WHO COUNTRY COOPERATION STRATEGY: GHANA

2002-2005

World Health Organization
Regional Office for Africa
Brazzaville

Contents

Pages

Abbreviations iv

Foreword vi

1. Introduction 1

1.1 Purpose of document 1
1.2 The consultation process 1

2. Government and People: Health and Development Challenges 2-15

2.1 Background 2
2.2 The status of health 4
2.3 Disease profile 5
2.4 Priority interventions 5
2.5 Health policies, strategies and programme of work 2002–2006 8
2.6 Health system challenges 9

3. Development Assistance 15-17

3.1 Partners in health development 15
3.2 Donor coordination 17

4. WHO Current Country Programme 18-23

4.1 Country office operations .... .18
4.2 Opportunities and challenges .... .22

5. WHO Corporate Policy Framework: Global and Regional Directions 23-25

5.1 Goal and mission 23
5.2 New emphases 23
5.3 Strategic directions 24
5.4 Core functions 24
5.5 Global and regional priorities 24
5.6 Making WHO more effective at country level 25

6. WHO Strategic Agenda 25-30

6.1 Introduction 25
6.2 Guiding principles: Investing in health 26
6.3 Overview of strategic areas 26

7. Implementing the Strategic Agenda 30-32

7.1 Country office 30
7.2 Regional office 32

7.3 Headquarters 32

8. Conclusion 33

Selected References.. 34

ANNEXES

1. Proposed Organogram for WHO Country Office, Ghana 35

Abbreviations

ANC	Antenatal Clinic
AOW	Area of Work
ARI	Acute Respiratory Infection
ARV	Antiretroviral
BCG	Bacille Calmette Guérin
BSS	Behaviour Surveillance Survey
CCA	Common Country Assessment
CCM	Country Cooperating Mechanism
CCS	Country Cooperation Strategy
CFR	Case Fatality Rate
CHAG	Christian Health Association of Ghana
CHIM	Centre for Health Information Management
CHO	Community Health Officer
CHPS	Community-based Health Planning and Service
CMH	Commission on Macroeconomics and Health
CSRPM	Centre for Scientific Research into Plant Medicine
CVD	Cardiovascular Disease
CVP	Child Vaccination Programme
CWIQ	Core Welfare Indicator Questionnaire
DANIDA	Danish International Development Agency
DFID	Department for International Development
DHMT	District Health Management Team
DOTS	Directly Observed Treatment Short-Course
DPT3	Diphtheria, Pertussis and Tetanus-third dose
EB	Extra-budgetary
EPI	Expanded Programme on Immunization
GAC	Ghana AIDS Commission
GAVI	Global Alliance for Vaccines and Immunization
GDHS	Ghana Demographic Health Survey
GFATM	Global Fund for AIDS, Tuberculosis and Malaria
GHS	Ghana Health Service
GOG	Government of Ghana
GPRS	Ghana Poverty Reduction Strategy
HIPC	Highly-Indebted Poor Country
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
HQ	Headquarters
HRD	Human Resource Development
IDSR	Integrated Disease Surveillance and Response
IEC	Information, Education and Communication
IGF	Internally Generated Fund
IMCI	Integrated Management of Childhood Illnesses
IMR	Infant Mortality Rate
ITN	Insecticide Treated Net
JICA	Japan International Cooperation Agency
LB	Live Birth
MDAs	Ministries, Departments, Agencies
MDGs	Millennium Development Goals

MNT	Maternal and Neonatal Tetanus
MOF	Ministry of Finance
MOH	Ministry of Health
MTCT	Mother to Child Transmission
MTEF	Medium-term Expenditure Framework
MTHS	Medium-term Health Strategy
NACP	National AIDS Control Programme
NADMO	National Disaster Management Organization
NCD	Noncommunicable Diseases
NEPAD	New Partnership for Africa's Development
NGO	Nongovernmental Organization
NID	National Immunization Day
NPO	National Professional Officer
OPD	Outpatient Department
ORT	Oral Rehydration Therapy
PHD	Public Health Division
POW	Programme of Work
PPME	Policy, Planning, Monitoring and Evaluation
PRSP	Poverty Reduction Strategy Paper
RBM	Roll Back Malaria
RTI	Road Traffic Injury
SS	Surveillance System
STI	Sexually Transmitted Infection
SWAP	Sector-Wide Approach
TBA	Traditional Birth Attendant
TFR	Total Fertility Rate
U5MR	Under Five Mortality Rate
UNCT	United Nations Country Team
UNDAF	United Nations Development Assistance Framework
UNDP	United Nations Development Programme
UNFIP	United Nations Funds for International Partnership
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
URTI	Upper Respiratory Tract Infection
USAID	United States Agency for International Development
VCT	Voluntary Counselling and Testing
VPD	Vaccine Preventable Disease
WHO	World Health Organization

Foreword

To better guide WHO in its strategic and technical support to Ghana, a process of extensive consultation was embarked upon with a majority of the stakeholders in health. This consultation has resulted in this document – WHO Country Cooperation Strategy. The document consists of eight sections.

Section one provides an overview of the purpose of the document referring to key policy documents that have informed the strategic agenda and the consultation process. Stakeholders consulted have also been mentioned.

Section two provides a situation analysis of the people, political context and socio-economic situation. An overview is also given of the health situation and disease profile with particular reference to priority diseases for intervention. Furthermore, the current health policies, strategies and programmes designed to respond to the health situation are examined in light of the existing health system and challenges.

Section three addresses the current level and magnitude of the overseas development assistance by health partners within the context of ongoing health reforms. Matters of donor coordination are also discussed.

Section four examines the current programme of work at WHO country level and identifies opportunities and challenges for WHO to enable it to build upon its achievements.

Section five addresses WHO corporate approach, strategic directions, functions, priorities and focus for the African Region.

Section six addresses the strategic agenda of which there are four components: strengthening health systems, health management and information or surveillance systems, scaling up priority health interventions and health promotion. The guiding principle for this agenda is increased investment for health.

Section seven provides insight to the implications for all levels of the organization. Country level implications will involve capacity building, institutional strengthening and increased budgetary resources. It emphasizes the importance of WHO acting as a unified organization at county level to ensure proper coordination.

Section eight concludes that given the difficult socioeconomic situations, significant achievements in health development seem to have been made. The major challenges facing the health sector are high levels of communicable diseases and increasing levels of noncommunicable diseases, severely underfunded health sector, lack of adequate human resources and weak health systems. The proposed WHO Country Cooperation Strategy, if properly implemented, will help address the situation. Crucial to this will be the need to strengthen the WHO Country Office.

1. Introduction

1.1 Purpose of document

The purpose of this WHO Country Cooperation Strategy (CCS) is to improve the quality and effectiveness of the work of WHO in Ghana, supporting government efforts to achieve national health goals. It sets out the strategic directions and medium-term agenda of work in Ghana for the entire WHO secretariat and the Organization's three levels (Headquarters, Regional and Country offices) for the next 4 years. Through the CCS, WHO aims to be more responsive to country needs by being more selective and focused on national health priorities within the framework of WHO priority areas. The Organization aims to provide an optimum balance between the needs and expectations of the country on one hand, and the comparative advantage of WHO on the other, fully taking into account the activities of other development partners.

In setting out the medium-term strategic agenda, the CCS has been guided by the Ghana Second Health Sector Five-Year Programme of Work (2002–2006); the Ghana Poverty Reduction Strategy (GPRS); the WHO Corporate Strategy, outlining global priorities for the period 2002–2005; the WHO African Region Strategic Framework 2002–2005, defining priorities for the Regional Office for Africa for the same period; the report of the Commission on Macroeconomics and Health; the United Nations Development Assistance Framework (UNDAF II 2001–2005); the Common Country Assessment report (CCA 1999). In addition, the CCS has been developed in the light of attaining the long-term results of the Millennium Development Goals (MDGs).

WHO will work to maximize synergies and achieve optimum complementarities with all stakeholders and development partners, in line with the strategies developed in this document. The wide consultation with stakeholders in health in Ghana reflects the direction of the health sector and will hopefully be embraced by all. This will facilitate the implementation of the concepts expounded in this Country Cooperation Strategy.

1.2 The consultation process

The process of developing this CCS document involved extensive consultations with government (ministries, departments and agencies), development partners and NGOs. The CCS Team was made up of senior policy-makers from the MOH and staff members from the three levels of WHO (WHO Country Office, WHO-AFRO and WHO-HQ). The ministers of health, education, local government, finance, economic planning, regional cooperation and women and children's affairs as well as members of the Council of State were among the policy-makers consulted. The team also held extensive consultations with senior officials of the Ministry of Health and Ghana Health Service, the Director-General of the Ghana AIDS Commission, the leadership of the Coalition of NGOs in Health and the Christian Health Association of Ghana (CHAG), heads of training institutions (Provost of the College of Health Sciences, Principal of the School of Public Health, Rector of the Postgraduate College of Surgeons and Physicians and Registrar of the Nurses and Midwives Council), heads of UN agencies, World Bank and other development partners (DFID, DANIDA, JICA, USAID, European Union, Netherlands Embassy). After these consultations, a stakeholders meeting was organized to present the findings and obtain suggestions to a proposed strategic agenda that emanated from the consultations. The consultative process took about ten weeks.

2. Government and People: Health and Development Challenges

2.1 Background

2.1.1 Geography and people

Ghana is a tropical country situated on the west coast of Africa between latitudes 4 and 11 degrees north, and bounded by Côte d'Ivoire on the west, Burkina Faso on the north and Togo on the east. The population of Ghana, according to the 2000 population census,[1] is 18.4 million, out of which 50.2% are female and 49.8% are male. The population growth is 2.6% (2000 census) and the total fertility rate 5.5 (GDHS, 1998). Life expectancy at birth is 57 years, and 46% of the population is below the age of 15. About 60% of the population live in the rural areas. The average population density is 77 per sq km, a ranging from 897 in Greater Accra Region to 31 in Northern Region. The principal religions are Christianity, Islam and African traditional religion.

2.1.2 Political context

There is a democratically elected government in place with a president, a cabinet, a parliament and an independent judiciary. The country is divided into ten regions and 110 decentralized districts. The districts are administered by assemblies. The scope of decentralization and the mandate of the district assemblies are yet to be realized.

Figure 1: Map of Ghana showing the ten administrative regions

[1]Population and Housing Census. Ghana Statistical Services, 2000.

2.1.3 Socioeconomic situation

The country has a mixed economy, consisting of a dominant agricultural sector (small-scale peasant farming) which absorbs about 60% of the total adult labour force, a relatively small capital intensive modern sector dominated by mining and a few other industrial activities, and a rapidly expanding informal sector dominated by petty traders, small artisans, technicians and small businessmen. The national per capita income is about US$ 400. The inflation level is about 18%, annual growth rate 4% (2001 Budget Statement and Economic Policy, February 2002) and population growth rate around 3%. The national literacy rate is 47.9 with an urban/rural distribution of 63% and 39%; the female literacy rate is 36.4% with urban/rural distribution as 51.7/28.4 (Core Welfare Indicator Questionnaire Survey, 1997).

A decline in economic performance due to internal and external factors has negatively affected the performance of all sectors, including health, with limited resources. The population living below the poverty line has fallen from about 54 % in 1991–1992 to just fewer than 40% in 1998–1999 (Ghana Statistical Services, 2000).[2] Inter-regional inequalities still persist; for example, the incidence of poverty fell most sharply in Accra and the forest localities, whereas it barely declined in savannah areas.

Table 1: Geographical distribution of incidence of poverty

	Year	
Region	**1992**	**1999**
Upper East	66.9	88.2
Upper West	88.4	83.9
Northern	63.4	69.2
Brong Ahafo	65.0	35.8
Ashanti	41.2	27.7
Volta	37.7	57.0
Eastern	48.0	43.7
Greater Accra	25.8	65.2
Central	44.3	48.4
Western	59.6	27.3
Total	54.03	39.5

Source: Ghana Poverty Reduction Strategy 2002–2004.

[2]These figures refer to a poverty line of 900,000 cedis per adult per year at 1998/99 prices. The report also estimates a lower poverty line of 700,000 cedis, below which people are in extreme poverty.

2.2 The status of health

Current health indicators are shown in Table 2. The U5MR declined by 27% from 154 per 1,000 to 108 per 1,000 live births between 1986 and 1997; IMR declined from 77 per 1,000 live births to 57 per 1,000 live births in the same period. There are very large inequalities across geographical areas and socioeconomic groups; for example, the U5MR ranges from 62 per 1,000 live births in Greater Accra Region to 171 per 1,000 live births in Northern Region. In addition, 26% of children under-five are stunted, and one in every four children is underweight.[3] The maternal mortality ratio for Ghana has been computed at different times by various methods. The national estimates vary from 214 to 740 per 100,000 births.[4]

The EPI coverage in children (zero to 11 months) for 2001 is as follows: BCG 91.0%, DPT3 76.0% and measles 81.0%.[5] However, there are significant disparities in coverage by region and locality. In nine out of 110 districts, DPT3 coverage is lower than 50%.

Antenatal coverage was at 89% in 1998. Overall utilization is higher in the urban than rural areas (seven percentage points higher). There are also regional variations in ANC with the highest coverage of 96.1% in Ashanti Region, and the lowest coverage of 69.1% in Upper West Region. The average number of antenatal visits made by pregnant women is 2.8, and 44.3% of deliveries are supervised by trained medical personnel.[6]

Table 2: Health indicators

Infant Mortality (per 1,000 live births)	57
Under 5 Mortality (per 1,000 live births)	108
Maternal Mortality (100,000 live births)	214
Stunting in children under 5 (%)	26
Children under five malnourished (underweight) (%)	25
Crude Birth Rate (per 1,000)	39
Crude Death Rate (per 1,000)	12
Life expectancy: males females	54–56 years 56–59 years

Source: Ghana Demographic and Health Survey, 1998; The Health of the Nation, 2001.

[3]Ghana Statistical Services and Macro Systems Inc., Columbia, Maryland, 1989; Ghana Demographic and Health Survey, 1988.
[4]The Health of the Nation. MOH, 2001.
[5]National EPI Report, 2001.
[6]Ghana Demographic and Health Survey, 1998.

2.3 Disease profile

The epidemiological situation of Ghana is similar to other sub-Saharan countries, i.e. a predominance of communicable disease conditions, undernutrition and poor reproductive health with emerging importance of noncommunicable diseases such as neoplasm, diabetes and cardiovascular diseases.

The major causes of morbidity are listed in Table 5. The major causes of mortality are anaemia, respiratory tract infections, hypertensive diseases, malaria, diarrhoea, gynaecological conditions, accidents and injuries, cardiac conditions, tuberculosis and meningitis.

Table 3: Top 15 reported diseases, 1995 to 2000 (percentage distribution)

	Disease	1995	1996	1997	1998	1999	2000
1	Malaria	40.07	40.35	42.17	41.42	41.89	43.93
2	Upper respiratory tract infection	8.34	8.28	7.93	7.93	8.00	8.06
3	Diarrhoeal diseases	4.67	4.67	4.41	4.59	4.94	5.35
4	Diseases of skin, incl. ulcers	6.42	6.59	5.06	5.01	4.65	4.26
5	Accidents, incl. burns and fractures	4.10	4.41	3.92	3.70	3.81	3.46
6	Pregnancy and Complications	2.83	2.64	3.00	3.12	3.58	2.87
7	Acute eye infection	1.85	2.02	1.83	2.34	2.44	2.71
8	Intestinal worms	3.49	2.54	2.33	2.51	2.36	2.35
9	Hypertension	1.72	1.68	1.66	2.03	2.22	2.01
10	Gynaecological disorders	1.82	2.08	1.95	1.92	2.16	1.61
11	Anaemia	1.29	1.36	1.48	1.65	1.81	1.94
12	Rheumatism and joint pains	1.55	1.58	1.53	1.48	1.75	1.74
13	Diseases of oral cavity	1.03	0.95	1.06	1.14	1.48%	1.35
14	Ear infection	0.91	0.92	0.99	0.97	1.18	1.15
15	Pneumonia	0.73	0.78	0.94	1.13	1.06	1.26

Source: GHS Centre for Health Information Management, Report of Health and Disease Analysis Taskforce, 2001.

2.4 Priority interventions

2.4.1 Malaria

Malaria is the most important cause of morbidity (40% of OPD attendance) and mortality. It also accounts for the majority of childhood admissions and 22% of childhood mortality. A Roll Back Malaria Initiative partnership with a five-year strategic plan exists.

A major focus for the control of malaria is the promotion of the use of insecticide treated nets which currently stands at 9.1% for children under-five and 7.8% for pregnant women. The other area of focus is access to prompt and correct treatment within 24 hours of illness. Only 11.7% of children under-five have access to this.[7] These two areas of focus together with other interventions are aimed at reducing the current case fatality rate (CFR) of 13.2% for all ages.[7] A tax waiver on imported bed nets is in place;

[7]Malaria Baseline Survey. MOH, 2001.

however, the tax on insecticides is yet to be waived. A campaign has begun to improve malaria case management in the homes to ensure that all children under-five receive appropriate doses of antimalarial drugs within 24 hours of a fever.

2.4.2 Water, diarrhoeal diseases and sanitation

Access to safe water is estimated at 56% with an urban/rural distribution of 76%/46%, respectively. Access to safe waste disposal is 55% with urban/rural distribution of 62% and 44%, respectively.[8] As a result, diarrhoeal diseases are still a major cause of mortality, contributing to the high U5MRs in the country. Diarrhoea accounts for approximately 4.5% of all cases seen in outpatient departments. Of all children under-five, 18% were found to have diarrhoea in the two weeks preceding the Ghana Demographic and Health Survey carried out in 1998; 69% of these children received ORT or increased fluids during their episode of diarrhoea.

2.4.3 Epidemic-prone diseases

As a result of poor access to safe water and sanitation coverage, cholera has re-emerged as an endemic disease in the country. There were two major epidemics in 1991 and 1999 with case fatality ranging from 2.2 to 3.4%. The seasonal flooding in certain parts of the country increases the risk of cholera outbreaks.

Yellow fever has been known to be endemic in Ghana ever since the history of the disease. The recent three outbreaks were all in northern Ghana: Northern Region in 1983, Upper West Region in 1993/94 and in Upper East Region in 1996/97.

The three northern regions and part of Brong Ahafo Region lie within the meningitis belt of Africa. There were major epidemics in all the three regions in the belt (Northern, Upper East and Upper West) 1983/84 and 1996/97 with several focal outbreaks in between. In the 2001/2002 season, there were outbreaks in several districts in the northern part of the country. The overall case fatality rate was much higher than the upper limit of the expected 10%. The range was 7% to 25.6%.

2.4.4 Tuberculosis

Tuberculosis is a major public health problem. DOTS is operational in all regions; however, not all districts are implementing DOTS. The Country Programme is not performing well. The case detection rate is 27%, and the cure rate 55%, although the expected case detection rate is 55% and the expected cure rate is 85%. There are difficulties with quality and supervision of DOTs. A review of the programme took place in August 2002 and a five-year strategic plan is being developed. Application for funding from the Global Fund for AIDS, Tuberculosis and Malaria (GFATM) for DOTS implementation and urban tuberculosis control has been approved.

2.4.5 HIV/AIDS/sexually transmitted infections

The national HIV prevalence rate is 3.6%.[9] Rates of 17% and 3.4% have been recorded among patients with sexually transmitted diseases and blood donors, respectively. Commercial sex workers in

[8]Common Country Assessment. Ghana, 1999.
[9]National AIDS Control Programme, 2001.

Accra and Kumasi were found to have rates of 75.8% and 82%, respectively.[10] There is presently no estimate of vertical transmission of HIV from mother to child. However, there is some work underway to obtain these estimates. A cumulative total of 43,589 cases was reported from 1986 to 2000; about 89% were aged 15–49 years, and 62.1% were women.

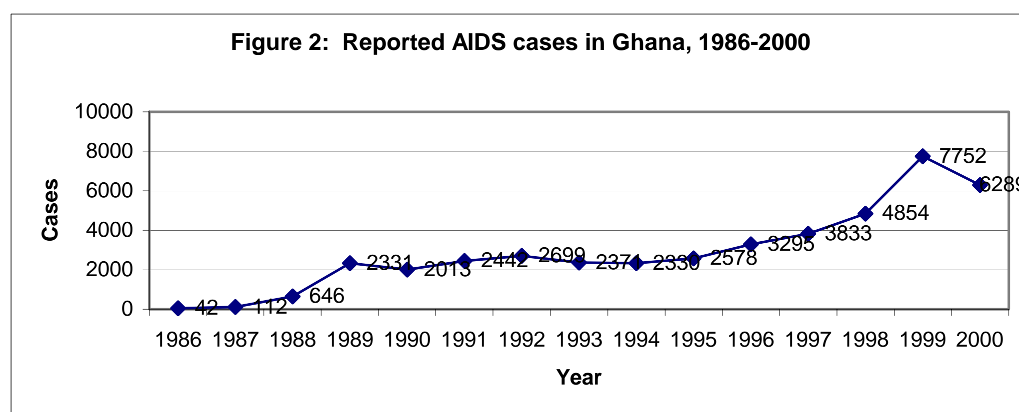

Figure 2: Reported AIDS cases in Ghana, 1986-2000

Source: National AIDS Control Programme, MOH, 2001.

The Ghana AIDS Commission was formed in 2001 to coordinate the implementation of a multisectoral response. Community response to HIV/AIDS has been initiated through the District Response Initiative now being implemented in 41 out of 110 districts. However, there are difficulties with resources to fund district action plans.

HIV sentinel surveillance was started in 1991 and there are presently 26 sites. A first round of the Behaviour Surveillance Survey (BSS) has been completed. The groups surveyed were female sex workers, miners, youth and police. A plan for local production of antiretroviral drugs (ARVs) has started.

2.4.6 Guinea-worm disease

Guinea-worm disease is a serious public health problem in Ghana. The peak season coincides with peak farming, resulting in significant suffering and reductions in food production to the poor. The majority of guinea-worm disease cases come from 15 districts within three regions (Northern, Brong Ahafo and Volta) and account for 95% of all cases seen. Significant achievements were made in the reduction of guinea-worm disease burden between 1990 and 1996; however, case-load since 1996 has stagnated.

2.4.7 Noncommunicable diseases

With changing lifestyles, noncommunicable diseases such as hypertension, diabetes, chronic renal diseases, cancer and mental diseases are on the increase. There is a rise in tobacco use, alcohol and other substance abuse. Diabetes accounted for 6.4% of all medical admissions at the Korle-Bu Teaching Hospital in 1986–1987, compared with 3.5% a decade earlier.[4] Reported cases of hypertension increased by 67% from 1989 to 1998, whereas OPD attendance increased by 39% in the same period. Limited data from drug related admissions in three psychiatric hospitals indicate that approximately 50% of admissions

[10]HIV/AIDS Strategic Plan 2001–2005. MOH, 2001.

are young people aged 21–30 years. Road traffic accidents are increasing and are responsible for approximately 1,300 deaths and 10,000 injuries annually.[4]

2.4.8 Safe motherhood

Three major delays account for high MMRS: delay in taking a decision to access health services, delay in arrival at the health facility and delay in receipt of quality care within the facility. Insufficient access to referral services, inadequately staffed and equipped referral centres, and inability to pay for referral services are some of the factors that need to be addressed to reduce maternal mortality. Safe motherhood is a priority for the health sector, particularly in the three northern regions, so as to reduce the unacceptably high rates of maternal mortality.

2.5 Health policies, strategies and programme of work, 2002–2006

The second health sector programme of work, 2002–2006, has been developed. The goal is to contribute to the reduction of health inequalities in Ghana, inequalities between the north and south, urban and rural areas, and those related to gender, education and disability status. The emphasis is on district, sub-district and community-based quality care. The current health sector policy strategies are to:

(a) ensure access to health services;

(b) improve the quality of health delivery;

(c) improve the efficiency of health service delivery;

(d) foster partnerships in improving health;

(e) improve financing of the health sector.

Key policies of the five-year Programme of Work include:

(a) emphasis on community-based care, focusing on posting nurses to communities;

(b) reforming the financing arrangements for the sector, replacing the user-fees with pre-payment and insurance arrangements of various kinds;

(c) focus on development led by the private sector through increased emphasis on the use of non-government and private health providers;

(d) emphasis on priority interventions such as HIV/AIDS, malaria, guinea-worm disease, EPI and TB;

(e) staff motivation and health worker incentives.

In March 2001, the government adopted the Highly-Indebted Poor Country (HIPC) Initiative. A key component of the HIPC Initiative is the Ghana Poverty Reduction Strategy (GPRS). The strategy includes support for human resource development and access to basic services, such as health, HIV/AIDS control, population management, water, sanitation and education. The GPRS outlines interventions for all sectors in the period 2002–2004.[11] The health component of the GPRS is as an integral part of the five-year POW. The strategies are as follows:

(a) bridging equity gaps in the access to quality health services;

(b) ensuring sustainable financing arrangements that protect the poor;

(c) enhancing efficiency in service delivery.

These strategies in addition to those of other sectors such as water and environmental sanitation[12] are expected to result in the achievement of GPRS targets (Table 4). The Millennium Development Goals (MDGs) and New Partnership for African Development (NEPAD) will influence the five-year POW and GPRS.

Table 4: Ghana Poverty Reduction Strategy targets

Year	**1998**	**2004**
Infant mortality rate	57/1,000	50/1,000
Under-five mortality rate:		
National	108/1,000	95/1,000
Northern	171/1,000	130/1,000
Upper East	155/1,000	116/1,000
Upper West	156/1,000	117/1,000
Central	142/1,000	107/1,000
% Children under-five malnourished (underweight)	25%	20%
Maternal mortality rate	214/100,000	160/100,000
Report cases of guinea-worm disease	7,402	0

Source: Ghana Poverty Reduction Strategy, 2002−2004.

2.6 Health system challenges

2.6.1 Organization and Management

As with other ministries, the operationalization of the Ministry of Health is guided by the Civil Service Act. The separation of functions between the Ministry of Health and the main service provision agencies (Ghana Health Service, teaching hospitals) is expounded in Act 525. The private sector, including NGOs, and the traditional system are also very important service providers. In addition, there are the following regulatory bodies: Medical and Dental Council, Food and Drugs Board, Pharmacy Council, and Nurses and Midwives Council. This reorganization is part of the health sector reforms being

[11]Ghana Poverty Reduction Strategy Paper, 2001.

[12]Responsibility for health care lies with the Ministry of Health, while that for safe water is with the Environmental Sanitation Agency, Ghana Water Company Ltd., Ministry of Local Government and Rural Development and district assemblies.

undertaken to improve efficiency in the health system. Other aspects of the reforms being implemented are:

(a) decentralized planning and budgeting systems, strengthening of financial management and performance monitoring system, and investing in overall management development capacity within the sector;

(b) sector-wide approach (SWAP);

(c) strengthening of existing regulatory bodies and existing laws.

The reorganization at the national level of the MOH and the GHS is still at its early stages and will need to quickly readjust according to the lessons learned. The sector is organized along a five-tier system: national, regional, district, sub-district and community.

The Minister of Health is the head of the health sector. The MOH is responsible for policy formulation, planning, and donor co-ordination and resource mobilization. The Ghana Health Service is responsible for service delivery under the management of the Director-General. There is a Ghana Health Service Council which oversees the activities of the GHS. The teaching hospitals are autonomous with governing management boards.

There is a variety of providers (see Table 5) in the public, private and informal sectors. It is estimated that the private providers account for about 40% of the total patient care nationally.[4] There is also a Coalition of Nongovernmental Organizations (NGOs) working in the health sector. There is a need for definition of the linkages between the MOH and the Coalition and how they can be funded and supported. The Christian Health Association of Ghana (CHAG) is an umbrella organization which brings together Christian mission hospitals and clinics. They provide a significant portion of the health services.

Table 5: Health facilities by type and ownership

Type of facility	Government	Mission	Quasi-government	Private	Total
Teaching hospital	2	0	0	0	2
Regional hospital	9	0	0	0	9
District hospital	62	29	0	0	91
Other hospital	10	20	23	71	124
Health centre	488	42	2	25	558
Clinic	374	90	50	571	1085
Maternity home	7	0	0	313	320
Total	952	181	75	980	2189

Source: Health of the Nation, 2001.

2.6.2 *Improving access to priority interventions*

Overall, more than 60% of the population (92% in urban and 45% in rural areas) have access to health services.[13] Access is defined as living within one hour travel time (by any available means) from the health facility. The government estimates showed that half the population does not have access when the travel time is halved.[14]

Recent analysis of the health sector has demonstrated that communities are keen to take care of their own health and want services that are more community friendly and closer to them. However, access to basic health services is below what is expected. This is particularly true for certain mountain and riverine communities where it is difficult to retain staff from the formal sector.

The Community-based Health Planning and Service (CHPS) strategy is one of the initiatives to increase access to service. CHPS is a close-to-client health delivery system. Currently, 72 out of 110 districts are implementing various components of the initiative. A good start has been made, but much remains to be done in terms of recruiting and retaining nurses. The basic prerequisites are housing, schools, safe water and telephones that will attract nurses and other health professionals to these locations.

The per capita outpatient visits in Ghana increased from 0.32 in 1996 to 0.42 in 2000 (Health of the Nation, 2001). However, there is evidence that utilization is falling in recent years due to difficulties with ability to pay for services. Gender issues also affect utilization. The CHPS strategy to improve access must be costed and expanded in a stepwise manner. It should be backed by a strong and well-resourced supervision system.

2.6.3 *Essential drugs and medicines*

From 80 to 85% of the population of Ghana is estimated to be within one hour of a public or private facility where at least 20 essential medicines will be available. However, there are still problems of poor distribution, high cost, poor quality and irrational use of medicines by both health care providers and consumers.

Estimates indicate that between 70 and 80% of the population use traditional medicines which are cheaper than allopathic medicines, especially in the management of malaria. However, there are concerns about regulation with regard to the safety, quality, promotion and rational use of such drugs. The production, quality, promotion and use of traditional medicines need to be regulated to ensure their safety and rational use.

2.6.4 *Financing*

The health sector is currently severely under-financed. It is projected that the current per capita expenditure (including donor inflow) ranges from USD$ 6 to USD$ 9 (1997–2000). Government is the largest contributor to the sector (although there are annual variations). Government expenditure reached only 77% of the expected level between 1997 and 1999. Donor financing for the same period similarly fluctuated, achieving only 67% of the expected total. The projected envelope of resources for the current

[13]UNICEF Annual Report, 1988.
[14]Core Welfare Indicators Questionnaire (CWIQ). GSS, 1997.

POW is US$ 1,112,860,000. Government allocation for the period is estimated at US$ 37,860,000, with donor inputs projected at US$ 400,000,000 and internally generated funds (IGFs) at US$ 75,000,000. A shortfall of US$ 92,300,000 is expected. The financing of the health component of GPRS is expected to cost approximately US$ 200,000,000 per year.

Commercial loans were relied upon to meet the shortfall. However, there is a decline in that direction. IGFs accrue from user fees and contribute far more to the sector than was anticipated. During the period 1997–1999 the contribution was 100% of the target. These funds have constituted 30–40% of non-staff running costs of government facilities and over 50% of the same costs in mission hospitals. User fees are regressive for the poor and have the potential of widening inequalities in access to health service.

The current per capita expenditure of approximately US$ 9 must be increased significantly by 2007 to come close to the recommended 30–45 US$ as recommended by the Commission on Macroeconomics and Health (CMH) in order to provide an essential package of services. This increase must take into account the need for provision of antiretroviral drugs for HIV/AIDS patients. Some of this increase can come from increased donor inflows, HIPC inflows and other sources such as the GFATM, RBM and GAVI. Given the recent experiences of flow of resources through these new initiatives, it is expedient that the MOH at this stage develop coordinated mechanisms to receive, distribute and monitor such funds. The formation of a local commission on macroeconomics and health has begun.

User fees, which are required to be paid up front, are regressive for the poor and contribute to the widening of inequalities. The exemptions policy has some difficulties of timely reimbursements, insufficient funds and the application of a means test. The National Insurance Scheme includes community prepayment schemes. Getting communities to pay for services that will be consumed later will need extensive community sensitization and education. Given the level of poverty in some communities, the government will still have to contribute to community funds to take care of the poor.

The movement of some donors towards budgetary support will present a major challenge as there will be no direct control on the funds available to the health sector (i.e. funding provided for budgetary support will subsidize the national budget and may not be directed to the health sector). Assuring adequate resource allocation and flow to health will be an enormous challenge.

2.6.5 Enhancing private sector participation

Given current levels of service delivery by the private sector and NGOs, the two are well placed to do more. A private health sector policy is in place. However, to maximize this potential, it is necessary to strengthen the capacity of the private sector unit within the MOH so that the requisite instruments are in place to engage, monitor and evaluate the performance of private providers and agreements. There is also a need to put in place incentives and legislation to improve the environment for engaging the private sector. The skills of the private sector unit must therefore be strengthened in the area of public-private sector partnerships.

2.6.6 Human resources

While there has been substantial increase in the production of human resources for health, the attrition is significant as there is unbridled brain drain of all cadres of staff from the sector. Staff are ill motivated and remunerations are low. The distribution of the existing human resources within the country favours urban areas, and the skill mix does not reflect health sector needs. Doctor population

ratio is 1:16,587. This ranges from 1: 4,317 in Greater Accra Region to 1: 64,000 in Northern Region. Greater Accra Region has about 61% of all doctors. The dentist population ratio is 1:639,900. Nurse population ratio is 1:1,230 (this excludes nurses in the two teaching hospitals). A human resources policy detailing projected need and supply is yet to be finalized, as are more rationalized staffing norms.

Another concern is the depletion of teaching staff at all the health training institutions (Table 6). There is heavy reliance on retired teachers. Furthermore, partnerships between training institutions and the public sector are very weak, thereby leading to underutilization of the limited human resources.

Table 6: Distribution of health professionals by region, 1999

Region	Doctors	Dentists	Pharmacists	Medical Assistants	Nurses
HQ	239	1	12	1	*
Korle-Bu	285	3	37	-	*
Komfo Anokye	184	1	22	1	*
Greater Accra	150	9	31	55	3894
Volta	57	-	10	29	1560
Eastern	74	5	18	43	2019
Central	47	2	11	31	1134
Western	69	3	18	40	1056
Ashanti	62	1	21	46	2118
Brong Ahafo	59	1	9	32	1048
Northern	29	1	7	29	942
Upper Eastern	25	1	7	14	706
Upper Western	14	1	4	5	495

Source: The Health of the Nation. MOH, 2001.

*Nurses at this level captured under GAR and Ashanti Region.

A human resource policy is in place and there is an urgent need to finalize the human resources plan. Central to this is an analysis of the supply of various health personnel against demand in both the private and public sectors. Such an analysis will also facilitate redistribution of existing staff in favour of the deprived districts. Another important aspect of the plan will be to develop a staffing norm that will reflect the skills mix for each level of care. This will ensure better rationalization of staff in order to enhance the motivation and retention of staff. As an interim measure, the decentralization and budget management centres should:

(a) allow regions and districts to have a greater say in the management, hiring and firing of staff for their particular jurisdiction;

(b) subvent personnel emolument costs to regions and hospitals so that they can use whatever savings that accrue from unfilled posts and efficiencies to pay various categories of allowances to retain staff according to the degree of hardships in the duty station;

(c) ensure that staff quarters are properly maintained and provided with basic furniture.

These measures will require enhanced capacity at the regional and district level for implementation. The training institutions, particularly the universities, are under the jurisdiction of the Ministry of Education. There is a need for frequent dialogue between the training institutions and the Ministry of Health. This dialogue, will ensure the following:

(a) greater use of the limited resources that exist in both institutions;

(b) curriculum modification to take into account new developments in service delivery;

(c) support from training institutions for MOH in-service training;

(d) involvement of training institutions in the formulation and development of health policies.

2.6.7 Capacity for scaling up priority interventions

Although an essential package of priority interventions has been defined, there are difficulties with capacity for scaling up. Some DHMTs do not have the required complement of staff, and some staff at district and sub-district levels require planning and management skills.

Resources for service delivery and supervision are found to be wanting. An essential package of interventions has been identified, but there must be a concerted effort to ensure that resources are allocated to address priority areas. Similarly, capacity must be built to enable staff to use and manage resources in an expeditious manner. Strategic officers may have to be placed at the regional level to closely follow up the implementation, supervision and use of resources for priority programmes. Scaling up will also require a strengthened health system to ensure the availability and distribution of drugs and equipment backed by a robust health management and information system.

2.6.8 Monitoring health systems performance

Significant achievements have been made in the decentralization process and monitoring the reform process. However, it is important for the central level to monitor the performance of the regional and district levels to ensure that district activities conform to national priorities, particularly with regard to the priority interventions.

Enhancing the functionality of the DHMT by improving the work environment and providing necessary operating manuals is crucial to the achievement of goals and objectives. The gradual replacement of the user-fee scheme with a prepayment scheme also needs to be monitored to ensure that the poor do not suffer.

Reorganization at the central level is at an early stage. However, it is important to ensure the following:

(a) forum for dialogue and information sharing between the MOH and its implementing agencies;

(b) clear job descriptions of the various functionaries in the MOH and GHS;

(c) guidelines describing the process of separation, linkages and the methods of operation for collaboration.

Monitoring the impact of health interventions against the GPRS indicators involves: generating evidence to document the gains in a disaggregated manner. This will be particularly crucial for the poor. Monitoring the NEPAD health component and MDGs requires evidence of gains and inequalities, documenting constraints and best practices. Regarding the impact of public policy on health status, some public policies may have a negative impact on public health gains. These should be quickly identified and the necessary evidence provided to policymakers for review or removal. An active surveillance system should monitor changes in the patterns of both communicable and noncommunicable diseases. As partners move towards budget support, it will be necessary to monitor resource flows to the health sector in terms of volume and timeliness. This must be done for HIPC inflows also.

2.6.9 Working with partners for intersectoral action

Some key determinants of health are outside the purview of the health sector. These include poverty, educational status (particularly of women and girls), access to water and sanitation, development of access roads, prevention of road traffic accidents, high population growth and community development. Building partnerships is crucial for improving health status and reducing poverty.

There is also increasing awareness about the benefits of recreation and physical activity to health as well as the need for healthier lifestyles. Schools should allocate adequate time for exercise and sporting activities. There is also a vibrant press and electronic media capable of disseminating health messages. The Ministry of Health should provide leadership in developing a comprehensive health promotion and protection strategy that will incorporate all these stakeholders. A lot of advocacy will be required.

3. Development Assistance

Health services are financed through private and public means. Public funding comes from government consolidated funds, credit and donors as well as user charges (IGFs). From Ghana Vision 2020, the MOH developed a medium-term health strategy (MTHS) document and the first five-year POW that provided guidance and orientation for developments in health. A second health sector five-year POW 2002–2006 has been developed with a health component for the GPRS.

Donor funding to the health sector has improved substantially from 25% of total public health budget in 1992 to 28% in 1997 and 31% in 1999. However, this still falls far below the government's expectation of 40% per annum as stated in the MTHS. It is worthy to note that IGF has increased far above projections in the MTHS at 13% in 1997, 15% in 1999 and 22% in 2001.

External aid is channelled through direct budget support, contribution to the health fund or earmarked funding. Government encourages partners to contribute to the health fund and expects that by 2006, 90% of donor funds will be channelled through the health fund.

Disbursement of funds from the health account is guided by the Accounting, Treasury and Financial (ATF) rules and regulations as laid down in the Common Management Arrangement (CMA II) and Memorandum of Understanding by all partners.

Tracking of earmarked funds (WHO inclusive) so that they can be captured in the National Health Account is a challenge. As partners contribute to budget support or the Common Fund, there is a loss of individual partner identity. This presents an opportunity for WHO to provide support in critical

areas such as setting standards, monitoring and evaluation. The following development partners contribute to the health fund: The Netherlands, DFID, UNICEF, World Bank, EU and DANIDA.

3.1 Partners in health development

There are about 17 major donors operating in the health sector. These include multilateral, bilateral and nongovernmental organizations (NGOs). The multilateral organizations include UNICEF, UNFPA, UNAIDS, WHO, WFP, UNDP, ADB and World Bank. The bilaterals are EU, DANIDA, JICA, DFID, GTZ, CIDA, Nordic Development Fund, France, USAID and the Netherlands. More than 400 NGOs are active in the health sector. They are coordinated through an umbrella organization, Coalition of NGOs. The donor community and the government have recognized the tremendous contribution by NGOs and are therefore working in partnerships with them.

Apart from direct support by individual UN agencies through the United Nations Development Assistance Framework (UNDAF), the UN Country Team provides support to the health sector through joint programming. UNDP considers UNDAF an excellent opportunity for WHO to support government in health policy formulation, standard setting and monitoring of health indicators for the MDGs. UNICEF contributions have generally been in the areas of EPI-plus, HIV/AIDS, girl child education, early child development and child protection. A major concern for UNICEF is PMTCT, the prices of ITNs and essential drugs in the private sector. UNICEF expects WHO to advocate for increased capacity for HIV/AIDS counselling in the country as well as support the MOH to regulate prices of essential drugs in the private sector. It also requests WHO to influence the implementation of a population policy. The UNICEF regular country budget amounts to US$ 3.7 million while the extra-budgetary resources are $11 million per annum. UNFPA continues to focus on reproductive health, gender issues and population services. UNFPA is committing US$ 20.8 million to the country programme for the next five years. FAO supports food production with the aim of addressing the problem of national and household food security and accessibility. FAO would like to cooperate with WHO on the issue of HIV/AIDS, interventions for malnutrition and onchocerciasis. UNESCO has taken a leading role in involving schools and teachers in HIV/AIDS control. Working with WHO will be crucial in this area, particularly in adolescent health. Working with UNAIDS to support the Ghana AIDS Commission (GAC) will be essential for a multisectoral response to HIV/AIDS.

The World Bank is actively supporting the Ghana AIDS Response Project (GARFUND) with a US$ 25 million loan over a four-year period. The World Bank has demonstrated its commitment to water and sanitation with its intention to provide US$ 100 million to the urban water restructuring project. Through the World Bank mechanism, the country has qualified for some debt relief through the HIPC initiative. It is believed that about 15% of this will go to the health sector. The World Bank expects WHO to take a leading role in the eradication of guinea-worm disease and the fight against malaria and HIV/AIDS.

The EU contribution to the health sector is Euro 11 million, 38% as direct contribution to the health account, 47% to procurement and 14% to technical assistance, in particular the Centre for Health Information Management (CHIM). The EU supports the STI and HIV/AIDS control programme with Euro 1.897 million (1997–2002).

JICA is involved in the Polio Eradication Initiative and guinea-worm disease eradication in addition to providing equipment and capacity building. Support is also provided to the Noguchi Memorial Institute for the control of parasitic diseases, yellow fever and other diseases.

DANIDA health project support for the period 1998–2002 is a total of DKK 225 million (8.5 DKK = US$ 1) out of which approximately 67% goes to the health fund.[1515] DANIDA assistance supports the development of health systems including strengthening the procurement system and capital investments, the implementation of prepayment schemes and improvement of exemption policy. Furthermore, they support strengthening of financial management, planning, budgeting and collaboration with the private sector.

Overall DFID support during the period 1997–2001 was approximately 30 million pounds, of which 62% went to the health fund. The rest is earmarked for specific key areas such as capacity building in management of the health system and HIV/AIDS surveillance.

The Netherlands contribution to health has been on the increase from Euro 1.8 million in 1999, Euro 4.2 million in 2000, Euro 6.4 million in 2001 and an estimated Euro 19.4 million in 2002. In addition, the Netherlands supports the District Response Initiative for HIV/AIDS.

USAID supports the health sector in three areas: reproductive health, HIV/AIDS and child survival. The total support amounts to US$ 18 million.

The African Development Bank (ADB) is concluding discussions to support a third cycle of assistance to the sector. This will include infrastructure development, supply of equipment, capacity building to address HIV/AIDS, safe motherhood, common endemic diseases and strengthening blood transfusion services. The total support is UA 29.37 million, UA 22.12 million being the foreign component and UA 7.26 million being the local component. WHO is expected to provide technical assistance for the HIV/AIDS and blood transfusion components of the project.

Consultations with partners have had positive results. Partner expectations are that WHO should:

(a) play a leading role in the coordination of partners in health matters;

(b) guide the development of indicators for monitoring the implementation of the GPRS, five-year POW, MDGs and health component of NEPAD;

(c) assist other partners in monitoring their programmes and provide credible evidence;

(d) provide technical guidelines on various issues.

3.2 Donor coordination

SWAPs has been a key instrument for donor coordination. Through this mechanism, guidelines and approaches have been developed for partners. The CMA allows for a common management, planning and budgeting cycle which conforms to a uniform national medium-term expenditure framework (MTEF). In addition, two annual joint summits are held between MOH and partners. Monthly partners and MOH meetings offer opportunities for coordination and dialogue. With the UNDAF, the UNCT thematic groups provide an additional avenue for coordination through joint programming with initiatives to harmonize the programming cycles of resident agencies to the UNDAF cycle. A good example of joint programming under UNDAF II is where WHO provides technical leadership for coordination of joint

[15]DANIDA Health Sector Programme Support, Phase III. Ghana, August 2002.

proposals for guinea-worm disease eradication and Buruli ulcer control for funding by the UN/Japan Human Security Fund and United Nations Fund for International Partnership (UNFIP), respectively.

The UNCT meets monthly, providing members an opportunity to discuss and share information on health matters. Further coordination brings together donors, government sectors, other partners and NGOs. These are the Interagency Coordinating Committee for Guinea-worm Eradication Programme, the EPI and RBM Partnership committees. There is also the Country Cooperating Mechanism (CCM) for the Global Fund for AIDS, Tuberculosis and Malaria (GFATM).

4. WHO Current Country Programme

Following its independence, Ghana established formal links with WHO. In addition to direct technical support from WHO, Ghana through its institutions and established agreements with WHO has been able to provide technical support and information to other member states in the sub region, particularly in the areas of traditional medicine and laboratory support for polio eradication. A field office has been opened in Tamale to provide adequate support to the northern sector of the country.

4.1 Country office operations

There was a major expansion in WHO Ghana Country Office (WCO) in the 2000–2001 biennium; the number of technical staff increased from six to eleven, giving a total staff strength of 27. There has been significant increase in financial mobilization during this current biennium (2002–2003) compared to the 2000–2001 biennium. For 2000–2001, the total budget (regular and extra-budgetary) was US$ 5,928,256 as against an estimated US$ 12,046,635 in the 2002–2003 POA (see Table 7). Most of this increase is due to extra-budgetary resources for these initiatives: Roll Back Malaria, Polio Eradication, Supplemental Immunization for Measles Accelerated Control and HIV/AIDS/STI Surveillance. There has also been mobilization of resources from partners at the local level, e.g. US$ 750,000 for HIV/AIDS. The current country programme comprises 19 Areas of Work (AOW) which reflect the priorities of the five-year POW, MOH and WHO Regional Office for Africa.

4.1.1 Research policy and promotion

Emphasis is being placed on building capacity for research through training and networking, and also developing strategies and mechanisms for getting research into the policy agenda. The health economist and the WR are responsible for this AOW.

4.1.2 Resource mobilization, external cooperation and partnership

Collaboration is with MOH, UN, bilateral agencies, NGOs and CSOs to ensure adequate resource mobilization and allocation for the implementation of activities in the POW and the GPRS. The WR and the health economist are responsible.

4.1.3 Human resource development

A programme to upgrade the managerial and technical skills of programme officers has been developed and is being implemented.

4.1.4 Organization of health services

Support is to various aspects for human resource development of MOH. Financial support is provided for the participation in external meetings, the establishment of prepayment schemes and to the setting up of parameters for measuring health system performance. Universities and schools of medicine have also been supported. The health economist is responsible.

4.1.5 Child and adolescent health

Support includes the expansion of the IMCI strategy, capacity building and institutional strengthening of adolescent health programmes. Linkages between IMCI, RBM, VPD and the strategy for Integrated Disease Surveillance and Response (IDSR) are being facilitated. Support is also being provided to develop a school health policy. There was a mission to assess IMCI implementation in 2001. A review and planning meeting for IMCI and RBM took place in May 2002 and was supported by WHO/AFRO and WHO/HQ.

Ghana is one of the countries in the Multicentre Growth Reference study (coordinated by WHO-Headquarters) to establish a new international Growth Reference Curve that reflects growth patterns of healthy breastfed infants and children. WHO/HQ also provided technical assistance to carry out a study to field-test the WHO Manual on Referral Care. The NPO for IMCI is responsible for this AOW.

4.1.6 Making Pregnancy Safer

Current assistance is to build capacity at the district level for managing obstetric emergencies and complications, and to improve awareness at the community level to promote prompt referral of obstetric emergencies. The NPO for FHP is responsible.

4.1.7 Surveillance, prevention and management of noncommunicable diseases

Support includes strengthening capacity for the implementation of programmes for the prevention and control of noncommunicable diseases. Support is being provided for the implementation of the WHO STEPwise approach to surveillance and noncommunicable diseases. MOH is to adopt the regional strategy for the control and prevention of NCDs. The NPO for FHP is responsible for this AOW.

4.1.8 Emergency preparedness and response

Support is directed to produce a health policy and strategic plan on disaster prevention and management, and capacity building for surveillance and rapid response to disasters, at national and district levels. Support was channelled through the National Disaster Management Organization (NADMO) for flood victims. The DPC is responsible.

4.1.9 Communicable disease prevention, eradication and control

Capacity building and institutional strengthening of the MOH to plan, implement and evaluate communicable disease prevention, eradication and control are supported. The WHO in partnerships with the private sector provides drugs for leprosy and lymphatic filariasis control programmes. HQ provides financial and technical support for Buruli ulcer control. There were missions to support the lymphatic filariasis and Buruli ulcer programmes. The DPC is responsible for this AOW.

Support is provided for the implementation of the EPI, particularly polio National Immunization Days (NIDs) and accelerated control of measles and maternal and neonatal tetanus (MNT). Routine immunization is being supported by GAVI. Two additional vaccines against hepatitis B and *Haemophilus influenza* have been added to the routine programme. There is one international staff as well as an NPO for EPI. There were several missions to support the immunization programme.

4.1.10 Communicable disease surveillance and response

Support includes capacity building and institutional strengthening for early detection and effective containment of epidemics and the implementation of the WHO Regional Strategy for IDSR. There is also support for yellow fever surveillance, prevention and control through the child vaccination programme (CVP). WHO supports VPD surveillance and response with assistance from international STOP Teams recruited by WHO/CDC. Ghana is also supported to implement the Epidemic Prone and Vaccine Preventable Diseases project. An NPO has been recruited for project support. A short-term professional is stationed in Tamale to support VPD surveillance in the three northern regions.

4.1.11 Tuberculosis

Support is towards building capacity of health personnel and strengthening institutions to expand and effectively implement DOTS. The programme has been reviewed with support from WHO/AFRO and WHO/HQ. The DPC is responsible for this AOW.

4.1.12 Blood safety and clinical technology

Support is for building the requisite institutional capacity for organizing and managing an effective, safe and efficient blood transfusion service. The linkage between BCT and HIV/AIDS is also being emphasized. WHO/AFRO undertook a mission to support policy development and capacity building. The DPC is responsible.

4.1.13 Malaria

WHO collaborates with partners to expand RBM at the district level. Emphasis is on case management, promotion and use of ITNs. WHO-HQ supports the monitoring of drug sensitivity of chloroquine at sentinel sites with Noguchi as well as institutions undertaking studies in home management of fevers. A collaborative effort between WHO, DFID and Ghana Red Cross is being developed to promote access and use of ITNs. Missions were undertaken by WHO/AFRO and HQ to support ITN policy development and review the status of chloroquine efficacy. The NPO for RBM is responsible for this AOW.

4.1.14 HIV/AIDS/STIs

Collaboration in HIV/AIDS/STIs is with the National AIDS Control Programme (NACP), the Ghana AIDS Commission (GAC), UNAIDS and other partners for capacity building and institutional strengthening. WHO collaborates with various partners to support the national response. Work with DFID is to strengthen the surveillance system to monitor trends of the HIV/AIDS/STI epidemic. WHO, UNAIDS Programme Accelerated Fund (PAF), the Ministry of Local Government and Rural Development, and the Netherlands Government are working to scale up DRI, whereas WHO, PAF, UNICEF, NMIMR and MOH (Reproductive and Child Health) are instituting and expanding PMTCT and

VCT services. WHO, PAF and the MOH (NACP and BTS) are collaborating in capacity building of health workers on ART and blood safety. The NPO for HIV/AIDS is responsible for this AOW.

4.1.15 Health promotion

Support for health promotion includes the development of appropriate and comprehensive advocacy strategies and training to increase knowledge and awareness on healthier lifestyles. Other areas of collaboration include the Healthy Cities project and the Participatory Hygiene and Sanitation Transformation initiative (PHAST). The NPO for HIP is responsible. In addition, a library assistant has been recruited to support and strengthen health literature and information services.

4.1.16 Mental health and substance abuse

Support to the MOH includes establishment of baseline information on mental health so as to develop an appropriate communication strategy for the promotion of mental health. The programme of Nations for Mental Health is now operational in four districts. A programme to improve awareness and develop a baseline in substance abuse at schools is being supported. The NPO for HIP is responsible.

4.1.17 Tobacco

Support is to build capacity through the National Steering Committee on tobacco to develop the necessary strategies including legislation to address tobacco use. Studies on smoking among school children through the Global Youth Tobacco Survey (GYTS) as well as studies on smoking in public places have been supported. The NPO for HIP is responsible.

4.1.18 Essential drugs and medicines

Support to the MOH is towards improving access to essential medicines, especially for priority diseases such as malaria, HIV/AIDS and tuberculosis, and ensuring their rational use. Currently, WHO is facilitating technology transfer for the local production of ARVs and other medicines for opportunistic infections in the management of AIDS and therefore provides support to assess the status of the country's implementation of Trade Related Aspects of Intellectual Property Rights (TRIPS).

Support to the Food and Drugs Board in the area of capacity building (personnel and other resources) is to contribute to the assurance of quality and safety of medicines. In addition, WHO is funding ongoing research into the clinical efficacy and safety of herbal preparations used in the treatment of malaria and HIV/AIDS. Support is being provided for a baseline survey of the pharmaceutical sector which will inform WHO of areas of priority interventions as well as monitor the impact of interventions in the sector. NPO/EDM is responsible for this area of work.

Table 7: Funding of Priority Areas, 2002–2003 (US$)

AOW		Regular budget	Extra-budgetary	Total	% of total budget
Research Policy and Promotion	RPC	30,000	50,000	80,000	0.7
Resource Mobilization, External Cooperation and Partnership	REC	40,000	75,000	115,000	1.0
Human Resource Development	HRS	30,000	0	30,000	0.2
Organization of Health Services	OSD	280,000	132,000	412,000	3.4
Child and Adolescent Health	CAH	36,000	106,000	142,000	1.2
Making Pregnancy Safer	MPS	60,000	26,000	86,000	0.7
Emergency Preparedness	EHA	45,000	30,000	75,000	0.6
Communicable Disease Prevention, Eradication and Control (including VPDs)	CPC	145,000	4,360,000	4,505,000	37.4
Communicable Disease Surveillance and Response	CSR	35,000	400,000	435,000	3.6
Tuberculosis	TUB	60,000	30,000	90,000	0.7
Blood Safety and Clinical Technology	BCT	40,000	20,000	60,000	0.5
Malaria	MAL	40,000	3,200,100	3,240,100	26.9
HIV/AIDS/STIs	HIV	60,000	1,274,535	1,334,535	11.1
Surveillance, Prevention and Management of Noncommunicable Diseases	NCD	30,000	25,000	55,000	0.5
Health Promotion	HPR	28,000	14,000	42,000	0.3
Mental Health and Substance Abuse	MNH	30,000	10,000	40,000	0.3
Tobacco	TOB	12,000	8,000	20,000	0.2
Essential Drugs and Medicines	EDM	0	281,000	281,000	2.3
Country Office Operation	COO	1,004,000	0	1,004,000	8.3
Total		2,005,000	10,041,635	12,046,635	100.0

4.2 Opportunities and challenges

The CCS provides new opportunities for WHO. The development of the CCS itself has been beneficial in that WHO was able to review and restate its mandate and form a number of new partnerships. Furthermore, the process brought out the major role that WHO can play as an advocate with partners at minimal cost. As partnerships were established, WHO and other stakeholders were able to express their expectations of each other. Notwithstanding this development, it is important that the expectations of partners be properly clarified so that they are not beyond the capacity of WHO. Orientations given on the CMH report at the time of developing the CCS were beneficial in that discussions were initiated on the amendment of the health and health-related components of the PRSP to reflect realities as expressed in the report.

The CMH report were provided new opportunities for WHO to work with partners, emphasizing roles such as monitoring and evaluation, tracking health impact and gains against health investments particularly for the poor. This role is more crucial as partners move towards budget support. The environment is conducive; there is a competent core of NPOs who have knowledge and experience from working at various levels within the health sector at various parts of the country, and who are also amenable to learning new skills. There is need for more certainty about extra-budgetary funds as well as a development fund to respond to urgent country needs and add visibility to WHO. There are competing demands on government time as there are increased projects being implemented. The scope of work is expanding and thus the need for additional resources for support.

5. WHO Corporate Policy Framework: Global and Regional Directions

WHO has been - and is still - undergoing changes in the way it operates, with the ultimate aim of performing better in supporting its Member States to address key health and development challenges. This organizational change process has, as its broad frame, the WHO Corporate Strategy.[16]

5.1 Goal and mission

The mission of WHO remains "the attainment by all peoples of the highest possible level of health" (Article 1 of WHO Constitution). The Corporate Strategy and the Policy Framework for Technical Cooperation with Member Countries of the African Region outline key features through which WHO intends to make the greatest possible contribution to health in the world, and indeed in the African Region. The Organization aims at strengthening its technical, intellectual and policy leadership in health matters, as well as its management capacity to address the needs of Member States.

5.2 New emphases[16]

The WHO Corporate Strategy emphasizes the following WHO responses to the changing global environment:

(a) adopting a broader approach to health within the context of human development, humanitarian action and human rights, focusing particularly on the links between health and poverty reduction;

(b) playing a greater role in establishing wider national and international consensus on health policy, strategies and standards by managing the generation and application of research, knowledge and expertise;

(c) triggering more effective action to improve health and to reduce inequities in health outcomes by carefully negotiating partnerships and catalysing action on the part of others;

(d) creating an organizational culture that encourages strategic thinking, global influence, prompt action, creative networking and innovation.

[16] WHO EB105/3. A Corporate Strategy for the WHO Secretariat.

5.3 Strategic directions[16]

On the basis of these new emphases, WHO has set out four strategic directions for its contribution to building healthy populations and combating ill-health. These strategic directions, which are interrelated, provide a broad framework for the technical work of the Secretariat:

(a) reducing excess mortality, morbidity and disability, especially in poor and marginalized populations;

(b) promoting healthy lifestyles and reducing risk factors to populations;

(c) developing health systems that equitably improve health outcomes, respond to peoples' legitimate demands, and are financially fair;

(d) developing an enabling policy and institutional environment in the health sector, and promoting an effective health dimension to social, economic, environmental and development policy.

5.4 Core functions[16]

The typology of WHO core functions, presented below, is based on the comparative advantage of the Organization at all its levels:

(a) articulating consistent, ethical and evidence-based policy and advocacy positions;

(b) managing information, assessing trends and comparing performance of health systems; setting the agenda for and stimulating research and development;

(c) catalysing change through technical and policy support in ways that stimulate action and help to build sustainable national capacity in the health sector;

(d) negotiating and sustaining national and global partnerships;

(e) setting, validating, monitoring and pursuing proper implementation of norms and standards;

(f) stimulating the development and testing of new technologies, tools and guidelines for disease control, risk reduction, health-care management and service delivery.

5.5 Global and regional priorities[17]

In order to be more effective and efficient in its interventions, the Organization has selected a limited number of global priorities on which to focus over the four-year period (2002-2005). The global priorities selected on the basis of those criteria are: malaria, HIV/AIDS and TB; noncommunicable diseases (cancer, cardiovascular diseases and diabetes); tobacco; maternal health; food safety; mental health; safe blood; and health systems.

The WHO African Region[18] is facing enormous health challenges in relation to health. The WHO Regional Office for Africa has decided to focus its attention on 12 priorities closely related to the 11 global priorities, but adapted to the regional context. These 12 priorities are: HIV/AIDS; tuberculosis;

[17] WHO: General Programme of Work 2002–2005
[18] The Work of WHO in the African Region, Strategic Framework 2002–2005.

malaria; maternal health; child and adolescent health; strengthening of health systems; blood safety; humanitarian and emergency action; health promotion; noncommunicable diseases control including mental health; and poverty and health.

5.6 Making WHO more effective at country level

The expression of WHO Corporate Strategy at country level will vary from country to country. Taking into consideration country-specific health and development challenges, the involvement of other external partners, WHO's current work in and with the country, and the global and regional policy frameworks, WHO will look at getting the balance right between its key functions at the country level. This means the Organization will act more as an adviser, a broker and a catalyst and will involve itself in routine implementation in case of specific, clearly identified initiatives, with a time-limited perspective. A working typology of WHO functions at country level has been developed based on the broader core functions presented above.

The specific functions at country level are:

(a) supporting routine long-term implementation;

(b) catalysing adoption of technical strategies and innovations; country-specific adaptation of guidelines; and seeding large-scale implementation;

(c) supporting research and development; policy experimentation; development of guidelines; stimulating monitoring of health sector performance; and trends assessment and anticipation;

(d) sharing information; generic policy options and positions; guidelines and standards; case studies of good practice; and advocacy;

(e) providing specific high-level policy and technical advice; serving as broker and arbiter; exercising influence on policy, action and spendings of government and development partners.

6. WHO Strategic Agenda

6.1 Introduction

WHO will work in collaboration with the MOH and all other partners whose work impacts on the health of the people to ensure that the WHO global health mandate and comparative advantage will serve to achieve optimal health status and reduced inequalities in health outcomes for all people living in Ghana. The purpose of the CCS, as highlighted in this document, is to describe the WHO strategic role in contributing to the implementation of the GPRS (2002−2004) and the Ghana MOH five-year Programme of Work 2002−2006 (five-year POW 2002−2006). In doing so, WHO will continue to advocate for health as the centre of development. The GPRS, NEPAD and MDGs will provide orientation for addressing Ghana's health priorities and assessing progress made.

6.2 Guiding principles: Investing in health

Given the current five-year POW and the health component of the GPRS, WHO will work with the MOH, ministries of finance, economic planning and regional co-operation, other MDAs, UN Country Team, bilateral partners and civil society to advocate that health be placed at the centre of development

and promoted as the trigger for economic development as reflected in the report of the Commission on Macroeconomics and Health (CMH). In this light, WHO will lead the advocacy for the mobilization of additional resources to the health sector from the regular budget, external partners and other funding sources, such as the Global Fund for HIV/AIDS, Tuberculosis and Malaria (GFATM). WHO will work with partners to support MOH to establish the necessary mechanisms and capacity to access, utilize and manage these funds.

Furthermore, WHO will work with the MOH and all partners to ensure that within the health resources package, adequate funds are allocated to agreed priorities at all levels. In line with the GPRS, WHO will work with the MOH, ministries of economic planning and regional cooperation, finance and relevant research institutions to generate country specific evidence to demonstrate the economic burden of major diseases.

WHO will work with the MOH and the Ministry of Economic Planning and Regional Cooperation and research institutions to track the resource flows and evaluate the impact of these investments in health on the GPRS outcomes and achievements of the MDGs and NEPAD.

WHO will work with the UN Country Team, MOH, MOF, parliamentarians, research institutions and other MDAs and civil society to monitor and evaluate the impact of public policies on the health status of the population and in particular the health of the poor (e.g. policies on environment, education, taxation, gender). The CMH report will be internalized and used as a working document to revisit the health component of the GPRS.

6.3 Overview of strategic areas

Based on the broad consultative process, WHO has identified four strategic areas to concentrate its cooperation efforts with Ghana during the next four years (2002–2005). This will be done in line with the five-year POW 2002–2006, GPRS, MDGs, WHO mandate and comparative advantage. These areas are discussed below.

6.3.1 Strengthening health systems

A strengthened health system that is responsive to the legitimate needs of the population will ensure that basic quality services are within easy reach of the communities.

The loss of human resources from the health sector is high and almost equal to the number of people being trained. WHO will support the MOH and other relevant MDAs to develop a human resource strategic plan that will address the demand in all categories of health workers, taking into consideration the supply and demand of all stakeholders.

WHO will support the MOH, training institutions and other relevant MDAs in the implementation of the Human Resource Decentralization Policy and develop strategies for human resources development planning and management. This will address issues such as respect and recognition of all health workers, career structures, accountability and responsibility, skills mix, staffing norms and workload analysis, preservice training and continuing professional development, supervision and management, an active management information system and last, but not least, the necessary working conditions and incentives to retain staff and improve motivation. In addition, WHO will support curriculum reviews of the training institutions to meet the emerging challenges within the health sector. WHO will support the MOH and work with the Ministry of Local Government and Rural Development in its efforts to institutionalize and

build the capacity of local management teams at district and subdistrict levels. WHO will work with the MOH and other partners to strengthen the capacity and institutions required for planning, costing and expanding CHPS.

National capacity will be enhanced by special agreements with research, service and teaching institutions which are already or have the capacity to be WHO Collaborating Centres. WHO will develop a roster of national experts as a pool of resources for the country which can also be utilized to advance the WHO Ghana country office programme of work.

WHO will assist the government, training institutions and professional health regulatory bodies to mitigate the negative impact of the brain drain by establishing fair trade agreements (e.g. with governments which actively recruit health professionals). WHO linkages with other agencies such as the International Organization for Migration (IOM) will also support the MOH in harnessing the national capacity in health outside the country for health development.

WHO will assist the MOH and work with the Ministry of Local Government and Rural Development (MLGRD) to monitor the reform process of decentralization and evaluate the impact of such reforms on health status and the goals of the GPRS.

WHO will support the MOH and other stakeholders to develop policies and strategies that will improve the environment and promote private sector participation and public private partnerships for improved access. This will include capacity building, institutional strengthening for developing an accreditation system for the private sector, contractual arrangements formulation and any necessary legislation. Furthermore, opportunities will be explored to regulate and improve their performance.

WHO will work with MOH, MDAs and civil society to develop capacity for assessment of health system performance and in particular the stewardship functions of developing a patient's charter of rights and to ensure an equitable distribution of resources at all levels.

WHO will work with the MOH and Ministry of Finance to establish the National Health Accounts. n addition, WHO will work with the government to ensure fairness and financial risk protection by developing prepayment methods, including health insurance schemes and other financing mechanisms that protect the poor.

WHO will work with MOH and other partners to improve the country's access to good quality, efficacious and safe essential medicines, especially for priority diseases such as malaria, HIV/AIDS and tuberculosis. WHO will work with MOH, the Centre for Scientific Research into Plant Medicine (CSRPM) and other partners to develop policies and strategies for the safe and efficacious use of traditional medicines, with the ultimate goal of promoting their integration into the mainstream health care delivery system.

WHO will strive to strengthen the capacity of the MOH to provide appropriate health response to emergencies and disasters. In addition, by using its comparative advantage as an international agency with a global health mandate, WHO will engage all partners in dialogue about the WHO regional and global strategies on health. WHO will work with other sectors and agencies whose activities impact on health by advocating for the mainstreaming of health into their activities. These include the water and sanitation, education, roads and transport, agriculture and population sectors which need to understand that the majority of their investments have a lasting indirect impact on health and hence adequate investments should be made. Through the UNDAF, WHO will work with the UN Country Team to coordinate efforts that address similar priority health concerns and jointly facilitate the mobilization of

additional resources from facilities such as GFATM and UNFIP. WHO will work closely with the MOH to coordinate donors. WHO will work closely with all partners to monitor gains and losses in health status, particularly in relation to MDGs, PRSP and the health component of NEPAD.

6.3.2 Health management information system/surveillance system

To measure gains in health status, particularly among the poor, calls for a strengthening of the current health management information system to demonstrate such changes. The current surveillance systems which cover communicable diseases (including endemic, epidemic-prone and vaccine-preventable diseases) as well as those targeted for elimination and eradication have been integrated and over time will be extended to include risk factors of diabetes, cardiovascular diseases, cancer, accidents and injuries. In particular, WHO will:

(a) strengthen routine HMIS to provide accurate information to measure gains and failures in heath status trends and resource flows particularly in a disaggregated manner in response to the MDGs, GPRS and health component of NEPAD;

(b) support MOH capacity to strengthen, harmonize and expand current surveillance systems through the integrated disease surveillance system;

(c) strengthen the capacity of hospitals, research institutions and zonal laboratories for laboratory diagnosis and confirmation of epidemic-prone and vaccine-preventable diseases;

(d) strengthen capacity for community-based surveillance systems using the guinea-worm disease eradication experience;

(e) support MOH capacity for inclusion of selected noncommunicable diseases into the surveillance system.

6.3.3 Scaling up priority health interventions

For most of the priority interventions, there are existing tools and strategies for addressing the problems. The challenges now are for scaling up these interventions and the necessary capacity to plan, mobilize, manage and monitor the required resources for scaling up. In this regard, WHO will work with CHAG and the Coalition of NGOs for capacity building and institution strengthening to better support government efforts for scaling up services. WHO will make available current international standards and treatment guidelines to the MOH in the areas of clinical, pharmaceutical and laboratory practice for adoption, adaptation and use in Ghana. WHO will focus on priority health interventions with poverty, gender and life course perspectives.

With regard to HIV/AIDS/STIs, WHO will focus on capacity building in quality control and regulation requirements by the MOH and pharmaceutical sector for local production of ARVs and make such drugs available, accessible and affordable. WHO will also strengthen the capacity of the NACP and work with partners such as GAC, schools, religious organizations, traditional opinion leaders, civil society and NGOs to:

(a) support implementation of national strategies and actions on care and support for people living with HIV/AIDS, including prevention and treatment of opportunistic infections, provision of palliative care, support to family caregivers and orphan care through the District Response Initiative (DRI);

(b) support implementation of sectoral plans for addressing HIV/AIDS;

(c) develop a package of interventions to address the needs for special groups such as prisoners and sex workers;

(d) develop a package of interventions to increase awareness and promote responsible behaviour among the youth;

(e) strengthen capacity of MOH for HIV/AIDS/STIs surveillance;

(f) strengthen capacity of MOH for management of STIs;

(g) support voluntary counselling and testing (VCT);

(h) support the Prevention of Mother to Child Transmission (MTCT) Programme;

(i) support MOH to ensure blood safety.

In malaria, WHO will assist the government and work with research institutions, NGOs and the private sector in coordinating partnerships to scale up activities for the Roll Back Malaria initiative, particularly the prompt home management of fevers and increased access and use of ITNs, especially by children under five years and pregnant women as is required by the Abuja Declaration on Roll Back Malaria.

Regarding tuberculosis, WHO will assist the government and work with research institutions, NGOs and the private sector in coordinating partnerships to strengthen capacity for the expansion of DOTS; support institutional strengthening for the quantification, supply and distribution of anti-TB drugs; build capacity for monitoring drug resistance and co-infection with HIV.

WHO will support MOH and work with the development partners, private sector, research institutions, training institutions and NGOs for the eradication and/or elimination of all diseases as required by global and regional strategies and resolutions of WHO.

WHO will assist the government and work with the UN Country team, Ministry of Health, Ministry of Women and Children's Affairs and other bilateral partners in reproductive health to:

(a) advocate for the mainstreaming of gender issues in health policies and health interventions;

(b) support the implementation of the safe motherhood strategy;

(c) combat harmful traditional practices such as female genital mutilation through advocacy; working with religious leaders, civil society and the Ministry of Women and Children's Affairs; publicizing and enforcing the existing legislation;

(d) advocate for intersectoral efforts that will reduce maternal mortality and morbidity.

In child and adolescent health, WHO will support:

(a) the MOH to strengthen immunization services;

(b) expansion of the IMCI strategy;

(c) the MOH and partners to develop and implement policies and strategies (based on the WHO Global Strategy of Infant and Young Child Feeding) to promote good nutrition among children under-five at community level;

(d) the School Health Programme;

(e) the implementation of the Adolescent Health Strategy.

In noncommunicable diseases, the MOH will be assisted by WHO to:

(a) collaborate with research and training institutions and other relevant sectors in establishing baseline data on priority NCDs and common risk factors and ways to control them;

(b) monitor the emergence of NCDs and encourage selected interventions;

(c) support community-based home care for chronically ill and disabled persons and their families;

(d) support community mental health programmes and scale up the Nations for Mental Health Programme in the districts.

In health promotion, WHO will work with the MOH, media, schools, city councils, businesses, civil society and individuals in support of advocacy and the development of IEC strategies that will promote and bring to the forefront the need for healthy lifestyles and behaviour. WHO will work with the MOH, the Ministry of Justice, legislators, other MDAs and civil society to adopt and adapt the Framework Convention on Tobacco Control and develop a strategy for its implementation. WHO will work with MOH, law enforcement agencies, schools, religious groups and NGOs to establish baseline data, develop relevant policies and strategies to address substance and alcohol abuse. The WHO Ghana Country Office will implement the strategy for the promotion of the WHO image through technical support for World Health Days, launching and disseminating the World Health Report, and all other international health initiatives through sponsoring events such as healthy school competitions and disseminating information on major health events in the world.

7. Implementing the Strategic Agenda

The Country Cooperation Strategy sets out the strategic directions and medium-term agenda for the work of the entire WHO Secretariat in Ghana. There is no doubt that the strategic shift described above has implications for the Organization's work at three levels.

7.1 Country office

The WHO Ghana Country Office will increase its role as a broker and advocate for health. The Country Office will maintain a balance of highly experienced national professional officers (NPOs) and international experts.

Although a substantial increase of staff is not expected, there will be a need for a full-time programme officer to address issues such as human resources and partnerships under health systems. Where this cannot be provided under the regular budget (RB), effort to use associate professional officers (APOs) or UN volunteers should be explored.

With the opening of the field office in Tamale, the current programme officer provided for VPD surveillance should be maintained and the scope of work broadened. An administrative assistant will also be required for support.

The current IDRS/NPO in the programme to strengthen surveillance of epidemic-prone and vaccine-preventable diseases should be absorbed as a fixed term officer. The current post of administrative assistant/WR should be converted to AO/NPO. The international post of STP/EPI should be made fixed term. Existing NPOs and all supporting staff will take on additional functions which will require new skills such as advocacy, communication, negotiations, resource mobilization, management and administration. A human resource plan will be developed to ensure that NPOs and all supporting staff continue to benefit from new developments in their corresponding area of work and expertise.

Technical officers and secretarial support will be recruited as and when needed according to collaborative initiatives with partners. However, where possible, local experts and institutions will be used for support on short-term basis. In light of the CCS, WHO will jointly review the current plan of action with the MOH.

Institutional strengthening of the Country Office in its role as a knowledge-based organization will be done through:

(a) direct computer access of all WHO staff to online science journals and databases;

(b) upgrading of computer capacity in the Country Office;

(c) linking the Country Office telephone system to WHO regional and HQ internal telephone systems;

(d) strengthening capacity of Country Office staff to monitor the WHO programme through using the AMS;

(e) increasing the running costs for the expanded office and ensure an efficient pool of vehicles;

(f) strengthening library services with computers and access to online services for journals and databases.

The new WHO Ghana Country Office strategies have budgetary implications. There is need to make provision for a development fund to allow for discretionary use by WR to support activities of the government and other partners that have not been envisaged in the POA but will give visibility to WHO. About 50% of project support costs that WHO/HQ receives should accrue to the Ghana Country Office to help it meet administrative costs. Financial planning will be enhanced if there is more certainty of extra-budgetary (EB) funds. There is also a need to increase budgetary support to meet new challenges.

Reorganization of responsibilities within the office appears in Annex 1.

7.2 Regional office

The WHO Regional Office for Africa (AFRO) will create an enabling environment that will facilitate organizational change and institutional development issues arising out of the CCS. As a starting point, AFRO will review and identify the implications of Ghana CCS on the Regional Office. In addition, AFRO needs to disseminate the findings of the Ghana CCS document to the AFRO regional advisors. This is necessary in order to create a better understanding of Ghana's health system and needs within the Regional Office and hence improve the scope and quality of technical support provided to the country team.

Bearing in mind the need for additional resources to support the implementation of the strategic agenda, AFRO will also use the document to mobilize more resources for the Country Office. In this regard, the CCS document will be disseminated to key donors and stakeholders in health.

In the area of resource allocation, AFRO will seek to increase its resources to the Country Office in line with the issues and challenges facing the country as identified in the CCS document. It is also clear that AFRO decentralization of financial responsibilities has facilitated the work in the Country Office and this needs to be sustained. AFRO, however, needs to explore the opportunities for further delegation of authority, particularly in the area of human resource management.

AFRO needs to monitor the impact of the CCS, provide support for the country to implement the recommendations arising from this exercise and put in place a framework integrating CCS into the WHO managerial process.

7.3 Headquarters

In line with the principle of "ONE WHO", headquarters will work together with AFRO and the Country Office to mobilize resources and provide technical support for the implementation of the Ghana CCS. Headquarters will also work with AFRO to document lessons arising out of the CCS process and the impact of CCS on WHO work as a whole as well as in individual countries.

WHO headquarters will continue providing up-to-date technical information to countries, directly and through AFRO. It will provide sufficient WHO publications and other technical materials. Like the Regional Office, Headquarters needs to disseminate the findings of the Ghana CCS document to HQ clusters and departments, emphasizing that all HQ support needs to be in line with the strategic agenda. This is to create a better understanding of the country's health systems within the Regional Office and hence improve the scope and quality of technical support provided to the country team.

At country level, a lot of projects or collaborative effort takes place with direct communications between Headquarters and partners at the exclusion of the Country Office. WHO will benefit greatly and gain more visibility where the Country Office is informed about and involved in all such communication and transactions. This will also enhance transparency and accountability.

Finally, Headquarters will review the CCS document and use it as a basis for revisiting the WHO reform agenda.

8. Conclusion

In developing the CCS, several institutions were consulted and reference made to several publications. The findings reveal difficult socioeconomic situations due to internal and external factors, government commitment to address poverty and significant achievements in health development.

The major challenge facing the health sector is the situation of epidemiological transition characterized by high levels of communicable diseases and increasing levels of noncommunicable diseases. Additional challenges are the severely under-funded health sector, lack of adequate human resources and weak health systems.

WHO will need to pursue the following strategic agenda to support the country in addressing this situation:

(a) strengthening health systems;

(b) strengthening health information and surveillance systems;

(c) scaling up priority health interventions;

(d) health promotion.

Crucial to this will be the need to strengthen the WHO Country Office with the recommended measures and to ensure the coordination of all levels of WHO in supporting the country.

Selected References

Common Country Assessment. Ghana, 1999.

Core Welfare Indicators Questionnaire (CW10). GSS, 1997.

A Corporate Strategy for the WHO Secretariat. WHO EB105/3.

DANIDA Health Sector Programme Support, Phase III. Ghana, August, 2002

General Programme of Work 2002–2005. WHO.

Ghana Demographic and Health Survey, 1988.

Ghana Demographic and Health Survey, 1998.

Ghana Poverty Reduction Strategy Paper, 2001.

The Health of the Nation. MOH, 2001.

HIV/AIDS Strategic Plan 2001–2005. MOH, 2001.

Malaria Baseline Survey, 2001.

National AIDS Control Programme, 2001.

National EPI Report, 2001.

Population and Housing Census. Ghana Statistical Services, 2000.

UNICEF Annual Report, 1988.

The Work of WHO in the African Region, Strategic Framework 2002–2005.

ANNEX 1

Organogram for WHO country office, Ghana