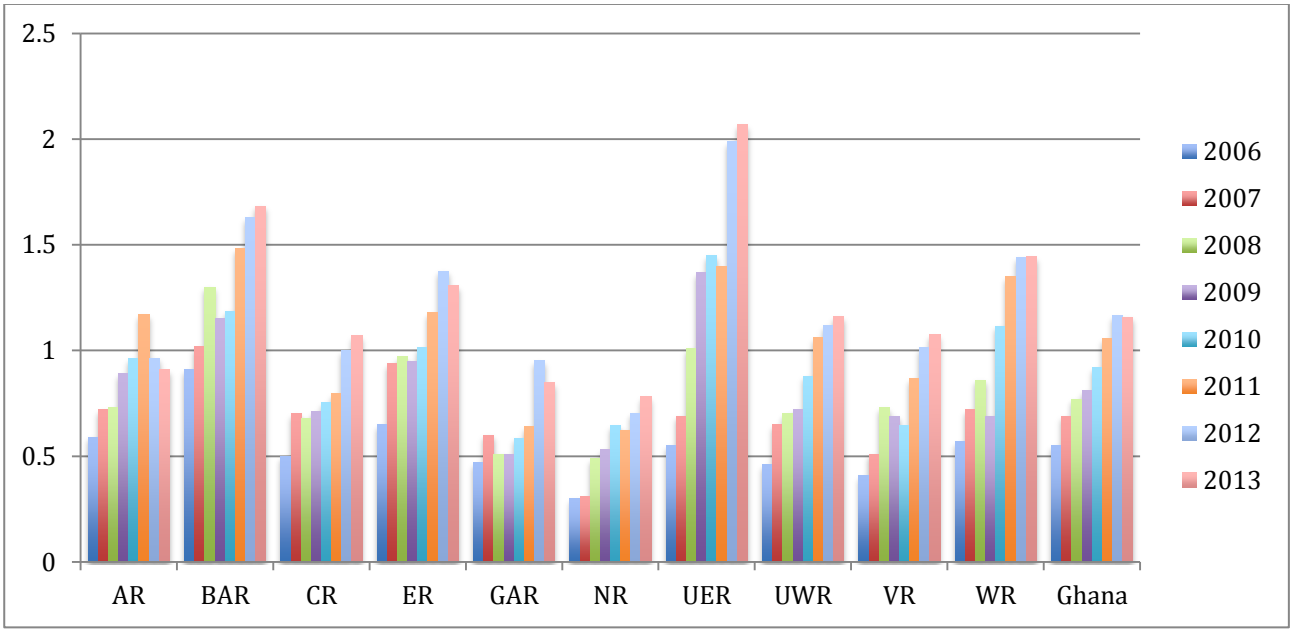
Out Patient Visits

2013 Performance: 1.16
2013 Target: 1.00
Source: DHIMS/THs
Outcome: +1

2007	2008	2009	2010	2011	2012	**2013**
0.69	0.77	0.81	0.92	1.05	1.17	**1.16**

Results: The average number of OPD visits per capita was 1.16 in 2013, which is a slight reduction from 1.17 in 2013. The figure is above the POW target of 1.0.

Discussion: After several years of increased number of OPD visits per capita since the introduction of NHIS, the national trend seems to have stabilised in 2013. The national average, however, covers large regional variations. The OPD per capita in Ashanti Region continued last year's drop from 1.17 in 2011 to 0.96 in 2013 and 0.91 in 2013. This trend is considered to be the result of introduction of capitation payment by NHIS in Ashanti Region in 2012. While decreasing trends were also observed in Eastern and Greater Accra Regions, the review team was not presented with any explanation for these trends. OPD per capita in Upper East Region continued to increase, and the regions was the first to reach an average of above 2 OPD visits per capita. Despite continued increase, Northern Region remains the lowest performing region with only 0.78 OPD visits per capita.



Year	AR	BAR	CR	ER	GAR	NR	UER	UWR	VR	WR	Ghana
2006	0.59	0.91	0.5	0.65	0.47	0.3	0.55	0.46	0.41	0.57	0.55

2007	0.72	1.02	0.7	0.94	0.6	0.31	0.69	0.65	0.51	0.72	0.69
2008	0.73	1.3	0.68	0.97	0.51	0.49	1.01	0.7	0.73	0.86	0.77
2009	0.89	1.15	0.71	0.95	0.51	0.53	1.37	0.72	0.69	0.69	0.81
2010	0.96	1.19	0.75	1.01	0.59	0.64	1.45	0.88	0.64	1.12	0.92
2011	1.17	1.48	0.79	1.18	0.64	0.62	1.40	1.06	0.87	1.35	1.05
2012	0.96	1.63	1.00	1.38	0.95	0.70	1.99	1.12	1.01	1.44	1.17
2013	0.91	1.68	1.07	1.31	0.85	0.78	2.07	1.16	1.08	1.45	1.16

% population living within 8 km of health infrastructure

2013 Performance: No new data for 2013
2013 Target: N/A
Source: N/A
Outcome: *N/A*

2010	2012
N/A	N/A

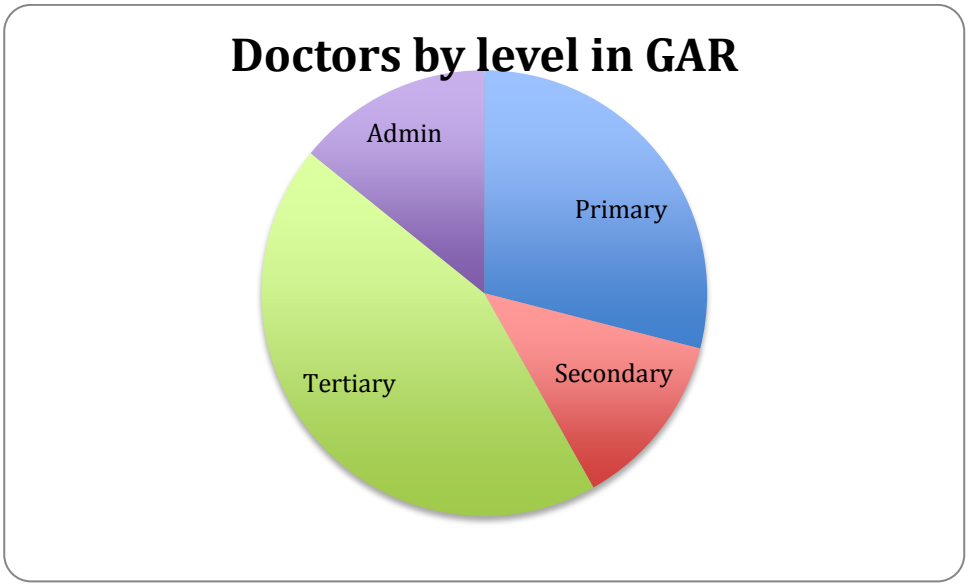
Doctor: Population Ratio

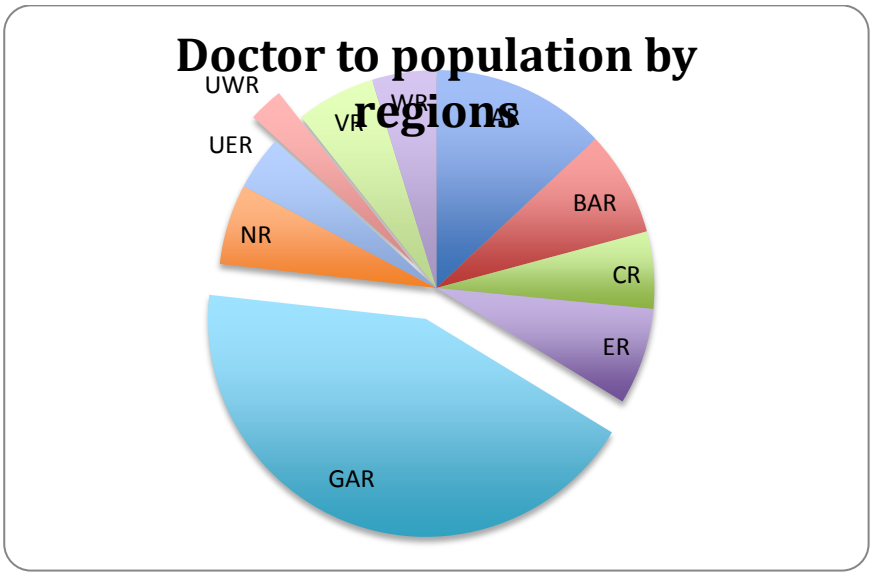
2013 Performance: 1:10,170
2013 Target: 1:9,500
Source: HR IPPD - MOH
Outcome: 0

2007	2008	2009	2010	2011	2012	**2013**
1:13,683	1:13,499	1:11,649	1:11,698	1:10,217	1:11,515	**1:10,170**

Result: With 363 additional doctors in 2013, the total number of doctors on MOH payroll increased from 2,252 in 2012 to 2,615 in 2013. Consequently, the doctor to population ratio improved from 1 doctor per 11,515 in 2012 to 1 doctor per 10,170 in 2013.

Discussion: There is a continuous improvement in the doctor to population ratio due to the increasing output from the four medical schools (UGMS, KNUST – SMS, UDS and UCC). Moreover, seventy-eight foreign trained doctors joined the service during the year. Though there seem to be general improvement of availability of doctors in the system, a substantial number are in the Greater Accra and Ashanti Regions making the distribution skewed away from the deprived areas. Greater Accra Region employs more than 50% of all government employed doctors in Ghana, but more than 50% of these are house officers, i.e. not fully qualified doctors. Of the remaining 669 fully qualified doctors (excluding house officers) in Greater Accra Region, 294 doctors work at tertiary level (285 at Korle-Bu Teaching Hospital and 9 at tertiary psychiatric facilities) and 69 are working at GHS and MOH head quarters. The second largest share is employed at primary level institutions in the region. With 95 doctors, the share of doctors working in administrative positions in MOH and GHS is 14%.





Doctors :population	AR	BAR	CR	ER	GAR	NR	UER	UWR	VR	WR	Ghana
2009	1:8,136	1:16,194	1:22,088	1:15,207	1:5,103	1:46,691	1:29,861	1:39,473	1:24,837	1:31,942	1:11,649
2010	1:8,506	1:16,390	1:25,021	1:16,988	1:4,578	1:34,437	1:36,088	1:50,151	1:26,478	1:26,110	1:11,698
2011	1:7,793	1:16,304	1:21,416	1:16,294	1:3,810	1:21,807	1:39,226	1:39,747	1:23,859	1:26,632	1:10,217
2012	1:9,828	1:16,679	1:23,405	1:19,467	1:4,246	1:20,195	1:38,279	1:45,565	1:24,728	1:29,082	1:11,515
2013	1:10,503	1:17,547	1:23,892	1:19,065	1:3,178	1:22,894	1:33,896	1:53,064	1:23,277	1:28,653	1:10,170

Nurse: Population Ratio

2013 Performance: 1:1,084

2013 Target: 1:800

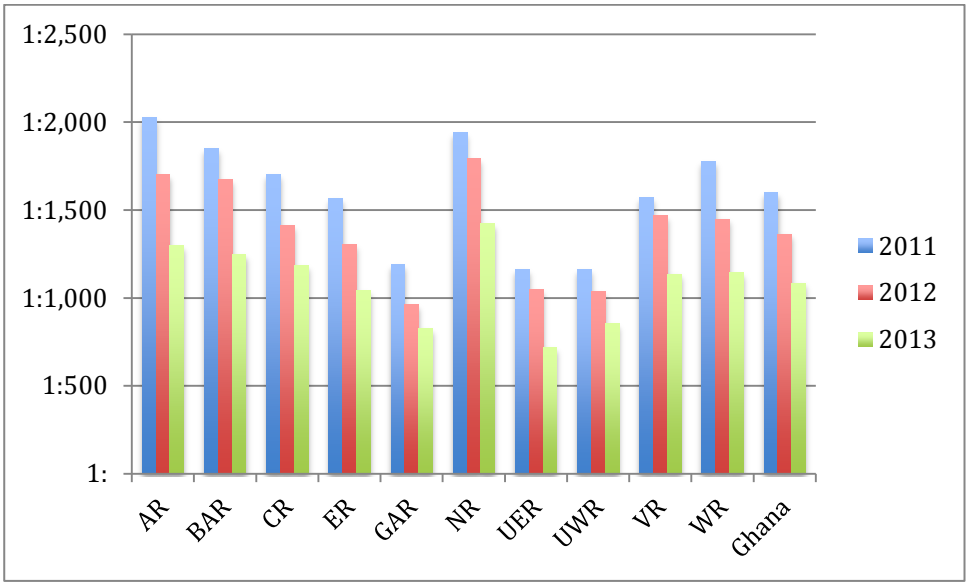
Source: HR – MOH

2011	2012	**2013**
1,262	1:1,362	**1:1,084**

Outcome: ***+1***

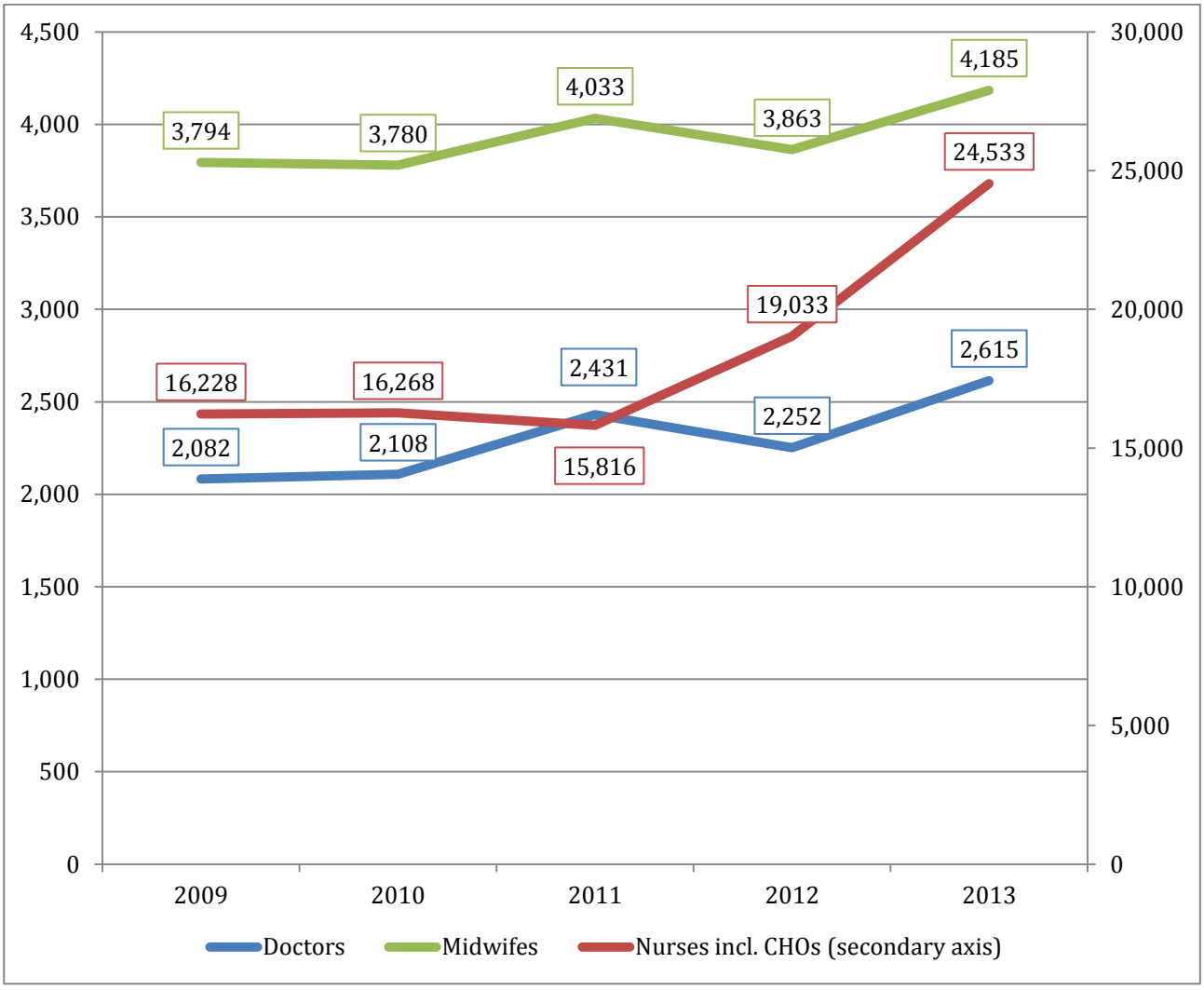
Result: The nurse population ration improved by 20% over 2012 but did not meet the target of one nurse to 800 citizens. Upper East Region had the best performance with one nurse per 715 citizens.

Discussion: The national average of nurse to population ratio has almost reached the WHO target of 1 nurse per 1,000 citizens. Behind the national average, there are concerns about the geographic distribution with the cities with teaching hospitals having the bulk of the nursing staff. The rapid improvement of the number of nurses in the system is as a result of increasing intake into existing nursing training schools and improvement in infrastructure of the training schools. While all regions experienced increased numbers of nurses, the increment was largest Ashanti and Greater Accra Regions with 1,028 and 882 additional nurses, respectively.



Total no. of nurses	AR	BAR	CR	ER	GAR	NR	UER	UWR	VR	WR	Ghana
2009	2,325	1,214	1,373	1,994	3,698	1,191	892	586	1,533	1,422	16,228
2010	2,397	1,207	1,370	1,914	3,846	1,194	904	583	1,477	1,376	16,268
2011	2,427	1,278	1,335	1,718	3,468	1,314	912	617	1,383	1,364	15,816
2012	2,968	1,447	1,657	2,106	4,438	1,466	1,026	704	1,514	1,707	19,033
2013	3,996	1,987	2,036	2,693	5,320	1,899	1,516	869	2,010	2,207	24,533

Nurses: population	AR	BAR	CR	ER	GAR	NR	UER	UWR	VR	WR	Ghana
2009	1:2,100	1:1,868	1:1,400	1:1,197	1:1,158	1:1,960	1:1,138	1:1,145	1:1,264	1:1,797	1:1,494
2010	1:1,994	1:1,915	1:1,607	1:1,376	1:1,043	1:2,077	1:1,158	1:1,204	1:1,434	1:1,727	1:1,516
2011	1:2,023	1:1,850	1:1,700	1:1,565	1:1,192	1:1,942	1:1,161	1:1,160	1:1,570	1:1,777	1:1,599
2012	1:1,699	1:1,671	1:1,412	1:1,303	1:960	1:1,791	1:1,045	1:1,036	1:1,470	1:1,448	1:1,362
2013	1:1,296	1:1,245	1:1,185	1:1,041	1:826	1:1,423	1:715	1:855	1:1,135	1:1,142	1:1,084



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

Milestone: Composite planning undertaken in 50% of districts

2013 Performance:
Source: MOH
Outcome:

Milestone: 2 questions included in GDHS on client satisfaction and knowledge of patient charter

2013 Performance:
Source: MOH
Outcome:

% MTEF on Health

2013 Performance: 15.2%
2013 Target: ≥15%
Source: MoH
Outcome: ***+1***

2007	2008	2009	2010	2011	2012	**2013**
14.6%	14.9%	14.6%	15.1%	15.8%	15.4%	**15.2%**

Results: Proportion of government MTEF allocated to the health sector remained above the Abuja target of 15% despite a minimal reduction of 0.2 percentage points from 2012 to 2013.

Discussion: The government of Ghana continues its commitment to financing health in the country. The majority of government funds, however, are allocated for compensation of employees.

% Non-wage GOG recurrent budget allocated to district level and below

2013 Performance: No information
2013 Target: 50%
Source: MoH
Outcome: -1

2007	2008	2009	2010	2011	2012	**2013**
49.0%	49.0%	62.0%	46.8%	55.3%	38.5%	-

Per capita expenditure on Health (USD)

2013 Performance: 41.2 USD
2013 Target: 31 USD
Source: MoH
Outcome: *+1*

2007	2008	2009	2010	2011	2012	**2013**
23.0	23.2	25.6	28.6	35.0	50.7	**41.2**

Result: The per capita expenditure on health was 41.2 USD in 2013. This is a decline of almost 10 USD from 2012 but well above the target of 31 USD per capita.

Discussion: The single spine salary policy (SSSP) was introduced in 2012 leading to increased salaries for government workers. In 2012, the government paid SSSP arrears dated back to 2010 pushing the per capita expenditure to an exceptionally higher level. The 2013 figure is lower than 2012 because no salary arrears were paid.

Budget Execution Rate for goods and Services

2013 Performance: 54.9%
2013 Target: ≥ 95%
Source: POW 2013 and draft financial statement
Outcome: *-1*

2010	2011	2012	**2013**
94%	82.1%	86.8%	**54.9%**

Result: Budget execution rate dropped by 32.2 percentage points from 86.8% in 2012 to 54.9% in 2013. The budget execution rate for goods and service is below the target of ≥95%.

Discussion: The low budget implementation rate for goods and services may be the result of vying GOG funds from goods and services to pay salaries. Budget execution for compensation of employees was 300% though the total budget for the health sector experienced no upward revision during 2013. If contributions from IGF, NHIF and SIP are deducted from the total amount, then what is left for public health services and administration is minimal. If we further remove donor funding from the total goods and services then practically there will nothing left for public health services.

% of annual budget allocations to item 2 and 3 disbursed by end of December

2013 Performance: No data
2013 Target: 50%
Source: MoH
Outcome: ***-1***

	2009	2010	2011	2012	**2013**
Disbursed by end June	39.0%	31.0%	-	-	**-**
Disbursed by end December	-	-	89.8%	-	**-**

% Population with valid NHIS card

2013 Performance: 36.8%
2013 Target: 75%
Source: NHIA
Outcome: +1

2010	**2011**	**2012**	**2013**
33.1%	32.8%	33.3%	36.8%

Result: Active membership increased with 10% from 2012 to 2013 but did not reach the target of 75%.

Discussion: The NHIS active cardholder rate has been rather stable around 35% of the population during the period of the HSMTDP 2010-2014. The ambition of the government is to provide universal health care coverage and NHIS is an important strategy for attaining this goal.

Since the introduction of NHIS the OPD per capita rate has doubled and in 2013 over 80% of total outpatients were insured while only 36% of the population were active NHIS members. It is evident that NHIS members use services more than those without active membership. The sector does currently not have a good picture of the main drivers of the increased uptake of services, and there can be several explanations for the observed trend.

Could this be a reflection of frivolous use of services by NHIS members (moral hazard), i.e. few insured patients consuming a lot of health service leading to inefficiency?

6. Could it be a reflection of high NHIS membership rate among those in need of services, i.e. persons only register when they fall sick and refrain from renewing membership the following year (adverse selection)?
7. Could it be a reflection of increased equity in utilization of health services, i.e. equal access for equal need?

While the third question was one of the reasons for establishing NHIS, moral hazard and adverse selection provide financial risks to NHIS, and these issues should be further analysed and addressed.

% of claims settled within 12 weeks

2013 Performance: No information
2013 Target: 80%
Source: N/A
Outcome: -1

2010	2011	2012	**2013**
n/a	n/a	-	**-**

% of IGF from NHIS

2013 Performance: 81.9%
2013 Target: 75%
Source: MOH
Outcome: +1

2010	2011	2012	**2013**
79.4%	85%	-	**81.9%**

Result: The proportion of IGF from NHIS remains above the target of 75% indicating that the majority of services rendered are financed by NHIS.

Discussion: While only about 36% of the population are active card holders, they consume over 80% of all services rendered. This poses a threat to the financial stability of NHIS as discussed above.

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

Milestone: 90% of district hospitals and 70% of health centres equipped with C/BEmOC equipment respectively

2013 Performance: Not achieved
Source: GHS
Outcome: *-1*

Milestone: Adolescent health corners established in 30 hospitals

2013 Performance: Not achieved
Source: GHS
Outcome: *-1*

Maternal mortality ratio

2013 Performance: No new data for 2013
2013 Target: N/A
Source: N/A
Outcome: *N/A*

1990	1995	2000	2005	2010
580	590	550	440	350

Total fertility rate

2013 Performance: No new data for 2013
2013 Target: N/A
Source: N/A
Outcome: *N/A*

1998	2003	2008	**2012**
4.6	4.4	4.0	**4.3**

Contraceptive Prevalence Rate (for modern methods – women 15-49 years married or in union)

2013 Performance: No new data for 2013
2013 Target: N/A
Source: N/A
Outcome: *N/A*

1998	2003	2006	2008	2012
13.3%	18.7%	13.6%	16.6%	23.4%

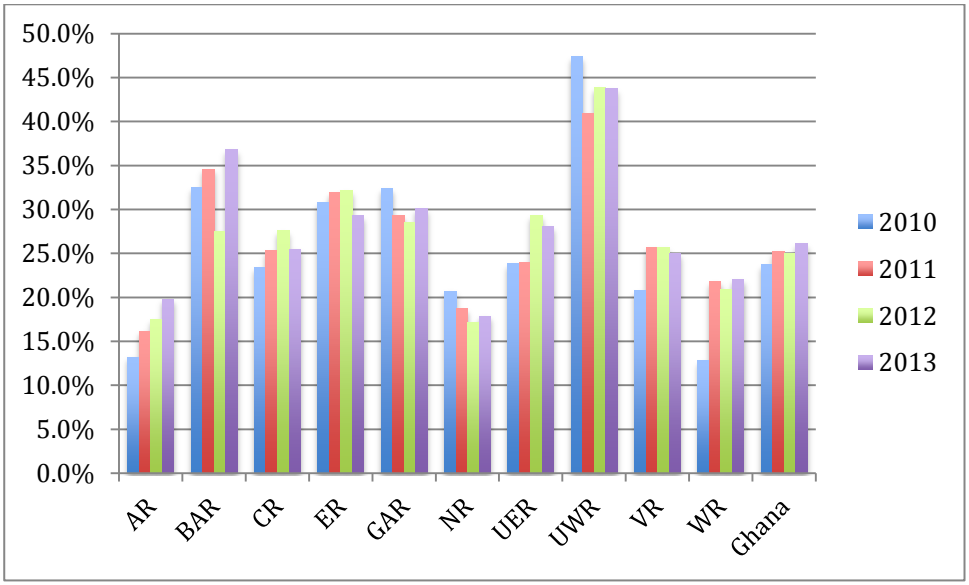
Family planning acceptor rate

2013 Performance: 23.4%
2013 Target: N/A
Source: DHIMS
Outcome: *0*

2010	2011	2012	2013
23.7%	25.2%	24.9%	26.1%

Results:

FP acceptor rate (ratio of number of FP registrants to WIFA) increased by 4.5% from 24.9% in 2012 to 26.1% in 2013. In the same period, Couple Year Protection (CYP) increased from 1,222,920 to 1,592,981. Northern and Ashanti Region continue to have the lowest performance.



Discussion: FP acceptor rate has steadily increased over the past years. Highest performance is observed in Upper West Region with almost 45% of WIFA. The lowest performance is observed in Northern Region, possibly due to traditional opposition to family planning combined with large access barriers, both geographical and financial. The performance of Ashanti Region is surprising low, and determinants for poor performance are expected to be different from Northern Region since Ashanti Region generally has both better geographical and financial access to health services. Information from the field indicates that the poor performance in general and for Ashanti Region in particular, may be a result of perverse incentives to under report rendering of FP services.

% of pregnant women attending at least 4 antenatal visits

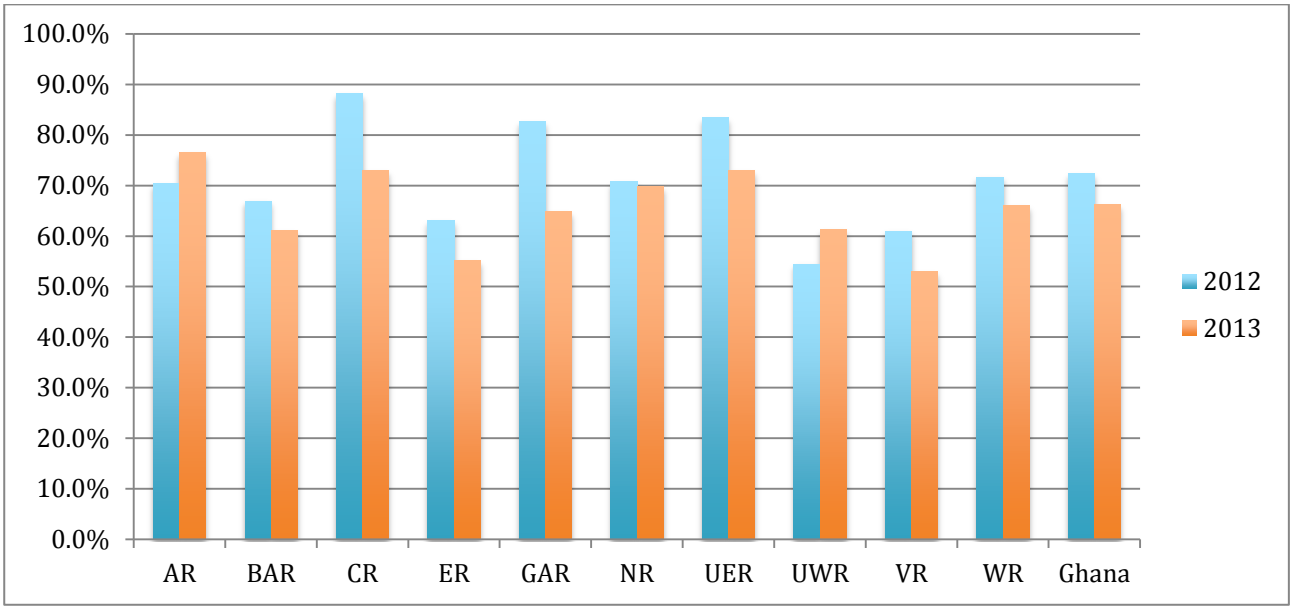
2013 Performance: 66.3%
2013 Target: 85.7%
Source: DHIMS
Outcome: -1

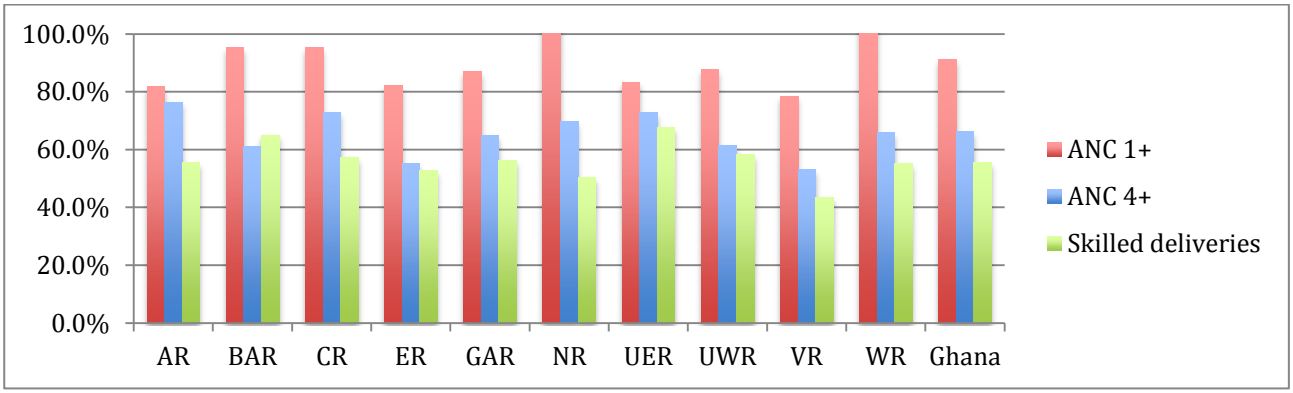
	2007	2008†	2009†	2010†	2011†	2012	**2013**
4+ ANC visits	62.8%	60.9%	66.6%	66.6%	70.7%	72.3%	**66.3%**

†AR, BAR, VR and GAR were excluded from national figure due to unreliable data

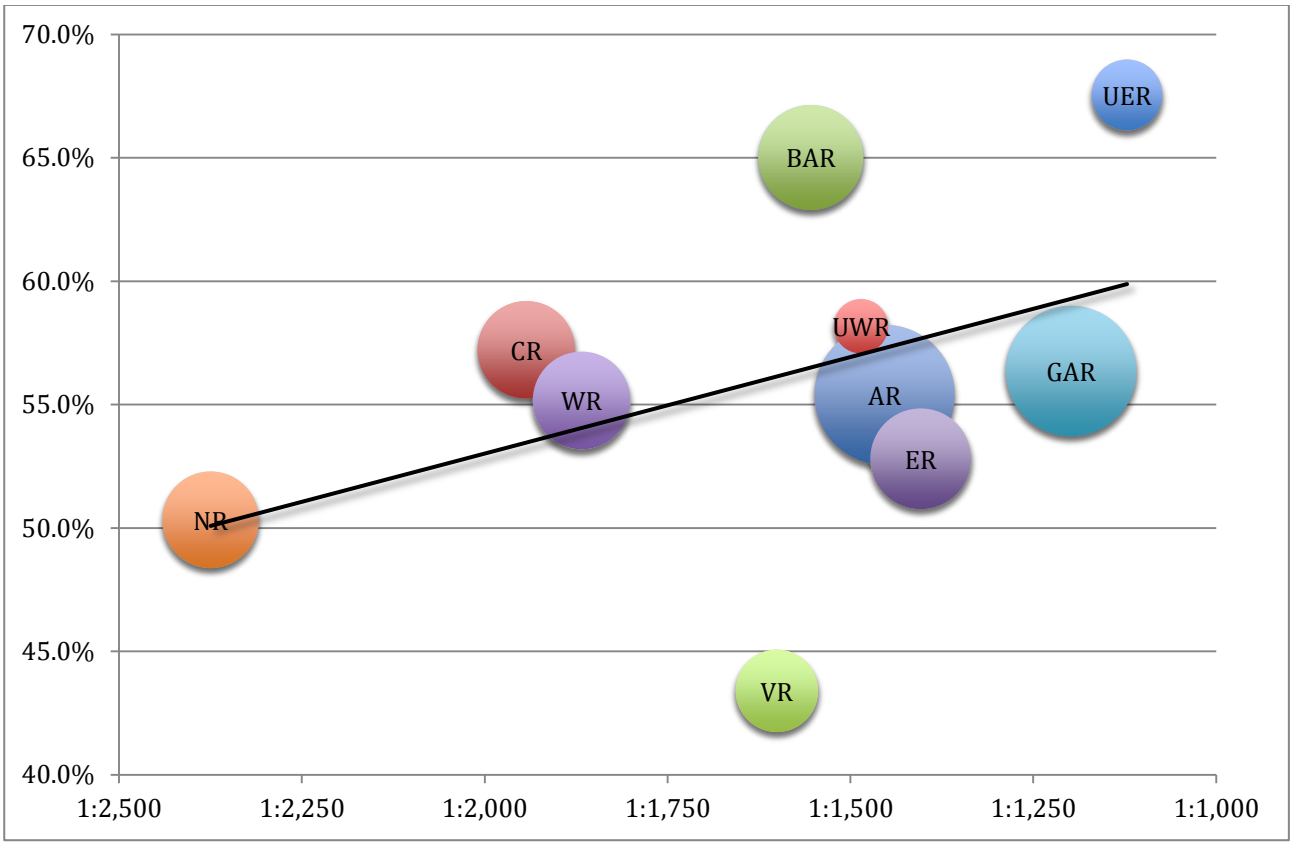
Results: The proportion of pregnant women going for four or more ANC visits dropped from 72.3% in 2012 to 66.3% in 2013. The performance is below the target of 85.7%.

Discussion: ANC 4+ coverage has been sporadic over the years and experienced a large drop this year. The factors contributing this drop are not clear. There have been challenges over the years regarding data management. This was however resolved in 2012. Looking at the trend, 8 out the 10 regions experienced declines in coverage despite improving midwife/population ratio. There may be the need to look at distributional, supervisory and logistics issues in an attempt to remedy the situation





	AR	BAR	CR	ER	GAR	NR	UER	UWR	VR	WR	Ghana
ANC 1+	81.9%	95.2%	95.2%	82.1%	86.9%	122.2%	83.3%	87.7%	78.3%	103.4%	91.2%
ANC 4+	76.4%	61.1%	72.9%	55.1%	64.9%	69.7%	72.9%	61.3%	53.0%	66.0%	66.3%
Skilled delivery	55.4%	65.0%	57.2%	52.8%	56.4%	50.3%	67.5%	58.2%	43.4%	55.2%	55.3%



Infant mortality rate

2013 Performance: No new information
2013 Target: N/A
Source: N/A
Outcome: *N/A*

1998	2003	2006	2008	2012
57	64	71	50	53

Under-five mortality rate

2013 Performance: No new information
2013 Target: N/A
Source: N/A
Outcome: *N/A*

1998	2003	2006	2008	**2012**
108	111	111	80	82

% Deliveries attended by a trained health worker

2013 Performance: 55.3%
2032 Target: 65%
Source: DHIMS

2009†	2010†	2011†	2012†	**2013**
34.8%	40.8%	49.1%	55.0%	**55.3%**

†Figures for previous years were recalculated due to double counting of deliveries in teaching hospitals

Outcome:*0*

Results: After several years of impressive increases in skilled delivery rate, the performance stabilised between 2012 and 2013 with only a marginal increase to 55.3%. The figures for previous years were revised in 2013 due to issues with double counting of deliveries in teaching hospitals. Though Korle-Bu and Komfo Anokye Teaching Hospitals are not reporting through DHIMS, they do provide data on maternal health to the sub-metro authorities where they are located and this reflects in the GHS aggregate data. This was not known till the latter part of 2013.

Discussion: Despite overall improvements in midwife to WIFA rate, seven out of ten regions experienced a decline in the skilled delivery rate. Volta Region continues to have the lowest performance at 43.4%. Upper East was performing best at 67.5% closely followed by Brong-Ahafo Region with 65%. Interestingly, the midwife to WIFA ratio in Brong-Ahafo is comparable to the ratio of Volta Region with 1:1,554 and 1:1,601, respectively. Based on these observed differences, the MOH will organise a fact-finding mission to Volta Region to better understand the determinants for continuous poor performance.

Under-five prevalence of low weight for age

2013 Performance: No new information for 2013
2013 Target: N/A
Source: N/A
Outcome: N/A

2006	2008	**2012**
18%	13.9%	13.4%

Health Objective 4: Intensify prevention and control of communicable and non-communicable diseases and promote a health lifestyle

Milestone: Emergency Response Strategy for diseases of epidemic potential reviewed/ 50% reduction in Yaws achieved

2012 Performance: Achieved
Source: RHN, PPME, MOH
Outcome:*+1*

Results: Emergency response strategies for diseases of epidemic importance have been revised. See Dr. Amankwa.

Milestone: 50% reduction in Yaws prevalence achieved

2012 Performance: Not achieved
Source: GHS
Outcome:*-1*

A baseline survey was conducted in three regions in 2008. The estimated prevalence was 0.70. A pilot survey was conducted in the eastern region covering three districts in 2013 and the prevalence was estimated at 1.30%. The surveys were not nationally representative and therefore could not provide the basis for estimating reduction in Yaws. The planned interventions could not be undertaken due to inadequate funding. Evidence from routine reporting however indicates increase in case reporting of yaws from 9,356 in 2012 to 18,110 in 2013. The sudden increase is as a result of active case search that was

conducted in 124 endemic districts. The conclusion is that the milestone of reducing yaws prevalence by 50% has not been achieved.

HIV prevalence among pregnant women 15-24 years

2012 Performance: No information
2013 Target: 1.6%
Source: NACP - GHS
Outcome: +1

2007	2008	2009	2010	2011	2012	**2013**
2.6%	1.9%	2.1%	1.5%	1.7%	1.3%	**1.2%**

Result: The HIV prevalence among pregnant women aged 15-24 years dropped by 0.1 percentage point from 1.3% in 2012 to 1.2% in 2013. The estimated HIV prevalence within the whole population for 2013 was 1.3%

Discussion: The HIV prevalence among pregnant women aged 15-24 years has steadily dropped from 2.6% in 2007 to 1.2% in 2012. This is a reduction of over 50%.

%U5s sleeping under ITN

2013 Performance: No new information for 2013
2013 Target: N/A
Source: N/A
Outcome: *N/A*

2006	2008	**2012**
21.8%	28.2%	41.5%

% children fully immunized by age one - Penta 3

2013 Performance: 86.0%
2013 Target: 90%
Source: GHS
Outcome: *0*

2007	2008	2009	2010	2011	2012	**2013**
87.8%	86.6%	89.3%	85.9%	86.5%	87.7%	**86.0%**

Results: EPI coverage has been stable close to 90% since 2007. Little deterioration over 2011. Seven of ten regions experienced a drop in coverage in 2013. Three regions have coverage below 80%.

Discussion: The Penta 3 coverage over the years has remained stagnant at around 86% and does not get to the set target. This may make children susceptible to disease outbreaks due our inability to achieve the herd immunity. Efforts should be made to identify and mitigate the challenges to raise the coverage to 90%. Improved strategies could include tracking of all children through a social network that requires all institutions that comes into contact with children. There may also be the need disaggregate data to the district and sub-district level to identify least performing districts and sub-districts.

The stable coverage can also be seen as a demonstration of the strength of the EPI programme. The effect of low and erratic flow of funds to the district level, which is an issue of great concern, appears not to have had much impact on delivering of immunization service. A lot more effort and input however will be needed to move the coverage to 90%. Weak supervision may also be a factor that will need to be addressed.

Year	AR	BAR	CR	ER	GAR	NR	UER	UWR	VR	WR	Ghana

2006	71.0%	96.8%	88.4%	92.4%	65.4%	115.2%	92.6%	88.6%	77.5%	91.1%	84.2%
2007	72.3%	100.2%	92.6%	93.9%	67.8%	123.7%	101.6%	93.0%	83.8%	93.3%	87.8%
2008	76.8%	97.3%	92.2%	87.5%	68.3%	114.5%	94.8%	93.0%	83.8%	89.0%	86.6%
2009	83.7%	95.0%	96.6%	90.1%	72.7%	123.0%	105.9%	94.5%	82.9%	88.6%	89.3%
2010	84.6%	83.3%	85.6%	86.9%	77.9%	110.4%	87.3%	79.9%	66.4%	96.3%	85.9%
2011	87.9%	94.3%	82.7%	86.8%	70.0%	105.3%	87.4%	78.3%	76.4%	98.4%	86.5%
2012	85.3%	97.4%	86.0%	90.9%	76.5%	107.6%	87.1%	72.1%	78.5%	94.6%	87.9%
2013	87.3%	91.3%	81.9%	84.4%	74.0%	110.5%	85.8%	79.5%	74.9%	90.8%	86.0%

HIV Clients receiving ARV therapy

2013 Performance: 84,169
2013 Target: 94,114
Source: NACP
Outcome: +1

2007	2008	2009	2010	2011	2012	**2013**
13,429	23,614	33,745	40,575	59,007	73,339	**84,169**

Results: HIV Clients receiving ARV therapy continues to increase but did not reach the goal of 94,114.

Discussion: The national prevalence estimate for 2012 was 1.37% or 355 thousand people living with HIV and AIDS.(PLWHA).

Guinea Worm

2013 Performance: 0 cases
2013 Target: <1
Source: DHIMS
Outcome: *+1*

2007	2008	2009	2010	2011	2012	**2013**
3,358	501	242	8	0	0	**0**

Results: There has not been a single case of Guinea Worm in Ghana since May 2010.

Discussion: Ghana would need to meet the criteria for certification. This demands intensified surveillance, community education and maintenance of water systems. It also demands improved resource allocation to ensure surveillance activities is taken to all corners of the country.

% households with improved sanitary facilities

2013 Performance: No new information for 2013
2013 Target: N/A
Source: N/A
Outcome: *N/A*

	2006	2008	2012
Not shared		12.4%	15.0%
Total	60.7%	71.2%	60.9%

% households with access to improves source of drinking water

2013 Performance: No new information for 2013
2013 Target: N/A
Source: N/A

2006	2008	2012
78.1%	83.8%	79.3%

Outcome: *N/A*

Obesity in adult population (women age 15-49 years)

2013 Performance: No new information for 2013
2013 Target: N/A
Source: N/A
Outcome: *N/A*

2003	2008	2012
8.1%	9.3%	-

TB treatment success rate

2013 Performance: 88.6% (2012 cohort)
2012 Target: 90%
Source: National TB Programme
Outcome: *0*

2007	2008	2009	2010	2011	**2012**
84.6%	85.4%	87.0%	85.3%	86.2%	**88.6%**

Results:

Discussion: TB treatment success rate improved slightly over 2011, but the increase was less than 5% margin.This however exceeds the World Health Organisation's target of 85%. This may attributed to improvement in follow-up of treatment upon discharge. Some region as are recording zero defaulter rate.

Health Objective 5: Strengthen institutional care including mental health service delivery

Milestone: Two additional halfway homes established for reintegrating former psychiatric patients

2013 Performance: No information
Source: Mental Health Authority
Outcome: ***-1***

Psychiatric patient treatment and rehabilitation rate

2013 Performance: No information
2013 Target: 30% over 2009 baseline
Source: Mental Health Authority
Outcome:*-1*

2010	2011	2012	**2013**
-	-	84.8%	**-**

Result:

Discussion:

Equity index: Ratio of mental health nurses to patient population

2013 Performance: No information
2013 Target: 30% over 2009 baseline
Source: Mental Health Authority
Outcome:*-1*

2010	2011	2012	**2013**
-	-	1:63	**-**

Result:

Discussion:

Number of community psychiatric nurses trained and deployed

2013 Performance: No information
2013 Target: 30% over 2009 baseline
Source: Mental Health Authority
Outcome:-1

2010	2011	2012	**2013**
-	-	400	-

Result:

Discussion:

% tracer psychotropic drug availability in hospitals

2013 Performance: No information
2013 Target: 80%
Source: Mental Health Authority
Outcome:-1

2010	2011	2012	**2013**
68%	64%	85%	-

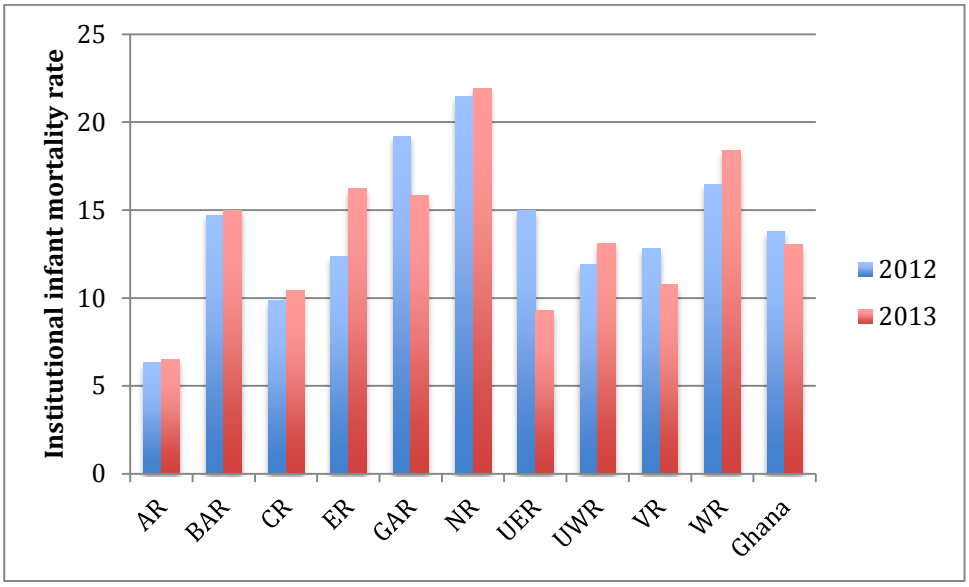
Institutional infant mortality rate

2013 Performance: 7.9
2013 Target: N/A
Source: DHIMS
Outcome: +1

2012	**2013**
13.8	**13.0**

Results: Institutional infant mortality improved from 13.8 deaths per 1,000 institutional live births in 2012 to 13.0 in 2013.

Discussion: The total number of infant deaths recorded at facilities in Ghana increased from 8,077 to 8,561. In the same period, the number of live births increased leading to an improvement of this indicator. The highest iIMR was recorded in Northern Region with 21.9 institutional infant deaths per 1,000 institutional live births. Ashanti was the best performing region with less than half the rate of Northern Region at 6.5 per 1,000 live births.



Basket of critical equipment functioning in hospitals

2013 Performance: No information
2013 Target: N/A
Source: ***N/A***
Outcome: ***-1***

2010	2011	2012	**2013**
-	-	-	-

Result: No information available to MOH. This basket of equipment is yet to be defined, this is a poor indicator. Consider facility survey to assess this indicator.

% tracer drugs availability in hospitals

2013 Performance: No information
2013 Target: N/A
Source: Chief pharmacist
Outcome: ***-1***

2010	2011	2012	**2013**
86.4%	94.1%	85.7%	-

Result:

Discussion:

% of hospitals assessed for quality assurance and control

2013 Performance: No information
2013 Target: 90%
Source: No data
Outcome: ***-1***

2010	2011	**2012**	**2013**
-	-	-	-

Result: No information available to MOH

Institutional under-five mortality rate

2012	**2013**

2013 Performance: 20.0
2013 Target: No target specified
Source: GHS
Outcome: +1

20.1	**17.9**

Results: Institutional under-five mortality improved from 20.1 per 1,000 institutional deliveries in 2012 to 17.9 in 1013.

Discussion: This indicator was recalculated for 2012 and 2013 due to improved data source in DHIMS II. The total number of children under five years was almost constant between 2012 and 2013 at approximately 11,750. The number of institutional live births increased in the same period leading to an improvement of this indicator. There are large regional differences with the highest iU5MR in Northern Region (40.8) and the lowest in Ashanti Region (9.3). This is a result of relatively many under-five deaths in Northern Region and a relatively low number of institutional live births. It is worth noting, that iU5MR in the other two northern regions is considerably lower than for Northern Region.The number of institutional child deaths in Upper East Region reduced from 1,309 in 2012 to 456 in 2013, mostly because of a large reduction in the number of deaths of children between 1 and 5 years (the institutional and neonatal mortality rates did not experience similar improvements).

iU5MR	AR	BAR	CR	ER	GAR	NR	UER	UWR	VR	WR	GHS total
2012	9.1	19.8	14.5	15.0	22.2	37.9	44.4	19.9	18.4	21.0	20.1
2013	9.3	19.7	13.9	21.8	17.1	40.8	15.0	19.0	14.8	22.3	17.9

Institutional MMR

2013 Performance: 161
2013 Target: 150
Source: GHS
Outcome: 0

2010	2011	2012	2013
164	174	152	**155**

Results: Institutional Maternal Mortality ratio remained stable from 2012 to 2013 at just over 150 maternal deaths per 100,000 live births. The change was within the 5% margin of sustained performance.

Discussion: The total number of maternal deaths increased from 899 in 2012 to 1,016 in 2013. The number of institutional live births increased in the same period leading to unchanged performance. Since the total number of women delivering in facilities is increasing, it is also expected to see an increase in the total number of maternal deaths. Moreover, if the increase in institutional deliveries is a result of improved access to emergency obstetric care, e.g. presence of new ambulance, one would expect to see a more high-risk profile of the women delivering in facilities. This indicator is therefore difficult to use to measure

clinical quality of maternal services. On the other hand, the ministry considers any maternal death to be one death to many, and will continue to improve access to and quality of maternal health care services.

iMMR	AR	BAR	CR	ER	GAR	NR	UER	UWR	VR	WR	GHS total
2010	151.6	141.9	149.0	191.6	207.1	139.7	137.9	157.7	219.4	137.0	164.1
2011	197.4	127.4	123.8	207.3	242.4	170.8	127.4	159.6	200.6	101.0	174.4
2012	76.9	166.8	113.2	172.9	205.3	211.7	135.8	145.9	173.8	131.8	151.8
2013	125.3	138.3	121.6	199.5	198.1	173.7	108.4	192.9	161.0	152.7	154.6

Step 2: Grouping of indicators and milestones

Health Objective 1: Bridge equity gaps in health care and nutition services and ensure sustainable financing arrangements that protect the poor		
1.1	% children 0-6 months exclusive breastfed	N/A
1.2	Equity: Poverty (U5MR)	N/A
1.3	Equity: Geography - Services (supervised deliveries)	+1
1.4	Equity: Geography - Resources (nurse:population)	-1
1.5	Equity: NHIS - Gender (Female/Male cardholder ratio)	N/A
1.6	Equity: NHIS - Poverty (Ratio lowest wealth quintile to whole population who wholds NHIS cards)	N/A
1.7	Outpatients attendance per capita (OPD)	+1
1.8	% population living within 8 km of health infrastructure	N/A
1.9	Doctor: population ratio	+1
1.10	Nurse: population ratio	+1
Milestone: Financing strategy developed for the sector to ensure effective resource mobilization		+1
Total Health Objective 1		**+4**
Health Objective 2: Strengthen governance and improve efficiency and effectiveness in the health system		
2.1	% total MTEF allocation on health	+1
2.2	% non-wage GOG recurrent budget allocated to district level and below	-1
2.3	Per capita expenditure on health	+1
2.4	Budget execution rate (Item 3 as proxy)	-1
2.5	% of annual budget allocations to items 2 and 3 (GOG and SBS) disbursed to BMCs by end of year	-1
2.6	% of population with valid NHIS membership card	+1
2.7	Proportion of claims settled within 12 weeks	-1
2.8	% IGF from NHIS	+1
Milestone: Composite planning undertaken in 50% of districts		-1
Milestone: 2 questions included in GDHS on client satisfaction and knowledge of patient charter		+1
Total Health Objective 2		**0**
Health Objective 3: Improve access to quality maternal, neonatal, child and adolescent health services		
3.1	Maternal Mortality Ratio (MMR) per 100,000 live births	N/A
3.2	Total Fertility Rate	N/A
3.3	Contraceptive Prevalence Rate	N/A
3.4	FP acceptor rate	0
3.5	% of pregnant women attending at least 4 antenatal visits	-1
3.6	Infant Mortality Rate (IMR) per 1,000 live births	N/A
3.7	Under 5 Mortality Rate (U5MR) per 1,000 live births	N/A
3.8	% deliveries attended by a trained health worker	0
3.9	Under 5 prevalence of low weight for age	N/A
Milestone: 90% of district hospitals and 70% of health centres equipped with C/BEmOC equipment		-1
Milestone: Adolescent health corners established in 30 hospitals		-1

Total Health Objective 3		**-3**
Health Objective 4: Intensify and control of communicable and non-communicable diseases and promote a health lifestyle		
4.1	HIV prevalence among pregnant women 15-24 years	+1
4.2	% of U5s sleeping under ITN	N/A
4.3	% of children fully immunized by age one - Penta 3	0
4.4	HIV+ clients ARV treatment	+1
4.5	Incidence of Guinea Worm	+1
4.6	% households with improved sanitary facilities	N/A
4.7	% households with access to improved source of drinking water	N/A
4.8	Obesity in population (women aged 15-49 years)	N/A
4.9	TB treatment success rate	0
Milestone: Emergency response strategy for diseases of epidemic potential reviewed		+1
Milestone: 50% reduction in Yaws prevalence achieved		-1
Total Health Objective 4		**+3**
Health Objective 5: Strengthen institutional care, including health service delivery		
5.1	Psychiatric patient treatment and rehabilitation rate	-1
5.2	Equity index: Ratio of mental health nurses to patient population	-1
5.3	Number of community psychiatric nurses trained and deployed	-1
5.4	% tracer psychotropic drug availability in hospitals	-1
5.5	Institutional infant mortality rate	+1
5.6	Basket equipment functioning in hospitals	-1
5.7	% tracer drugs availability in hospitals	0
5.8	% of hospitals assessed for quality assurance and control	-1
5.9	Institutional under-five mortality rate	+1
5.10	Institutional MMR	0
Milestone: 2 additional half-way homes established for re-integration of former psychiatric patients		-1
Total Health Objective 5		**-5**

Table 4: Health Objective group scores

Step 3: Sector score

The outcome of the holistic assessment based on the HSMTDP indicators and cluster in 2012 is neutral with a score of 0, which is interpreted as a sector with sustained performance.

Health Objective 1	+1
Health Objective 2	0
Health Objective 3	-1
Health Objective 4	+1
Health Objective 5	-1
Sector score	**0**

Table 5: Holistic Assessment Tool Sector score

Annex 3: Analysis framework for POW 2013 implementation

Strategies	Priority action	Activity	Lead agencies	Expected Output	Status of implementation and comments	Remarks
HO 1: Bridge equity gaps in access to health care and nutrition services, and ensure sustainable financing arrangements that protects the poor						
1.1 Strengthen district health systems with emphasis on primary health care	1.1.1 Improve coverage of PHC services at sub-districts level through community health systems	Revise and develop new CHPS policy	MoH	New Policy approved	The CHPS policy has been revised. A strategic plan has also been developed to implement the policy.	Output achieved
		Revise training manuals and facilitators guide based on new policy	GHS	New manuals available	Training manuals for the community level has been developed and printed	Output partially achieved. CHO and health centre level manuals are outstanding
		Train sub-district teams as trainers and to support CHPS service providers	GHS	Staff in 300 sub-districts CHPS zones trained	Training has been organized in all districts in Volta region and 9 districts in central region	Output partially achieved
		Retrain and deploy CHOs to defined zone	GHS	900 CHOs trained	This activity was not done.	Output not achieved

Strategies	Priority action	Activity	Lead agencies	Expected Output	Status of implementation and comments	Remarks
		in collaboration with District Assemblies				
		Provide in-service training for Health Promotion Assistants and community volunteers to support CHO	GHS/DA/BGMS	2700 HPAs and Volunteers trained	Activity not done	Output not achieved
		Secure accommodation, transportation and service delivery kits	MoH/GHS/DA	All new CHPS zones fully equipped	Thousand Five Hundred kits were procured under the nutrition and malaria programme for distribution to the CHPS ZONE.	Output achieved
		Create and orient the Community Health Management Teams	GHS	450 CHMTs established	Community health management teams established in all districts in Volta region and 9 districts in the central Region	Output achieved.
1.2 Increase availability and efficiently in human	1.2.1 Complete staffing norms, and the development of the Human	Complete the development of staffing norms and roadmap for	MoH/GHS/TH/CHAG/Private Sector	New staffing norms implemente	Staffing norms tools developed and tested. Stakeholder consultation to be held in the first quarter of 2014	The staffing norm is not complete. It has to go through stakeholder consultation

Strategies	Priority action	Activity	Lead agencies	Expected Output	Status of implementation and comments	Remarks
resource for health	Resource deployment plan and implement	implementation		d		and approval processes
		Complete the HR policy and start implementation	MoH/GHS/TH/CHAG/Private Sector	Introduced deprived area incentives for 10 districts	Resource deployment plan was to be based on the staffing norm which is yet to be completed. Though the technical work on the staffing norm is complete? Stakeholder consultations are yet to begin	Output not achieved
HO2: Strengthen governance and improve the efficiency and effectiveness of the health system						
2.1 Strengthen the regulatory and inter-sector collaboration for governing the health sector	2.1.1 Support the implementation of the new and revised health sector regulations	Complete the development of the Legislative Instruments and the institutions captured under the Health Institutions and Facilities Act 829, 2011; Specialist Health Training Institution and Plant Medicine Research Act 833, 2012;Public Health Act 851, 2012;	MoH/GHS/TH/CHAG/Private Sector/Ambulance Service	Governing bodies established and Legislative Instruments approved by parliament	L.I. for HEFRA is under development The process for developing L.I. for ACT 833 has been initiated. The Public Health Act 851, is made up of 9 different constituents. The constituents need to be dealt with separately by different group of professionals. Consultations on way	This output has been partially achieved. Only one governing board (Mental Health) was inaugurated

Strategies	Priority action	Activity	Lead agencies	Expected Output	Status of implementation and comments	Remarks
		National Health Insurance Act 852, 2012			forward have been completed and a group has started work on the Framework Convention Tobacco Consumption. A zero draft has been completed.	
		Develop the institutions and systems under Specialist Health Training and Plant Medicine Research Act 833, 2011 and Public Health, Act 851	MoH/GHS and affected agencies	Governing bodies established and development of Legislative Instruments initiated	Governing bodies would need to wait for the L.I.s to be completed. This have delayed the establishment of governing bodies for the various institutions	This output has not been achieved due to extraneous factors
	2.1.2 Strengthen DHMTs and orient the district health Directorates to operate in accordance with LI 1961	Review and amend the Ghana Health Service and Teaching Hospitals Act 525 of 1996 to reflect the ceding of the oversight responsibility for service delivery to	MoH/GHS/MoLGRD/TH/CHAG	Act 525 amended	This activity has been delayed because of the ongoing consultative work on decentralization. It will be considered by a team of legislative drafters who will consider a new institutional framework for the sector vis-à-vis the	This output is outdated. It has been overtaken by the decentralization process. The amendment of the law has

Strategies	Priority action	Activity	Lead agencies	Expected Output	Status of implementation and comments	Remarks
		district assemblies			amendment agenda	been suspended until a new institutional framework based on government policy framework on decentralisation completed.
		Re-orient national, regional districts and relevant stakeholders on the implications on LI 1961	MoH/GHS/CHAG	50 Management teams at national, regional and districts oriented	The L.I. 1961 is to be amended as part of a local government legislative consolidation exercise. The orientation is therefore on hold. Stakeholder consultative meetings were held as part of a process to collate views to review and consolidate various local governance laws. A draft bill has been prepared as a result.	The output has been achieved. The consultation were held under the auspices of the IMCC and LGSS

Strategies	Priority action	Activity	Lead agencies	Expected Output	Status of implementation and comments	Remarks
		Train district staff in composite planning and budgeting	MoH/GHS/CHAG	Staff in 215 districts trained	This activity was not done	Output not achieved
	2.1.3 Set up a Private Health Sector Council as a coordinating mechanism for the private sector and strengthen public-private partnership	Develop and implement institutional framework for the Private Health Sector Council (PHSC)	MoH/Private Sector	Private Health Sector Council inaugurated	Private health sector council has not been set up. The private health sector alliance which is an umbrella organisation for the private sector is undergoing re-organisation. A new constitution has just been drafted for the group awaiting approval after which consultations will start for the possible inauguration of the council	This output has not been achieved
		Develop and sign memorandum of understanding between MoH and PHSC	MoH/PHSC	Partnership framework signed	Provision made in the new policy for an advisory body which yet to be inaugurated.	Output not achieved
		Review and sign memorandum of	MoH/CNH	Partnership framework	The process has started. Consultations are going	

Strategies	Priority action	Activity	Lead agencies	Expected Output	Status of implementation and comments	Remarks
		understanding between MoH and Coalition for NGOs in Health(CNH)		signed	on It is hoped the MOU will be signed during the second quarter of 2014	Output not
	2.1.4 Strengthen collaboration with Ministry of Local Government and Rural Development, Ministry of Food and Agriculture and Ministry of Education and Ministry of Youth and Sports	Work with MOFA on the IHR to develop collaborative surveillance systems on all food hazards (e.g. zoonotic, radiated, nuclear etc.)	GHS/MOFA/FDB	Food safety indicators reflected in Public Health annual report	GHS	
		Engage and scale up the school health programme in basic and secondary schools	MoH/GHS/Ministry of Education/GES	200 Lead SHEP coordinators trained in school health	GHS/FHD Designed a ration tool for school feeding in collaboration with Ghana School Feeding Programme Manual on healthy eating for schools developed in collaboration with Ghana School Feeding Programme.	

Strategies	Priority action	Activity	Lead agencies	Expected Output	Status of implementation and comments	Remarks
	2.1.5 Initiate the decentralization process in line with the district assembly decentralization programme				The decentralization process has been initiated. A proposed institutional framework has been submitted to the inter-ministerial coordinating committee. The ministry will be waiting for further direction.	Output achieved
2.2 Strengthen systems for improving the evidence base for policy and operations research	2.2.1 Develop a new National Health policy and a Health Sector Medium Term Development Plan	Develop a national health policy	MoH	Policy developed and approved	Terms of reference for the review of exiting policy have developed. The policy team awaiting for the release of funding	Output not achieved
		Develop a Health Sector Medium Term Development Plan	MoH	HSMTDP developed and approved	A draft medium term development plan is ready. It is being fine tuned for submission to the health sector working group meeting for adoption.	Output partially achieved
	2.2.2 Generate evidence and engage with the	Engage with GSS to review protocols for DHS to ensure the	MoH	Indicators on patient satisfaction	Engagement with GSS is ongoing. Questions on patient satisfaction have	Output achieved

Strategies	Priority action	Activity	Lead agencies	Expected Output	Status of implementation and comments	Remarks
	DHS process to measure client satisfaction and knowledge of patient charter	health indicators are adequately reflected		and patient chartered measured	been included in the DHS.	
		Support the conduct of operational research	MoH/GHS	10 operational research conducted	8 operational researches done and 7 are in the process of developing a proposal.	Output partially achieved
		Develop research capacity in research institutions	MoH/GHS/Research agencies	10 health research officers given CPD	110 staff had CPD on proposal developments and ethical scientific reviews	Output achieved
		Support the conduct of clinical trials	MoH and research agencies	Evidence of research staff engaged with at least 1 clinical trial	Clinical trials on-going in all the research centres	Output achieved
HO3: Improve access to quality maternal, neonatal, child and adolescent health and nutrition services						
3.1 Reduce the major causes contributing to maternal	3.1.1 Increase access and use of modern contraceptives, antenatal and	Increase access to modern FP services	GHS/CHAG/Private Sector/CSOs	40% FP use (to synchronize with MAF)	FP acceptor rate was 26.1%	Output not achieved. Considering past coverages, the

Strategies	Priority action	Activity	Lead agencies	Expected Output	Status of implementation and comments	Remarks
and neonatal deaths	post-natal care and improve access to adolescent health services in health facilities					target was not realistic
		Undertake clinical audit to improve quality of antenatal and postnatal care services	GHS/CHAG/TH/ Private Sector	ANC and PNC clinical audit report available		
		Increase access to antenatal and postnatal care	GHS/CHAG/Private Sector	4 visits of ANC increased to 80% and 60% PNC	ANC coverage was 66.3%. Post natal coverage was 64.9.%	Output partially achieved
		Provide adolescent health training to essential health staff	GHS/CHAG/Private Sector	OPD staff trained on managing adolescent health services in 50 facilities		
	3.1.2 Implement MAF: Improve availability, quality and access to comprehensive/ba	Improve access to safe blood for expectant mothers and newborns	GHS/TH/CHAG/ Private Sector/National Blood Service	MAF to provide	The PRIORITY ACTION for achieving the key activity planned for year was to strengthen Area Blood Centres and Blood banks by improving infrastructure and equipment. The National	

Strategies	Priority action	Activity	Lead agencies	Expected Output	Status of implementation and comments	Remarks
	sic Emergency Obstetric and Neonatal care services in health facilities				Blood Service planned to Provide Technical Assistance support for the construction and equipping of the Southern and Central Area Blood Centres in Accra and Kumasi respectively ACCRA: NBS HEADQUARTERS AND SOUTHERN AREA BLOOD CENTRE The Ministry of Health's Project Implementation Unit (P.I.U) and NBS worked with the Architectural Consultants (Osei Kuffour Sohnne and Partners) to supervise the completion of the civil works carried out by Berock ventures at the new headquarters and southern Area Blood Centre which is 99% now complete. Equipment specifications were determined, tendering process completed and contract awarded; contracts to supply the equipment were signed between	

Strategies	Priority action	Activity	Lead agencies	Expected Output	Status of implementation and comments	Remarks
					Ministry of Health and the respective companies. The NBS headquarters and Southern Area Blood Centre, is expected to be fully operational by end of November 2013. This is expected to greatly improve blood procurement and delivery in the southern zone and National Coordination of Implementation of Blood Safety activities in the whole country. An audit tour of the southern zone was carried out during the year. Consequently, plans are underway to expand operations of the catchment area from the current Greater Accra area and cover the entire southern zone of the country. The Nordic Development Fund (NDF) supported, Technical Assistance for COMPONENT 2 OF THE HEALTH SERVICES REHABILTATION PROJECT 3: for completion of the outstanding activities,	

Strategies	Priority action	Activity	Lead agencies	Expected Output	Status of implementation and comments	Remarks
					streamlining and improving the function of the entire NBS, was successfully implemented by Technical Assistance consultants. Under the CDC/PEPFAR Task order contract, Technical Assistant consultants from Safe Blood for Africa Foundation (SBfAF) visited at various times in the year to assist in the modernization and streamline processes. regarding all the components of the blood value chain. KUMASI: CENTRAL AREA BLOOD CENTRE Design for Kumasi ABC for the Middle Zone was completed and is available. Equipment specifications were determined and process for procurement of some equipment for blood donor services activities was done. Procurement process to be carried out as soon as a "No-objection" is received from the NDF. Funding for construction of civil works and equipment for Kumasi	

Strategies	Priority action	Activity	Lead agencies	Expected Output	Status of implementation and comments	Remarks
					ABC is being sourced by MOH PIU from MOFEP. Provide technical assistance in the design of civil works and equipment specifications for Tamale Blood Centre. TAMALE: NORTHERN AREA BLOOD CENTRE. Funds for civil works and equipment for Tamale ABC for the Northern Zone is being sourced by the MOH's PIU. The process of procurement for some equipment for blood donor services activities was done. Procurement process will commence as soon as a "No-objection" is received from the NDF. 1. Collaborate with aid agencies to supply blood bank refrigerators and other blood banking equipment on needs-based basis to hospital Blood Banks Nationwide	

Strategies	Priority action	Activity	Lead agencies	Expected Output	Status of implementation and comments	Remarks
					The Tamale Teaching Hospital blood bank was rehabilitated under the current TTH project and made functional. The NBS collaborated with GHS (Family Health Directorate) to provide specifications for cold storage equipment to be procured under the MAF project Thirty-five (35) new blood bank refrigerators were donated by UNFPA. A distribution list based on the MAF gap report and needs-basis was prepared for distribution to 35 hospitals across the country	
		Increase coverage of skilled delivery	GHS/TH/CHAG/ Private Sector	60% skilled attendance (synchronize with MAF)	The implementation of the MDG Accelerated Framework started in earnest in later part of the year. Various activities based on specific	

Strategies	Priority action	Activity	Lead agencies	Expected Output	Status of implementation and comments	Remarks
					institutional and district plans. Procurement of specific equipment to support the programme has delayed.	
		Increase access and quality of EmONC	GHS/TH/CHAG/ Private Sector	100% district and private hospitals EmONC compliant	The procurement process for the equipments has delayed because of the international nature of the bidding process.	Output not achieved
		Strengthen implementation of Life Saving Skills at district and sub-district level	GHS/TH/CHAG/ Private Sector	100 health facilities staff trained in LSS	Regional Trainers for Brong Ahafo, Ashanti and Eastern Regions established this year ensuring that all regions have their trainers Almost all regions have conducted Lief saving Skills (LSS) downstream training for their regions 487 midwives trained nationwide in LSS as at June 2013	

Strategies	Priority action	Activity	Lead agencies	Expected Output	Status of implementation and comments	Remarks
		Increase numbers of midwives trained, secure learning materials and expand training to private training institutions	MoH/NMC/private sector	At least two new straight midwifery degree programmes established	One midwifery degree programme was established at the Kwame Nkrumah University of Science and technology (KNUST).	
		Evaluate the experiences and perceptions of quality of service by women regarding child birth	GHS/CHAG/Private Sector	Report on quality survey available		
		Provide District Hospitals and Health Centres with CEmOC and BEmOC equipment	GHS	90% District Hospitals and 70% of Health Centres provided with CEmOC and BEmOC	Procurement of equipment delayed due to the nature of the bidding process (International competitive bidding.	Output not achieved
3.2 Reduce the major causes contributing to child	3.2.1 Train nutrition officers, public health nurses and other health workers to	Monitor use of salt iodization, zinc and vitamin A supplementation implementation	GHS/MOFA	90% domestic salt iodized; 100% reported	Coverage for salt iodization is 32%. The main challenges include low production from salt producers. This is due to	

Strategies	Priority action	Activity	Lead agencies	Expected Output	Status of implementation and comments	Remarks
morbidity and deaths	provide appropriate nutrition services to mothers and children	programme		cases of diarrhea given zinc supplement ; 90% Vit A provided to children	the scarcity of potassium iodate on the market and the reluctance of producers to incur additional cost through the purchase of the potassium iodate	
		Evaluate implementation of growth monitoring Chart	GHS/CHAG	Report submitted to MoH	This activity has not been implemented	
		Expand access to Community Management of Acute Malnutrition (CMAM)	GHS/CHAG	30 districts trained in CMAM	Training was organized for ….. new districts.	
		Assess prevalence of anaemia among children under five and pregnant women	MoH	Indicators on anemia in children and pregnant women included in DHS	Indicator on anemia included in the DHS module for the 2014 survey.	Achieved
	3.2.2 Increase	Increase coverage of	GHS/CHAG/private Sector	All antigens	The objective of this	

Strategies	Priority action	Activity	Lead agencies	Expected Output	Status of implementation and comments	Remarks
	access and coverage to EPI services including the newly introduced vaccines	all antigens		above 90%	activity was to;	
		Monitor the implementation of the two new vaccines	GHS	Report submitted to MoH	1. Update the programme's working document (Comprehensive Multi-Year Plan -cMYP) with new policies and innovations; and introduce Measles/Rubella (MR) vaccine. 2. Improve access to new - Human Papilloma Virus (HPV) vaccines and Innovative Technologies for vaccine preventable diseases 3. Accelerate the control and prevention of vaccine preventable diseases; and Conduct two rounds of polio vaccination nationwide (NIDs) 4. Increase and maintain routine immunization coverage for all childhood antigens to 90% and above; and Vaccinate all children under 1 year with the 11 EPI vaccines 5. Accelerate the control and prevention of	

Strategies	Priority action	Activity	Lead agencies	Expected Output	Status of implementation and comments	Remarks
					vaccine preventable diseases; and conduct nationwide MR campaign 6. 6 Promote and ensure injection safety Progress 1. cMYP updated to include measles / rubella (MR) new vaccine; and MR introduced 2. Three (3) rounds of vaccination completed in 17 districts in 3 regions CR -7 districts, NR - 8 districts, GAR-2 districts 3. Two rounds of Polio nationwide NIDs conducted 4. Ongoing: Annualized coverage are : BCG =98% OPV3 = 86% Penta 3 = 86%, Measles 1 = 84, Rota 2 = 83% and PCV 3 = 84%, YF 84% 5. MR campaign conducted nationwide. Vaccine now introduced into routine to replace measles vaccine at 9 months	

Strategies	Priority action	Activity	Lead agencies	Expected Output	Status of implementation and comments	Remarks
		Assess the prevalence of measles and yellow fever and effectiveness of interventions	GHS	Report submitted to MoH	In-depth assessment. Resources not secured - US$ 100,000	
		Evaluate the effectiveness of the cold chain systems	GHS/CHAG/private sector	Report submitted to MoH	In-depth assessment, Resources not secured US$ 100,000	
HO4: Intensify prevention and control of communicable and non-communicable diseases						
4.1 Improve upon prevention, detection and case management of communicable diseases	4.1.1 Reduce morbidity and mortality resulting from communicable diseases particularly malaria, HIV and AID, tuberculosis, and diarrheal diseases	Continue implementation of malaria interventions and evaluate the implementation of the AMFm ACT programme and its sustainability impact	MoH/GHS/Pharmacy Council/FDB	10% reduction in malaria case fatality in children and pregnant women and Report of AMFm evaluation submitted to MoH	Home base care (HBC) is a strategy geared towards communities with challenges in accessing health care. It is aimed at giving basic health care to a child as close to the home/ community as possible to avoid complications. It is also meant to get children suffering from MALARIA, PNEUMONIA (ACUTE RESPIRATRORY INFECTIONS) AND DIARRHOEA treated as	

Strategies	Priority action	Activity	Lead agencies	Expected Output	Status of implementation and comments	Remarks
					quickly as possible to prevent deaths. Home management of malaria (HMM) is one aspect of HBC. Implementation of HMM is in 136 districts nationwide. (This started before the creation of the new districts). Most of the districts were targeted because they have a high rural component. Regional Breakdown of slelected districts is as follows; Ashanti region – 21, Western Region – 14, Eastern region – 16, Volta region – 13, Brong Ahafo Region – 16, Greater Accra - 6, Upper West region – 9, Upper East region – 9, Northern Region - 20, Central Region – 12, Total	

Strategies	Priority action	Activity	Lead agencies	Expected Output	Status of implementation and comments	Remarks
					136 UPTAKE OF HOME MANAGEMENT OF MALARIA IS VERY LOW, Uptake was only 9% of the stated target of approximately 1,700,000 malaria treated at community level. About 26,000 Community Based Agents (CBAs) were trained country-wide. However, in our recent assessment approximately 7,800 CBAs and 500 supervisors are active. This is due to; - High attrition rate -inadequate of drugs -No remuneration of CBAs -Low motivation of supervisors who are to oversee the work of the CBAs -Low perception of CBAs in the communities -Presence of CBAs in communities where there is a health facility.	

Strategies	Priority action	Activity	Lead agencies	Expected Output	Status of implementation and comments	Remarks
					If however the three factors of remuneration, continuous supply of drugs and sustained mass media campaign are addressed, uptake of the intervention may increase. As a result of the challenges enumerated, the National Malaria control programme(NMCP) scaling down to communities and areas where access to health facilities is still a problem. Reasons for low uptake are as follows: • Lack of motivation (including financial) of Community Based Agents (CBAs) and their supervisors to ensure the effective roll out of the intervention. (HBC Monitoring Report, 2012). *GOG REQUESTED TO REMUNERATE.* APPROX COST PER YEAR:GH¢5,000,000 • Availability of only anti-	

Strategies	Priority action	Activity	Lead agencies	Expected Output	Status of implementation and comments	Remarks
					malarials in HBC-selected districts in the six regions apart from the three Northern and Central regions; Zinc, Oral rehydration salts (ORS),Paracetamol and Amoxycillin are yet to be supplied. *GOG HAVE BEEN REQUESTED TO SUPPLY THESE DRUGS*.APPROX COST PER YEAR: GH¢7,130, 000 AMfm survey was carried out during the year	
		Continue implementation of TB intervention including surveillance and assessment of health professional competency in TB case management	GHS/CHAG/Private Sector	Treatment Success Rate improved by 20% and assessment report submitted to MoH	• The overall objective was to procure diagnostics and develop capacity at districts to detect, manage TB and specifically; • Detect and notify national level smear positive TB • Improve private sector involvement in detction of new smear positive TB cases • Treat all detected TB	

Strategies	Priority action	Activity	Lead agencies	Expected Output	Status of implementation and comments	Remarks
					cases according to National guidelines and attain treatment success rate of ≥88% • Conduct test on eligible people for MDR-TB as per national guidelines and enroll all Laboratory confirmed MDR-TB cases on second line anti-TB treatment • Scale up and strengthen Community Based TB Care (CBTC) to support TB case management • Ensure continuing availability of TB drugs in the districts (Number & percentage of districts reporting no stock out of TB drugs on the last day of the quarter) Results; • Ongoing: Target for detection and notification was 4,976. Achievement as at 30 Jun 3,498 (70%) Ne w smear +_ve 7, 237 target 9,000 • All forms19,386 achieved 15,000 • Ongoing: Target for treatment success rate-4,744. Achievement as	

Strategies	Priority action	Activity	Lead agencies	Expected Output	Status of implementation and comments	Remarks
					at 30 Jun 4,175 (86%) • Ongoing: Target for Multi drug resistant TB (MDR-TB) was 100. Achievement as at 30 Jun was 130 (130%) • Ongoing: Baseline for CBTC was 5,556/15,286 (37%). Target was 6,397/10,662 (60%) Achievement as at 30 June was (57%) • Ongoing: Target on drug availability in districts was 135/170 (80%); Achievement as at 30 Jun 100/170 (58%)	
		Continue implementation of HIV/AIDS interventions and assess the HIV resource gap and drug availability/sustainability over the next five years	MoH/GHS/GAC	Resource gap and sustainability report available	The objective was to ; • provide Counseling, Test and give HIV test results • Provide HIV-infected women with a course of anti-retroviral prophylaxis to reduce Mother to Child Transmission • Provide HIV-infected pregnant women with HIV testing and counseling services • Infants born to HIV infected mothers to receive HIV tests within 2 months after birth	

Strategies	Priority action	Activity	Lead agencies	Expected Output	Status of implementation and comments	Remarks
					Progress; • Ongoing: Target for testing and counseling was 878,696; Achievement as at Sept was 463,997 (53%) • Ongoing: Target Prophylaxis for pregnant women was 17,639. Achievement as at Sept 5,110 (29%) • Ongoing: Target for HIV testing and counseling for pregnant women was - 589,312 Achievement as at Sept was 316,844 (54%) Ongoing: Target testing for infants born to HIV infected mother was 11,132 Achievement as at Sept 2,068 (19%) The objectives are; • Increase treatment, case and support for people living with HIV • People (adults and children) with advanced HIV infection to receive ART Progress; • Ongoing: Target	

Strategies	Priority action	Activity	Lead agencies	Expected Output	Status of implementation and comments	Remarks
					treatment for people living with HIV was - 94,114. Achievement as at Sept 84,169 (>100%) Ongoing: Target treatment for people with advanced HIV - 99,745. Achievement as at Sept 79,887 (80%)	
		Train CHOs in childhood illness and diarrhoeal disease management		500 CHOs trained		
	4.1.2 Complete the eradication certification process for guinea worm and polio, scale up elimination activities for leprosy, trachoma and yaws onchocerciasis, lymphatic filariasis and schistosomiasis	Maintain the disease free status and validate eradication of guinea worm and polio		0% cases detected for guinea worm and AFP 2 per 100,000	No cases of poliomyelitis were detected. AFP rate the year was 2.71	Output achieved
		Increase activities for the elimination of onchocerciasis, lymphatic filariasis, yaws, trachoma and leprosy		100% geographic and 80% therapeutic coverage	Organized Mass Drug Distribution in Oncho and Lymphatic Filariasis (LF) Endemic Communities Organized Case Search and Treatment of Cases and Contacts in Yaws and	

Strategies	Priority action	Activity	Lead agencies	Expected Output	Status of implementation and comments	Remarks
	and control buruli ulcer				Leprosy Endemic Communities	
		Update the prevalence maps for onchocerciasis, schistosomiasis and lymphatic filariasis		% case detection rate and availability of maps		
Improve prevention, detection and management of non-communicable diseases	4.1.3 Support the establishment of the NCD monitoring centre and data repository	Develop an NCD Monitoring Centre Institutional Manual and Operational Costs	MoH, GHS, TH	NCD Monitoring Centre framework developed	No	
		Develop a software for establishing a data repository and provide basic equipment's	MoH/GHS/TH	Software developed and repository established	No	
		Conduct non-communicable disease risk factor survey	GHS/TH	Survey report available	No	
	4.1.4 Promote healthy lifestyle, and strengthen the	Integrate healthy style into basic schools and teacher training	MoH/GHS	Curriculum introduced	Yes	

Strategies	Priority action	Activity	Lead agencies	Expected Output	Status of implementation and comments	Remarks
	prevention and management of non-communicable diseases particularly hypertension, diabetes, sickle cell disease and cancers, including FCTC implementation	curricula		in schools		
		Evaluate the regenerative health and nutrition programme	MoH/GHS	Impact evaluation report available	lack of funds	
		Develop guidelines for the implementation and monitoring of the tobacco and alcohol policy	MoH/GHS	100% tobacco and alcohol advertising and public exposure requirements enforced	Kyei Faried	
		Assess the performance and product portfolio of the Centre for Scientific Research into Plant Medicine	MOH/CSRPM/TMC	Report on product portfolio available		
		Develop manuals and train health professionals in the integrated management of non-communicable	GHS	Electronic copy of manual available and 200 health		

Strategies	Priority action	Activity	Lead agencies	Expected Output	Status of implementation and comments	Remarks
		diseases		professionals trained		
	4.1.5 Strengthen public health emergency response for diseases of epidemic potential, including international health regulation	Generate awareness on prevention and primary care on cholera and meningitis	GHS	KAP level at 90% in epidemic prone areas	no	
		Provide training and develop capacity of health professionals on case detection of notifiable diseases	GHS	% of staff trained	10 regional surveillance teams trained and 114 district teams trained on second edition of IDSR. About 67% of staff trained.	
HO5: Strengthen institutional care including mental health service delivery						
5.1 Enforce standards, guidelines and protocols to improve the quality of institutional care	5.1.1 Prepare health facilities to meet accreditation and licensing criteria in both the public and private sector	Secure technical assistance to undertake evaluation of outcomes of current accreditation status of facilities	NHIA/GHS/TH/CHAG/ Private Sector/MoH	Assessment report published		

Strategies	Priority action	Activity	Lead agencies	Expected Output	Status of implementation and comments	Remarks
		Develop a structured training programme to provide skills reorientation for service delivery and institutional management	GHS/TH/CHAG/ Private Sector	70 of facility teams trained		
		Provide basic equipment's to health facilities to meet category accreditation requirements	MoH	No of facilities re-equipped		
		Secure technical assistance to develop a policy on supportive supervision and monitoring framework	MoH/GHS	Policy developed and implemented	Technical assistance procure with support from PromPt USAID to develop draft framework	Funding has been procured from USAID to finalise policy in 2014.
		Implement a structured supportive	GHS/TH/CHAG/ Private Sector	4 regional hospitals, 1	Integrated structured	Support supervision

Strategies	Priority action	Activity	Lead agencies	Expected Output	Status of implementation and comments		Remarks
		supervision in selected hospitals		psychiatric, 10 hospitals and 10 health canters covered	supportive supervision not done but supportive supervision was carried out in some selected areas as outline in the remarks column	on malaria case management done in 42 health facilities in seven (7) regions. Namely: Volta, Eastern, Ashanti, Brong-Ahafo, Northern, Upper East and Upper West regions.	
	5.1.2 Strengthening quality assurance and improvement systems in health facilities	Create awareness on medico-legal issues among health professionals	MoH/GHS/TH/CHAG/Private sector	At least 300 heads of health facilities trained			
		Implement patient safety programme	MoH/GHS/TH/CHAG/Privat	20 Teams trained in	Not done		

Strategies	Priority action	Activity	Lead agencies	Expected Output	Status of implementation and comments		Remarks
		including adverse events monitoring	e sector	facilities			
		Revise QA manual and train frontline to implement QI	GHS/TH	20 hospitals frontline officers trained	Reviewed the Quality Assurance manual and developed a Quality Assurance and Safety book. Health managers from three regions – Western, Central and Greater Accra were trained as trainers (TOTs), thereafter, staff from selected facilities in Western		

Strategies	Priority action	Activity	Lead agencies	Expected Output	Status of implementation and comments		Remarks
					and Central Regions were trained to ensure that the district and sub-district facilities staff are trained.		
		Train health care providers (Frontline) on customer care	GHS	50 hospitals front line officers trained	Two hundred and eighty three (232) health providers from 131 health across the country facilities were trained on customer		

Strategies	Priority action	Activity	Lead agencies	Expected Output	Status of implementation and comments		Remarks
					care and quality assurance. Three hundred (300) staff of the Trust hospital, eighty (80) staff from the Adabraka Polyclinic and sixty nine (69) staff from four district in Ashanti region and four district from the Volta region were also trained on customer care and		

Strategies	Priority action	Activity	Lead agencies	Expected Output	Status of implementation and comments	Remarks
					quality assurance..	
	5.1.3 Improve emergency care services in health facilities	Reorient OPD and A&E staff on triaging and management of critical conditions	GHS/TH/CHAG/ Private Sector	10 teams trained in ten facilities	• 134 Clinicians from 17 district hospitals and clinics and one paediatric hospital were trained on Essential Surgical skills and management of key emergency conditions including Triage and Basic Life Support •Sixty five (65) from	

Strategies	Priority action	Activity	Lead agencies	Expected Output	Status of implementation and comments		Remarks
					the ten (10) regional hospitals and thirteen (13) district hospitals were trained to manage key surgical and medical emergencies.		
		Develop learning materials, algorithms for emergency teams in health facilities	GHS/TH/CHAG/ Private Sector	Electronic manuals available and teams in 10 regional hospitals trained			
		Deploy ambulances and medical technicians	Ambulance Service	100% deployment of all existing			

Strategies	Priority action	Activity	Lead agencies	Expected Output	Status of implementation and comments		Remarks
				ambulance and personnel			
		Provide in-service pre-hospital care training to medical technicians to enhance patient safety	Ambulance Service	At least 60% of existing staff trained			
5.2 Increase Access to Mental Health Service	5.2.1 Develop the Legislative Instrument of the Mental Health Authority Act, Act 846 and establish its governance and initiate the implementation of the community mental health strategy	Develop the institutional manual and establish the Mental Health Authority	MoH/PH	MHA established			
		Disseminate the Mental Health Act and its implications for practice	MHA	Information sections held in 30 facilities			
		Accredit health facilities to assess, manage and support the rehabilitation of patients with severe psychiatric conditions and intellectual	MHA	30 facilities assessed and accredited			

Strategies	Priority action	Activity	Lead agencies	Expected Output	Status of implementation and comments		Remarks
		disabilities					
		Train health care providers (Frontline) on the guidelines and protocols for mental health services	MHA	30 facilities teams trained			
		Establishment and operate halfway homes, hostels and rehabilitation of centres to rehabilitate people with psychiatric illnesses	MHA/DA	Establish at least 2 halfway home/hostels			
		Pilot the ASSIST tool for early detection of alcohol, tobacco and psycho-active substances	MHA/GHS	Project implemented in three (3) districts			
		Develop training modules on addiction and train health professionals to implement it		At least 30 nurses trained			