GHANA HEALTH SERVICE

2008 GHS Annual Report

EXECUTIVE SUMMARY

This GHS 2008 annual report has been structured to reflect some of the major activities by the GHS under the four health sector objectives and the results framework as measured by the key sector indicators. It represents a summary of many processes and reports. The preparation of the annual report is the final stage of the review process which starts with districts, through regions and ends at the national level. This report presents some key activities and outputs which took place during the year and a report on performance according to the key sector indicators.

The messages on healthy lifestyle and environment, specifically on healthy eating and exercise continue to influence GHS activities. Within the GHS, many meetings at both national and sub-national levels serve fruits and local nutritious food for snack and lunch. Health walks and health talks have featured very well within the regions and national levels. Though policies and guidelines for occupational health and safety have been disseminated, a lot more work is required to make the work environment safer. A number of guidelines were developed during the year. Most of these guidelines are yet to be printed and disseminated. Some has been printed and disseminated but do not have enough copies in circulation.

The District Health Information Management System (DHIMS) software has been deployed in all regions and is being used at the districts as the tool for consolidating and reporting on the sector indicators. Some service delivery facilities are using it. However the DHIMS faces major challenges. The low investment in ICT within the health sector is a factor militating against the use of the software. Lack of computers, servers, network, antivirus software and internet connectivity are some of the challenges faced by the service.

Significant progress was made in setting the agenda for action in human resource management. A posting committee was setup to coordinate posting. This is a significant step in ensuring transparency. The Leadership Development Programme started with the training of six teams of facilitators.

There were significant gains in the sector indicators. Antenatal and skilled deliveries recorded gains as well as postnatal care coverage. TB achieved a higher treatment success rate and the number of Guinea Worm cases dropped from 3,358 to 501. Outpatient visits increased with an OP per capita increasing from 0.69 in 2007 to 0.77 in 2008. Both indicators for doctor and nurse to population ratio improved slightly. There was a drop in both malaria case fatality and malaria mortality in children under five years. Immunisation coverage was high for measles and Penta III. The number of functional CHPS zones increased slightly from 345 to 401 representing about 7% coverage.

The service received fewer funds than approved in the 2008 budget for all the levels. There was significant nominal increase in the level of revenue from IGF in 2008. This is due to the increase in utilisation due to the NHIS. Disbursement of funds to GHS continued to be erratic affecting overall performance of GHS.

LIST OF TABLES

LIST OF FIGURES

Contents

ACRONYMS & ABBREVIATIONS

ACCPAC	-	Accounting Package
ADB	-	Agricultural Development Bank
ANC	-	Ante Natal Care
BCC	-	Behaviour Change Communication
BMCs	-	Budget Management Centres
CED	-	
CHEW	-	Community Health Extension Worker
CHO	-	Community Health Officer
CHPS	-	Community Health Planning Service
DC	-	Disease Control
DDHS	-	District Director of Health Services
DFID	-	Department for International Development
DHIMS	-	District Health Information Management Systems
DISHOP	-	District Health System Operationality
EMD	-	Estate Management Department
EPI	-	Expanded Programme on Immunization
FDB	-	Food and Drugs Board
GAIN	-	Global Alliance for Improved Nutrition
GAVI	-	Global Alliance for vaccines and Immunization
GHS	-	Ghana Health Service
GIS	-	Geographical Information System
GOG	-	Government of Ghana
GRB	-	Gender Responsive Budgeting
GSCP	-	Ghana Sustainable Change Project
GTZ	-	German Technical Cooperation
HASS	-	Health Administrative Support Services
HI	-	Health Information
HIRD	-	High Impact Rapid Delivery
HIV	-	Human Immune Deficiency Virus
HIV/AIDS	-	Human Immune Virus/ Acquired Immune Deficiency Syndrome
HR	-	Human Resource
HRD	-	Human Resource Division
ICD	-	Institutional Care Division
ICT	-	Information Communication Technology
IDSR	-	Integrated Disease Surveillance and Response
IEC	-	Information Education & Communication
IGF	-	Internally Generated Funds
IMCI	-	Integrated Management of Childhood Illness
IPTi	-	Intermittent Preventive Treatment
IRS	-	Indoor Residual Spraying
IST	-	In Service Training
KATH	-	Komfo Anokye Teaching Hospital

KNUST	-	Kwame Nkrumah University of Science and Technology
KRHTS	-	Kintampo Rural Health Training School
Lab	-	Laboratory
LDP	-	Leadership Development Program
MDAs	-	Ministries Department and Agencies
MDBS	-	Multi-Donor Budget Support
MDG	-	Millennium development Goal
MHAPP	-	Mental Health and Poverty Project
MoH	-	Ministry of Health
MTT	-	Multidisciplinary Ministerial Task Team
NACP	-	National Aids Control Programme
NGOs	-	Non-Governmental Organizations
NHI	-	National Health Insurance
NHIS	-	National Health Insurance Scheme
NHRC	-	Navrongo Health Research Centre
NMCCSP	-	National Malaria Control and Child Survival Project
OHS	-	Occupational health Strategy
OI/ART.STI	-	Anti Retroviral Therapy/ Sexually Transmitted Infections
OPD	-	Out Patient Department
PMTCT	-	Prevention of Mother to Child Transmission
PPM	-	Planned Preventive Maintenance
PPME	-	Policy Planning Monitoring and Evaluation
QA	-	Quality Assurance
QHP	-	Quality Health Partners
RHS	-	Regional Health Service
SBS	-	Sector Budget Support
ToTs	-	Trainer of Trainers
U5	-	Under Fives
UNICEF	-	United Nations International Children's Emergency Fund.
WAWI	-	West African Water Initiative
WVI	-	World Vision International

INTRODUCTION

The GHS 2008 Annual report documents the key activities undertaken and key performance measured by the sector indicators. The year 2008 marks the second year of implementing the second five year program of work (2007 - 11), which seeks to consolidate the gains made by the previous two programs of work (1997-2001 and 2002-2006). This focuses on building the health systems after the sector reforms as well as creating the foundation for the control and management of priority health interventions. It also represents the second year of implementation of the GHS five year strategic plan (2007-11).

The current priority areas for the GHS are on attaining the MDG 4,5 and 6, health promotion and disease prevention, while still seeking innovative and improved ways to increase access to highly effective and impacting curative service delivery and programs. The desired goal is to ensure generations of healthy human capital and overall socio-economic development through the adoption and practice of conscious well-informed healthy lifestyles and life choices.

The 2008 annual report is structured around the four health sector objectives:

1. Healthy lifestyles and environment
2. Health, Reproduction and Nutrition Services
3. General Health Systems Strengthening and
4. Governance and Financing

There are linkages between these four objectives. The Healthy Lifestyle and Healthy Environment theme is concerned with providing individuals and communities with information and necessary support systems that will make easy choices and reduce risk factors for diseases and overall reduction in disease burden. The linkage is further established through the promotion of Health, Reproduction and Nutrition Services and the strengthening of the general health system to be responsive to the dynamic health needs of all people living in Ghana. The ultimate goal of a healthy population will be achieved through the establishment of Effective Governance Structures and overall Financial Resourcing of the Service.

KEY ACTIVITIES PERFORMED

OBJECTIVE 1: HEALTHY LIFESTYLES AND ENVIRONMENT

Ghana Health Service has supported the development of the Health policy and is a key partner in its implementation. Indeed GHS has campaigned since 2004 for lifestyle changes through healthy eating and exercises.

Health Promotion and Awareness Creation of Risk Factors

The Regenerative Health and Nutrition Programme is a major health sector policy. At the Regions, these activities were incorporated into the Growth Promotion Sessions and Outreach visits. To lead the way GHS promoted the formation of keep fit clubs by the general public. The promotion has led to better eating habits even among GHS staff. Snack and meals served during GHS workshops are now healthier than before.

FIGURE 1:PARTICIPANTS DURING MOBILITY BREAK HAVING FRUITS AND EXERCISING

The GHS also encouraged the use of locally prepared Ghanaian drinks like flour water ('zomkom'), tamarind juice ('poha') at all levels during meetings and gatherings in place of the usual industrially prepared soft drinks which contain high sugars. The use of leaves of the 'Moringa' plant (popularly known as the 'magic tree') has caught up with a lot of people and has thus become a beverage and food for some people.

Nutrition Services and Food Safety

In 2008 a National Food Fortification Project was launched to promote health and ensure food safety. This is being implemented by the National Food Fortification Alliance under the auspices of the Ghana Health Service and the Food and Drugs Board (FDB) with support from the Global Alliance for Improved Nutrition (GAIN).

Environmental and Occupational Health and Safety

The year saw a lot of activities aimed at promoting environmental and occupational health and safety. The OHS policy for health workers was approved by GHS Council and disseminated to staff of GHS, teaching hospitals, quasi government institutions & regulatory authorities. OHS unit was established at the Eastern Regional Hospital in Koforidua.

A workplace HIV/AIDS policy was also put in place for all GHS staff. Environmental Occupational Health and IEC materials were developed and disseminated. The manual on Environmental Health and Sanitation was reviewed to include other waste management facilities such as bio digester and printed for distribution. The draft Guideline on Health and Safety was also finalised..

The Health Care Waste Management (HCWM) policy was completed, printed, and disseminated in workshops for all regions, quasi- government, CHAG, teaching hospitals, and regulatory bodies in Kumasi and Accra. This was done in collaboration with Institutional Care Directorate (ICD), Estate Management Unit (EMU) and the NACP. Sponsorship was provided by the WHO and World Bank respectively.

In June 2008, the department took part in a WHO workshop on injection safety. This meeting brought to the fore the risks from blood-borne pathogens to health staff, patients and the public that may result from unsafe injections. The workshop emphasized the need to integrate safe injection practices into health care waste management right from the point of administration of injections which generates the waste, to the final disposal point.

Piloting of waste management plans in Swedru Government Hospital and Kwanyako Health Centre respectively were initiated. These involved the assessment of HCWM practices, development of a training manual, and training of the HCWM committees and other senior staff of the two institutions. A separate training was organized for junior staff specifically involved in waste management. Basic equipment and tools like colour-coded waste bins, bin liners, gloves, weighing scales were presented to the 2 institutions to facilitate process of adopting standards provided under the HCWM policy. These activities were sponsored by the World Bank. Draft cabinet memo on HCWM policy was developed to provide the basis for legislation in future.

A study on the epidemiology of acute respiratory diseases among pre-school children and their relation with air quality parameters being monitored by the EPA has concluded. This was a follow-up to an earlier study which had described the pattern of reporting of acute respiratory illness in out-patient facilities in Accra. The results of these studies are expected to strengthen the evidence base for the setting of exposure limits for air pollutants by the EPA, and aid in advocacy for preventive efforts aimed at minimizing practices that favour environmental conditions which predispose the population to outdoor and indoor air pollution. This was sponsored by The United Nations Environmental Programme

(UNEP). The multidisciplinary study: 'Environmental Impact Assessment/ Strategic Environmental assessment' in the mining sector that had been on-going since 2006 was also completed.

This involved a

- follow-up to a pilot intervention studies for remediation of arsenic contamination of water in the Obuasi area,
- build the capacity of the DHMT to recognize morbidity from arsenic poisoning.
  However the plan of action to appropriately manage and provide prevention education to exposed communities had to be put on hold due to lack of funding.

The Environment and Occupational Health and Safety Unit represented the health sector at a meeting (WHO / UNEP / Inter- ministerial Conference on Environment and Health) of African Ministers of Environment and Health with the aim of fostering strategic alliances between the health and environment sectors of AU member countries. The deliberations focused on the fact that:

- 23% deaths (i.e. greater than 2.4million per annum) were attributable to environmental risk factors.
- New environment risks such as climate change, industrial expansion, new technologies, etc. were posing new threats to the health of the public. The outcome of this conference was the Libreville Declaration which called for :
  - The adoption of procedures for the practice of systematic assessment of health impacts from environmental risks.
  - Establishment & strengthening of environment and health institutions and the environmental health function within ministries of health.
  - Facilitation of the implementation of environment and health conventions like the Convention on Persistent Organic Pollutants (Stockholm) , Prior Informed Consent, Basel Convention on Hazardous Waste etc.

In all, sixty (60) farm workers from Ga East and Dangme West Districts were trained in safe handling of chemicals as well as forty (40) agricultural extension officers from northern region were trained in the prevention of poisoning.

Healthy lifestyle and Behaviours

In order to address the challenges in the implementation of Behavioral Change Communication (BCC) there was effective collaboration with NGOs and other organisations. BCC programmes were implemented in all Districts using all relevant stakeholders to form BCC groups composed of membership/personnel from the GHS, UNICEF, the Information Services Department, the West African Water Initiative (WAWI), the Carter Centre, World Vision International (WVI) and the Ghana Sustainable Change Project (GSCP).

OBJECTIVE 2: HEALTH REPRODUCTION AND NUTRITION SERVICES

The Ghana Health Service is working to attain the key indicators of the MDGs and has implemented the High Impact Rapid Delivery (HIRD) strategy. The main purpose of the strategy is to reduce maternal and child mortality to attain the MDGs 4 & 5. The GHS has in line with the above strategy, further strengthened its capacity to deliver services efficiently and effectively under the NHIS. The service continues to work with donors and local assemblies in establishing more functional CHPS zones to promote reproductive health and nutritional services.

In 2008, significant policy initiatives were introduced to sharpen the direction and practice of maternal health services in the country. During the year, the Minister of Health declared maternal mortality as a national emergency and set up a multi-disciplinary Ministerial Task Team (MTT) to mobilize resources and identify areas for technical support. The MTT proposed for the further investment in Community-based Health Planning and Services (CHPS) and Community Health Extension Worker (CHEW) approaches and the training of skilled birth attendants (especially nurses and midwives).

Clinical Care with Emphasis on Maternal and Child Health Services

The various policy measures by the MoH (free maternal care and the NHIS) resulted in an increase in access to health care by the general population especially the pregnant women, mothers and children. The effect of this policy increased utilisation at the health facilities with the year-on-year increase in the number of insured clients and per capita OPD attendance.

Two new specialist outreach services in medicine and neurosurgery were introduced at the Regional Hospitals. This was in addition to existing outreach services in Oral health and Eye Care services targeted in deprived areas.

During the year a number of guidelines and policies were developed to guide practitioners in the provision of quality health care to clients. The guidelines and policies to improve the quality of clinical care include;

1. Infection prevention and control policies & guidelines
2. QA strategic plan
3. Guidelines for QA in HIV testing in Ghana
4. Prevention of wrong site surgery
5. Adverse events monitoring guidelines
6. Customer care handbook, posters and video

A team of experts was constituted to complete the development of safe motherhood protocols. Document was prepared for printing in the last quarter of the year. Printing to be completed in the first quarter of the year 2009 and dissemination carried out later in the year.

GHS collaborated with Population Council of USAID for the successful registration of Misoprostol (Misotac) for obstetric use in Ghana. The policy direction is that Misotac shall be used for the prevention and management of post-partum haemorrhage at community, sub-district and district levels of the health care delivery system.

A meeting of the National Safe Motherhood Task Force was held in June 2008. Among recommendations made after deliberations of the group were:

- Review of the Midwifery curriculum with the view to strengthening the Skills and competencies components
- Operationalizing Confidential Enquiry into Maternal Deaths
- Contracting a consultant for the establishment of a Maternal Fund
- Making input for the review of guidelines for free maternal and infant care

National dissemination of the RH strategic plan and policy documents was done in August 2008. Each region was represented by the Deputy Director, Public Health, the Regional Public Health Nurse and the Regional Health Promotion Officer. In the course of the dissemination some key issues were raised which may need redress either during the review of the documents or through general health service guidelines.

Key challenges discussed included:

- The long-term plan for Traditional Birth Attendants needs to be included in the section of the policy on Human Resources
- The inclusion of sexuality in the current policy has training implications for service providers as there is currently inadequate knowledge in this area.
- There is the need for development of a protocol for terminal care as all cadres of workers at all levels have some role to playas stated in the standards
- Consensus-Building on Road Map for Accelerating Attainment of MDG 5

A meeting was held in September 2008, with representation from other divisions in the GHS and other MDAs. The road map, which was developed from the five-year RH Strategic plan for the GHS, focused on strategies for accelerating attainment of 75% reduction in maternal mortality and 30% reduction in newborn mortality.

Reduction of Malnutrition as a Public Health and Developmental Problem

The goal of the food fortification project is to reduce the micronutrient deficiencies among children ages two to five and women of reproductive age through fortification of wheat flour and vegetable oil. Currently all flour processed in the country by the major four Wheat Flour Mills is fortified with a cocktail of vitamins and minerals (Vitamin A , iron, folic acid, Vitamin -B1, B2, B3, B6 and Zinc. However, only two vegetable oil companies have started fortifying the vegetable oil that is processed or packaged in the country with Vitamin A.

To create the required awareness and generate demand for fortified food products, radio messages and print materials have been developed to inform consumers about benefits of consuming fortified foods. Materials produced include Fliers, posters on both oil and flour and aprons for bakers.

Media practitioners and bakers from all the regions were re-trained to improve their knowledge in fortification agents. The communication materials produced were launched as part of the training activities of bakers and media practitioners.

Survival Growth and Development of all Children

The National Malaria Control and Child Survival Project (NMCCSP) conducted training in growth promotion activities (7 national trainers, 24 regional trainers and at least 76 district trainers). District trainers have also trained at least 504 volunteers from18 communities each in 7 districts. The baseline survey was organized in the 19 districts using LQAS methodology in March 2008. The following materials were also developed;

- Handbook for trained volunteers
- Community registers, counseling cards, home visit notebooks and various charts

A thousand Salter Weighing Scales were procured and delivered through UNICEF. All 19 districts received 18 weighing scales each for CBGP. Under the Project, thirty-eight (38) Nissan 4x4 Pick-ups and138 Motorbikes were procured for distribution in November 2008 to the districts.

Disease surveillance, emergency preparedness and response

Among the activities performed in 2008 were the development of documents including;

1. The revision of Integrated Disease Surveillance and Response (IDSR) technical guidelines
2. The development of:
    a. National strategic framework for eradication of polio
    b. 5-year strategy for improving Community Based Surveillance
    c. Guidelines on surveillance and case management of Avian Influenza in Humans
    d. Guidelines for Management of OI/ART, STI
    e. Guidelines on Counseling and Testing
    f. Guidelines for evaluation of HIV test kits in Ghana
    g. PMTCT Guidelines
    h. YAWS Strategic Document

Access to Quality Maternal Newborn and Reproductive Health Services

GHS developed guidelines for community sensitization and mobilization, strategies for CHPS/CHEW involvement in reproductive health and capacity building of staff, and sharing of best practices. Training for midwives in life-saving skills has been enhanced in all regions.

Through advocacy from GHS, there was considerable multi-sectoral commitment to the HIRD strategy. The the Ministry of Women and Children's Affairs for instance, organized a workshop in November 2008 to mobilize women's groups, revision of education materials on adolescent sexual health by the Ministry of Education and a pledge from the Private Road Transport Union to sensitize members to support women in labour. The Family Health Division of the GHS, with support from WHO produced a draft strategic plan on health and development of adolescent and young people.

A meeting of stakeholders in the PMTCT intervention programme was held in July 2008. A major decision taken at this meeting was the introduction of Early Infant Diagnosis of HIV. The main purpose of this is to improve the quality of life for the HIV-exposed infant.

The introduction of this facility will enable HIV infected babies to be diagnosed early so that they can benefit from ART to improve their chances of survival. Guidelines for operationalizing Early Infant Diagnosis of HIV were developed later in October and the plan is to establish the facility in every Regional hospital.

STRATEGIC OBJECTIVE 3: GENERAL HEALTH SYSTEM STRENGTHENING

Within the context of the Ouagadougou Declaration and Framework for Strengthening Health Systems and Primary Health Care, the Ghana Health Service recognizes the need to strengthen health systems for better health outcomes. Key elements of the building blocks of health systems strengthening focused on human resource management, capacity building and training in leadership, management and team building and sustaining the health workforce. Other areas of focus were maintaining the health infrastructure development improving supply and logistics management, planning and resource allocation, financial management and ICT including health management information system.

Information Technology to Improve Information Management and Service Delivery

The District Health Information Management Systems (DHIMS) Database was revised and deployed in all regions and districts. It was used for data capture in all fully established districts and some service delivery points. The revised version allows data entry at multiple entry points in each district with a consolidation module at the regional and national levels. The regional information officers were trained as 'Trainer of Trainers' to train district information officers.

The Central Records/Archives Unit was successfully established with a central library headed by a qualified records manager.

Efforts are also being made to link the GHS Assets Management System to other similar databases. Health facility data on three regions (Eastern , Volta and Greater Accra regions) have all been updated.

HR Planning, Recruitment Deployment Retention and Management

During the year, the Human Resource Development Division organized a 3-day retreat involving a broad range of stakeholders. The retreat catalogued the existing and current HR challenges facing the Service and mapped out strategies to address them. The action points, which came out from the retreat were further developed into a 3-year activity plan from October, 2008 to September 2011. The plan is intended to guide and direct the activities of HRD to systematically address the HR challenges within the next three years.

Establishment levels were defined for the Grades of Assistants and Chief Technical Officers (DC, HI, Lab, E-Ray, Nutrition etc) as a measure to control and manage the wage bill of the Ghana Health Service. The process will continue for all categories of staff. The format for assessing the performance of leaders/managers was developed and is being used as the basis for reappointment of DDHS and Medical Superintendents.

During the year, GHS Postings Committee was set up to coordinate the posting of health staff. The proposal for advertising job vacancies and requesting all newly qualified health professionals to apply directly to the regions for recruitment was implemented. Regional quota for recruitment of various categories of Nurses and TOs (CH & HI), MAs etc were determined and advertised.

As at the end of 2008, qualified staff who applied directly to the regions had been interviewed by their respective RHDs for selection and postings to vacant areas in the regions. Recruitment and postings of other health professionals including doctors are expected to follow the same procedures in 2009. Guidelines on contract appointment have been developed and circulated to all regions to ensure compliance.

The practice of granting study leave with pay is currently being restricted to the needs of the service. Sponsorship for freshly qualified MOs for GPCSP has been reviewed. Freshly qualified MOs have to do 2 year service before being granted sponsorship. Correction of anomalies and distortions in the salary structure of the Clinical Engineering Department has been addressed. A new confidential appraisal form/system has been designed for assessing the performance of DDHS and Medical Superintendants has been developed and disseminated.

To strengthen the governance and management of HR, a number of policies and guidelines were developed and disseminated. Key documents developed and disseminated include;

1. IST policy and guidelines printed and disseminated with support from Quality Health Partners (QHP).
2. Policy guidelines for promotions, postings and counseling have also been developed and disseminated
3. Upgrading of OTTI curriculum to diploma level (collaboration with KNUST)
4. Facilitated development of curriculum for Physiotherapy Assistant training program (collaboration with ICD).
5. Curriculum for improving management of public health interventions in the sub-region (Collaboration with AFENET/SPH; WHO)
6. Supporting the development of Occupational Health Nurse Curriculum (collaboration with Occupational Health Division)

There were five sessions of District Health System Operationality (DISHOP) short course training organized in 2008 in collaboration with RHTS, Kintampo. Funds for the training were provided by the African Development Bank (ADB) through RHTS. Participants included the DDHS and 3 other core DHMT members. In total, 145 district staff were trained in DISHOP. Additionally, 3 DISHOP long course sessions were organized for 10 districts (95 staff) were taken through 5 IMCI training sessions.

Staff training & capacity development activities conducted include;

1. Training of two (2) audit staff in-country

2. The EMD in collaboration with German Technical Cooperation (GTZ) and the Ministry of Local Government, Rural Development & Environment conducted training in Planned Preventive Maintenance (PPM) for staff of District Assemblies in Ashanti and Brong Ahafo regions in Kumasi
3. A 5-Day capacity building workshop for forty (40) newly qualified health services administrators was organized in Kumasi.
4. Three members of staff at EMD were sponsored to participate in short courses in two Projects, risk management and infection control & design.
5. Three staff of CED were sponsored by India Government to participate in the management development Programme on the operation, maintenance and repair of equipment in India.
6. Two staff of CED participated in a training workshop at the Ghana Medical School and Ghana Atomic Energy Commission Training School all in Accra on Quality Assurance and Quality Control.
7. Training for District Transport Officers in Ashanti and Eastern regions was undertaken. Motorcycle Riders training was also organised for new riders in all regions.

Infrastructure to Support Effective and Efficient Service Delivery

The EMD in collaboration with EPI Programme undertook the construction of 50 incinerators in the newly created districts and a few other health facilities. Twenty five (25) of them were completed during the year. Seven of the new incinerators constructed were funded by the NACP. The seven incinerators are located in Suntreso Hospital, Dodowa, Pantang Hospital, Tema General Hospital, Ridge Hospital, Enyiresi Hospital and Effia-Nkwanta Hospital. The construction of offices of the Centre for Disease Control.

FIGURE 2: NEWLY CONSTRUCTED INCENERATOR

HASS provided technical advice in the development of briefs and designs for various proposed hospital projects for Teshie District Hospital, 5 Rural Clinics in the Northern Region, Winneba District Hospital and 8 Hospitals for various locations in Ghana.

HASS also made technical inputs into the ongoing ADB and NDF projects for 2 District Hospitals at Tarkwa and Bekwai and bloodbanks at Accra, Kumasi and Tamale.

An assets register has been developed and tested successfully at the Headquarters. The system would be rolled out to the regions and health institutions.

Supplies and Equipment Management

Routine maintenance of office equipment including air conditioners, office and residential buildings were undertaken. Planned preventive and corrective maintenance of official vehicles undertaken at facilities includes, Ada, Keta, Maamobi, Nadowli, Bimbila Hospitals, Reference Lab, Korle-Bu, X-Ray and Ultrasound machines at Asesewa, Kete-Krachi, Kintampo, Bole, Ashanti Mampong, Apam, Axim and KATH. The radio-communication system for the Upper West Region was completed and additional units installed.

Transport Availability and Management

The year under review saw a big stride in overhauling the motorcycle fleet which was captured in the 2007 report as being of critical essence due to the fact that this mode was mostly used at the district level and below where health service delivery takes place.

The contract for the supply of 4000 motorcycles has been signed and was expected to be delivered by the first quarter of 2009. This will completely overhaul the fleet with the disposition of the over-age ones to save cost of maintenance of the motorbikes.

Pick-ups which form about 65% of the entire four-wheel vehicles also need critical attention. The service had also initiated moves to acquire about 250 pickups for health institutions. This process was ongoing at the end of the 2008. The pick-ups are earmarked for hospitals, district health directorates with priority to the new and deprived districts.

TABLE 1: GHS VEHICLE FLEET STATUS (DEC.2008)

	NO. OF VEHICLES AND BIKE		AVERAGE AGE	
REGION	**BIKE**	**VEHICLE**	**VEHICLE**	**BIKE**
HQ	38	230	6.2	6.4
UWR	399	94	6.4	6.2
UER	169	63	8.4	6.5
BAR	265	108	6.9	6.1
NR	386	128	6.4	5.1
AR	243	118	11.3	7.2
CR	259	116	7	5.6
WR	277	101	7.1	4.4
VR	346	138	8.97	6.8
GAR	125	131	10.5	6.6
ER	233	117	10.12	8.7
TOTAL	**2740**	**1344**	**8.1**	**6.3**

The average Age for the vehicles and motor cycles increased in 2008, this represents 9.9% (Vehicles) and 6.8% (motorcycles) respectively. These increases were as a result of the service's inability to keep pace with the quantum of replacement required. This situation presents its own concomitant effect of

high running cost (fuel and maintenance) of old vehicles and low vehicle availability due to frequent workshop visit and unreliability.

Ashanti, Eastern and Greater Accra Regions have the worst over aged vehicle fleet with an average age of about 10 years. On the other hand Eastern and Ashanti Regions have the worst over aged motorcycle fleet with an average age of about 7 years.

The vehicle fleet had a net increase of a 3.9% with most of these vehicles brought in by targeted project-led procurement. The motorcycle fleet had net increase of 3.7%

The following programmes had been key sources of supply of vehicles and motorcycles to the service in 2008:

- National Aids Control Programme (NACP)
- Tuberculosis (NTB Programme)
- National Malaria Control programme (NMCP)
- Expanded Programme of Immunization (EPI)

Research and Development

Research in GHS is coordinated by the Health Research Unit (now Research & Development Division) which has been elevated to a division from 2009. The network of research centres (3) are located in Navrongo, Kintampo and Dodowa. The main activities of the research units in 2008 included;

- Data collection from whole communities over time
- New health threats
- Tracking population changes
- Assess policy interventions
- More accurate reflection of health and population challenges

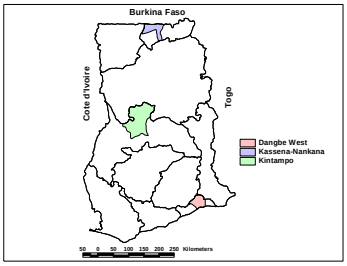


FIGURE 3: A MAP OF GHANA SHOWING THE THREE RESEARCH CENTRES

Key research projects conducted in 2008 were;

1. Impact of RDT use on the appropriate management of malaria
2. Assess the impact of introducing RDT on appropriate prescription of anti malaria drugs
3. Explore perceptions on use of RDT versus clinical diagnosis
4. Explore perceptions on use of RDT versus microscopy
5. Determine the cost effectiveness of RDT for the diagnosis of malaria
6. Malaria and Pneumonia
7. The impact of using anti biotic and anti malaria for the treatment of fevers in under five children using the home management approach with appropriate IEC.
8. Ethnographic studies with health education campaign

9. Malaria vaccine research
10. Anemia Control Research
11. Evaluated the use of microencapsulated iron powder (Sprinkles) to control anemia in children
12. Obaapa Vit A trial
13. The Mental Health and Poverty Project (MHAPP): (DFID, UK)
14. seeks to evaluate mental health policy development and implement and evaluate interventions that aim to break the negative cycle of poverty and mental illness
15. The elderly study: (Ghanaian Dutch Collaboration)
16. Anthropological study of the experience of mental illness: (ESRC, UK) contribute to the awareness of the burden of serious mental illness in Ghana, and to advocate for improved health and support services in rural communities.
17. IPTi Acceptability Studies-Ongoing
18. Human Rotavirus Vaccine Trial (Results from this study will inform WHO and GAVI support for introduction of rotavirus vaccines in EPI of developing countries)
19. The NHRC is presently playing a leading role in the testing of the Rotateq vaccine in Africa.
20. Safety and pharmacokinetic study in 4-11 year olds in Ghana next year

STRATEGIC OBJECTIVE 4: GOVERNANCE, PARTNERSHIP AND SUSTAINABLE FINANCING

Management Systems and Scale-up leadership Training

A number of activities related to staff training and capacity building in leadership took place in 2008. Under the DISHOP programme in collaboration with RHTS, Kintampo 5 sessions of DISHOP short course training were organized in 2008. A total of 145 staff (DDHS's, DHMT members) participated in the training.

A Leadership Training Course was organized for Directors in collaboration with KNUST where 38 regional and district directors were trained. A Pilot Leadership Development Program (LDP) was conducted in Central Region from January to July 2008 where 24 core DHMT members and 4 RHMT members were trained.

The following documents were developed as part of the management and capacity building strengthening system.

1. Ghana Health Service 5 Yr Strategic Plan
2. Child health policy and strategic plan
3. CHO training modules with reference materials
4. CHO work book
5. CHO training guide/facilitators' guide
6. Draft management manual for subdistrict managers, CHOs and NGOs
7. Draft monitoring and evaluation framework for GHS
8. Handbook and video clip on Customer care
9. Health Care Waste Management and Occupational Health and Safety Policy
10. Building Failure/Defects Manual with the assistance of a Danish Consultant
11. Manual on Plants and Flowers for Health facilities
12. Transport curriculum and Re-Development of Operational manual
13. Building Maintenance Management Manual

Gender and Equity

Gender Planning and Gender mainstreaming are global strategies for promoting gender equality. The GHS has developed Gender Mainstreaming Guidelines as a tool to guide senior managers in regions and districts for mainstreaming gender and promoting gender equality and gender equity, as well as increased focus on gender-related issues in health service delivery. They outline strategies for mainstreaming gender focusing particularly on addressing access to health care, quality of care, reproductive health needs and gender-based violence, among others. It is also expected to serve as a resource for advocacy and capacity building for the promotion of gender sensitivity in health service provision.

In addition to training regional gender focal persons, a team from PPME HQ attended a three day workshop on Gender responsive Budgeting (GRB) in Akosombo June 2008 with a theme "Institutional capacity enhancement for effective gender equality and women empowerment promotion". The aim of gender responsive budget is not to separate budgets for women and men but it's about ensuring that the needs, interests and priorities of individuals from different social groups are addressed i.e. rich and poor, urban and rural, boys and girls and physically challenged.

Participants were taught that GRB is not about asking for more money for women, but about whether the way national money is currently being distributed is having the desired impact on women, men, boys, girls and all other different groups of people. Its also about whether the current distribution channels are the most efficient, effective, economic and equitable way of achieving government objectives of poverty reduction and promoting gender equity.

Financing Mechanism and Financial Management Systems

The GHS continues to use regional financial monitoring teams who remain a major source of capacity development in financial management. These teams are responsible for supporting regions and districts in their financial management processes such as validation of financial information produced and entering it into ACCPAC for routine financial reporting.

The Internal Audit Division coordinated the BMCs' Responses to Auditor-General's draft report to Parliament for 2007 and used the opportunity to educate non-audit staff on emerging audit issues. A seminar on audit issues was organized for DISHOP Participants at KRHTS.

KEY PERFORMANCE INDICATORS BY OBJECTIVE

OBJECTIVE 2: Health Reproduction and Nutrition Services

TABLE 2: KEY SECTOR PERFROMANCE INDICATORS (2006-2008)

Indicator	2008 Target	Performance		
		2008	2007	2006
Institutional MMR (per 100,000 live births	175	200	224	187
HIV prevalence among pregnant women 15-24 yrs	<4.0%	2.20%	2.60%	3.20%
% U5 sleeping under ITN	60%	41.70%	55.30%	21.80%

Indicator	2008 Target	Performance		
		2008	2007	2006
ANC coverage	95%	97.40%	91.10%	88.40%
% Skilled delivery	50%	36.90%	32.10%	44.50%
PNC Coverage	60%	57.50%	56.70%	53.70%
Family Planning Acceptor rate	28%	33.80%	23.20%	25.40%
Penta 3 coverage	90%	87%	87.8%	84.2%
Measles coverage	90%	86%	88.0%	85.0%
TB treatment success rate	80%	84.70%	76.1%	72.6%
Incidence of Guinea worm	<2,000	501	3,358	4,129
OPD attendance per capita	0.7	0.77	0.69	0.55
Doc/population ratio	1:8559	1:12823	1:13683	1:14734
Nurse/population ratio	1:1756	1:1458	1:1537	1:2125

The total maternal death for 2008 was 953. Out of this number, 799 was audited representing 84% of deaths audited. The percentage of deaths audited improved in 2008 with three regions auditing 100% of maternal deaths.

Under 5 mortality due to malaria from inpatient admissions recorded 1.8% whilst the above 5yrs mortality from malaria recorded 1.5%. This generally is indicative of an improvement in the management of malaria in both children and adults on admission to the health facilities.

There has been an improvement in the case fatality rate of malaria in children over the previous years, which recorded 2.4% in 2007, 2.7% in 2006 and 2.8% in 2005. The dip in mortality case fatality for malaria is partly due to the efficiency and compliance to the malaria treatment protocols and also interventions such as IRS, use of ITNs and public education as depicted by the graph below.

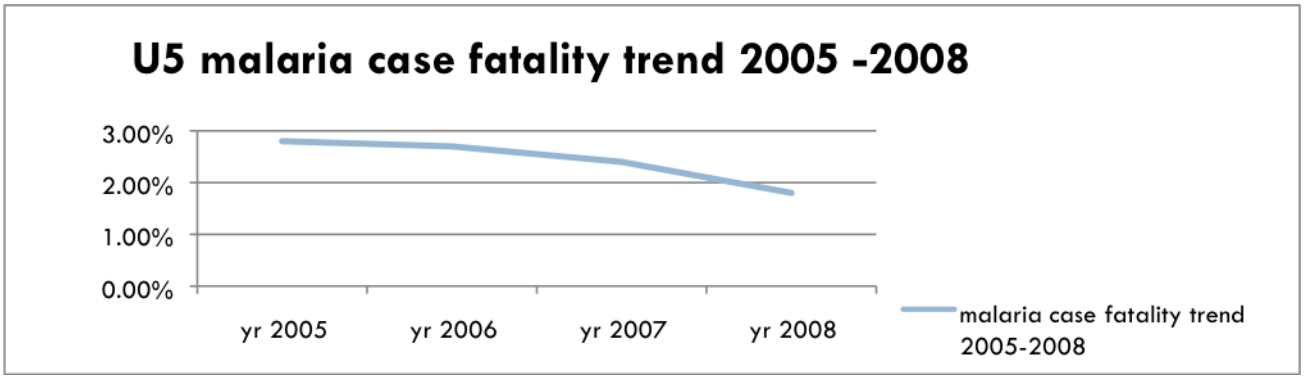


FIGURE 4: U5 MALARIA CASE FATALITY (2005-8)

However, the 1.8% U5 malaria deaths pose a great challenge to the health service. Malaria constitutes 34% of all the u5 deaths from admissions to the health facilities as shown in the chart below. The malaria deaths for the above fives was 9% compared to the under fives malaria deaths which stood at 34%.This is indicative that children under five are very vulnerable to malaria as compared with the other age groups as shown below.

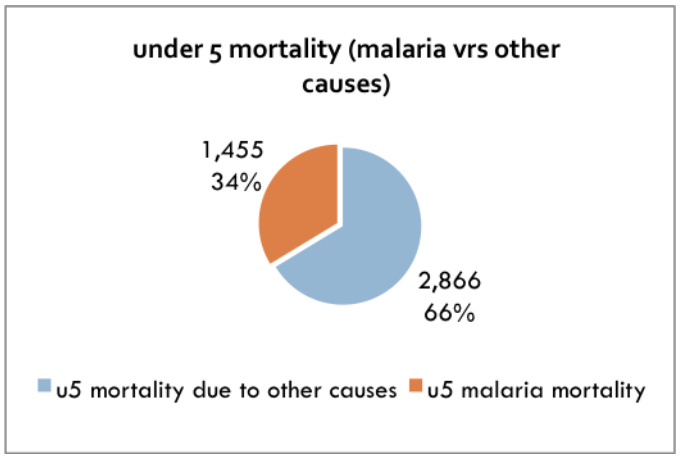


FIGURE 5: UNDER 5YRS MORTALITY - MALARIA VRS OTHER CAUSES

Community Based Health Planning and Services

The Community Health Planning and Services has been the overarching GHS strategy of bringing primary health care services closer to the door steps of individuals, households and the communities. The process of increasing the number of functional CHPS zones has been slow. Currently, there are 409 functional CHPS zones. In order to achieve the set targets there is the need to reinvigorate community engagement for the establishment of CHPS.

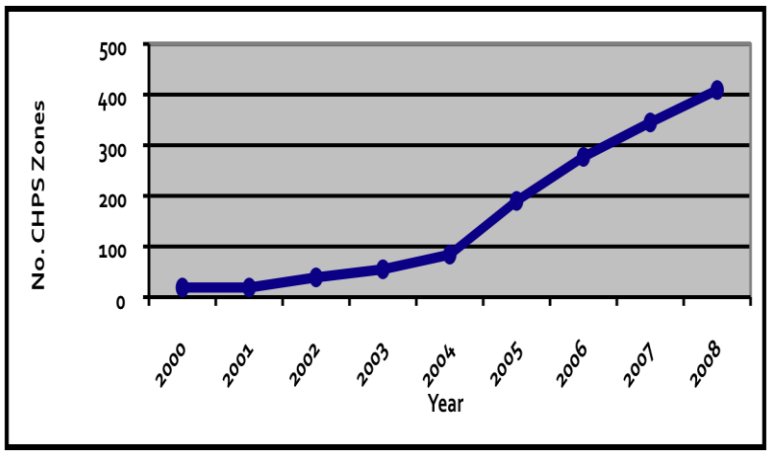


FIGURE 6: TRENDS IN FUNCTIONAL CHPS ZONES (2000-2008)

Table 3: Progress in the Implementation of CHPS by Region, 2006-2008[1]

Region	2006				2007				2008			
	Comp	% Pop.	Funct	% Pop.	Comp.	% Pop.	Funct	% Pop.	Comp	% Pop.	Funct	% Pop.
Ashanti	1	0.3	7	1.7	3	0.6	8	1.8	3	0.06	8	0.17
B/Ahafo	0	0	6	1.5	0	0	6	1.4	0	0	9	0.18
Central	22	4.6	31	6.9	30	5.6	46	8.9	32	0.58	46	0.85
Eastern	29	5.9	53	9.5	30	5.8	54	9.4	37	0.61	86	1.33
G/ Accra	0	0	5	2.1	0	0	5	1.9	0	0	5	0.18
Northern	27	5	29	5.9	29	5.2	35	6.5	33	0.58	39	0.70
U/ East	61	11.6	68	11.5	85	12.7	82	12.5	78	1.27	88	1.43
U/ West	10	1.2	20	2.4	24	3	29	3.6	35	0.41	41	0.49
Volta	15	3.4	27	4.9	20	4	37	6.2	23	0.46	42	0.69
Western	13	2.9	28	6.8	20	7.2	43	11.9	23	0.71	45	1.19
Totals	178	3.5	274	5.31	241	4.42	345	6.41	264	4.68	409	7.21

[1] *A completed CHPS zone is one in which all the key milestones have been achieved and there is a CHO resident in the community. A functional zone is one where there is CHO resident in the community even though one or more key milestones has not been achieved e.g. lack of a community health compound.*

Ante natal Care

Ante-natal coverage has increased over the last three years. National coverage shows significant progress between 2007 and 2008. Most of the increase can be attributed to the revised management of the free maternal health policy through the National Health Insurance Scheme.

At the regional level, there were equally significant increases in the utilisation of ANC services between 2007 and 2008.

	ANC		
Regions	2006	2007	2008
National	**88.4**	**91.1**	**97.4**
Western	93.0	91.7	95.8
Central	103.8	108.7	111.9
Greater Accra	77.2	77.2	93.4
Volta	87.1	87.4	93.4
Eastern	86.0	87.2	95.6
Ashanti	74.0	76.1	86.1
Brong Ahafo	97.4	101.8	103.2
Northern	109.0	116.8	127.6
Upper East	104.2	111.7	101.6
Upper West	90.3	96.3	91.1

TABLE 4: ANC TREND BY REGION (2006-2008)

Skilled Delivery

The national performance of supervised deliveries by skilled health personnel increased from 34.9% in 2007 to 46.1% in 2008, the highest level recorded over the past 4 years. The Northern region had the lowest supervised delivery rate of 29.7% and the Central region recorded the highest of 56.7%. The Ghana Demographic and Health Survey reported 58.7% coverage for supervised delivery.

	Skilled Delivery		
Regions	2006	2007	2008
National	**44.5**	**32.1**	**36.9**
Western	34.8	17.6	39.2
Central	74.0	22.3	56.4
Greater Accra	42.2	43.1	44.6
Volta	35.4	33.3	36.2
Eastern	38.7	43.1	46.4
Ashanti	40.8	26.7	47.5
Brong Ahafo	47.4	34.5	49.1
Northern	25.1	27.7	29.7
Upper East	38.4	43.5	38.3
Upper West	28.8	32.9	39.0

TABLE 5: TREND SKILLED DELIVERY BY REGION (2006-2008)

Immunisation

	Penta III		
Regions	2006	2007	2008
National	**84.2**	**87.8**	**87.0**
Western	91.1	93.0	88.9
Central	88.4	92.6	91.1
Greater Accra	65.4	67.8	34.2
Volta	77.5	83.8	70.7
Eastern	88.6	93.3	96.5
Ashanti	71.0	72.3	76.5
Brong Ahafo	96.8	100.2	102.9
Northern	115.2	123.7	113.4
Upper East	92.6	101.6	92.1
Upper West	92.4	93.9	92.2

TABLE 6: PENTA III COVERAGE BY REGION (2006-2008)

There has been a slight decline in EPI coverage though absolute number of cases has increased. The review of the district data (not shown here), revealed a decline in the number of districts reporting 80% Penta 3 coverage over the years.

Outpatient Attendance

There was significant change in OPD visits per capita which can be attributed to improved financial access due to increased registration with health insurance schemes. The cumulative impact of various efforts by the MoH and partners to improve the quality of clinical care and access to services is beginning to show positive results. In 2008, there was a total of 640,520 admissions into health facilities across the nation.

	OPD Per Capita		
Regions	2006	2007	2008
Western	0.57	0.72	0.88
Central	0.50	0.63	0.72
Greater Accra	0.47	0.27	0.51
Volta	0.41	0.49	0.73
Eastern	0.65	0.62	0.99
Ashanti	0.59	0.71	0.73
Brong Ahafo	0.91	1.00	1.24
Northern	0.30	0.28	0.49
Upper East	0.55	0.78	1.01
Upper West	0.46	0.70	0.73

TABLE 7: TREND OPD PER CAPITA BY REGION (2006-2008)

Fifty-nine percent (59%) [380,119] were insured and 41% [260,520] were uninsured, 65% were female and 35% male. Out of the 380,119 insured, 67% [255,458] were female and 33% [124,661] male. Of the 260,401 uninsured clients, 61% [157,725] were female and 39% [102,676] male. Relatively more women access health services using the NHIS than men (62% versus 55%) and more men are relatively uninsured than the females (45% versus 38%).

STRATEGIC OBJECTIVE 3: General Health System Strengthening

Doctor and Nurse to Population Ratio

The doctor and nurse to population ratio in the country is still high. However there is a gradual improvement over the past years. There are wide regional variations between the north and south which is of concern to GHS. There are plans to increase the training facilities to produce more doctors.

	Doctor:Population Ratio		
Regions	2006	2007	2008
National	**14,732**	**13,683**	**13,499**
Western	32,746	33,794	33,461
Central	31,675	29,260	26,887
Greater Accra	5,624	5,202	5,431
Volta	25,430	28,269	28,806
Eastern	22,019	18,141	17,837
Ashanti	11,681	10,667	9,936
Brong Ahafo	25,635	22,479	21,257
Northern	67,154	92,046	73,257
Upper East	28,897	33,111	47,130
Upper West	45,568	43,253	47,130

TABLE 8: TREND IN DOCTOR POPULATION RATIO BY REGION (2006-2008)

	Nurse:Population Ratio		
Regions	2006	2007	2008
National	**1,537**	**1,454**	**1,353**
Western	2,368	1,993	1,775
Central	1,577	1,476	1,312
Greater Accra	993	976	952
Volta	1,302	1,266	1,138
Eastern	1,251	1,173	1,111
Ashanti	2,136	2,024	1,932
Brong Ahafo	2,036	1,099	1,767
Northern	2,126	1,868	1,770
Upper East	1,298	1,243	1,126
Upper West	1,315	1,266	1,042

TABLE 9: TREND IN NURSE POPULATION RATIO BY REGION (2006-2008)

There are concerns about the ageing of midwives and Medical Assistants that must be addressed. This needs critical consideration if the nation is to scale up interventions aimed at achieving MDGs 4 and 5 targets. The number of midwives in the age group 51 to 59 constitutes more than 50% of the total. This implies that in the next five to ten years, this large proportion of midwives will be retiring creating a large gap.

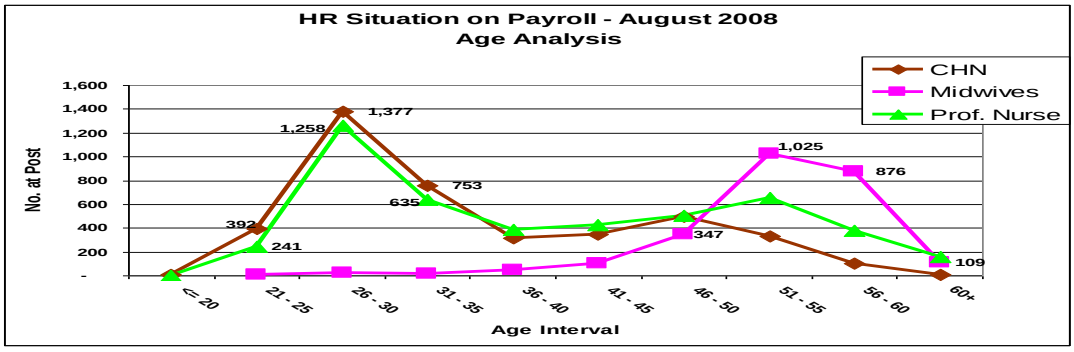


FIGURE 7: HR SITUATION FOR CHN, MIDWIVES & PROF. NURSES BY AGE GROUPS

STRATEGIC OBJECTIVE 4: Governance, Partnership and Sustainable Financing

Financing mechanism and financial management systems

Financing in the GHS and health sector overall is changing. *The health sector general budger is curently being financed through the Multi-Donor Budget Support (MDBS) facility anchored in the Ministry of Finance and Economic Planning. Currently donors contributing to the health fund are shifting their support increasingly to the MDBS facility.* The relative shares of different sources are changing, the graph below shows trends in the resource envelope for service delivery since 2006 with decreasing shares of GOG and SBS and increasing share of IGF driven by the NHI.

National Health Insurance Scheme

The various policy measures by the MoH (free maternal care and the NHIS) resulted in an increase in access to health care by the general population especially the pregnant women, mothers and children. The effect of the NHIS can be seen with the year on year increase in the number of insured clients and the per capita OPD attendance.

In all categories (insured/non-insured/total), women accessed more services than men. Again more women in both insured and uninsured accessed more health services due to the free maternal care policy. Comparatively, more women access health services using the NHIS than men (62% versus 55%) and more men are relatively uninsured than their female counterparts (45% versus 38%). The evidence points to the fact that, this deliberate policy of making healthcare available and accessible to mothers are yielding results.

The insured patronize health facilities more, and had better outcomes than the uninsured. Overall 3% of all admissions experience a fatal outcome. This poor outcome is however higher in the uninsured group, 5%, and is much lower for the insured 2%. Relatively more males die in both the insured and the uninsured groups, (53% versus 47% in the insured group, 56% versus 44% in the uninsured group, 55% versus 45% overall). Further more, in relative terms, more men die uninsured than insured. Sixty-two percent (62%) more men die uninsured versus 38% insured, compared with women 59% uninsured versus 41% insured.

One possible explanation to this observation could be that, whereas more women are admitted into health facilities, they are more likely to come out with a better outcome than the men. This observation demands a more in-depth analysis to identify the issues that promote this outcome and reinforce them for an even better outcome.

Health Expenditure

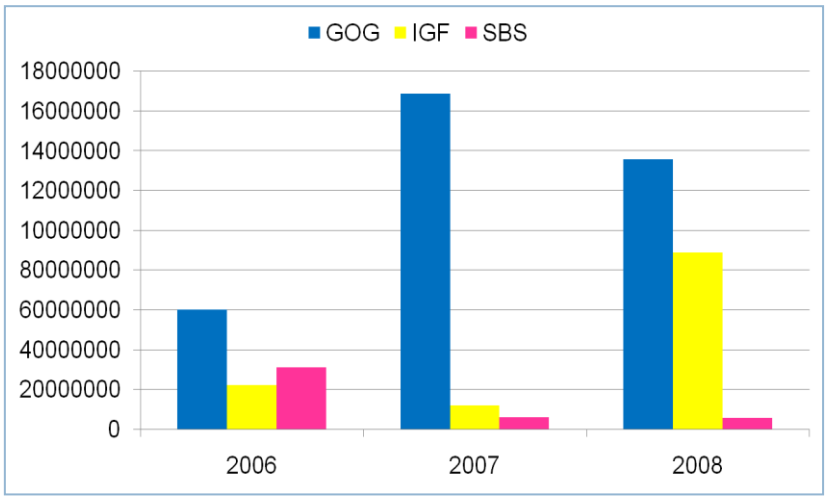


FIGURE 8: TREND IN TOTAL REVENUE BY SOURCE OF FUNDS (2006-2008)

The districts continue to receive the greater share of the GHS service budget with a marked increase in 2008. In 2008 funding to the districts received a higher proportional share compared to the HQ and RHS in the preceding years.

Even though funding to the GHS increased in 2008, in real terms all levels received less than their approved budget with HQ receiving 78%, Regional Level 52% and District Level 67%.

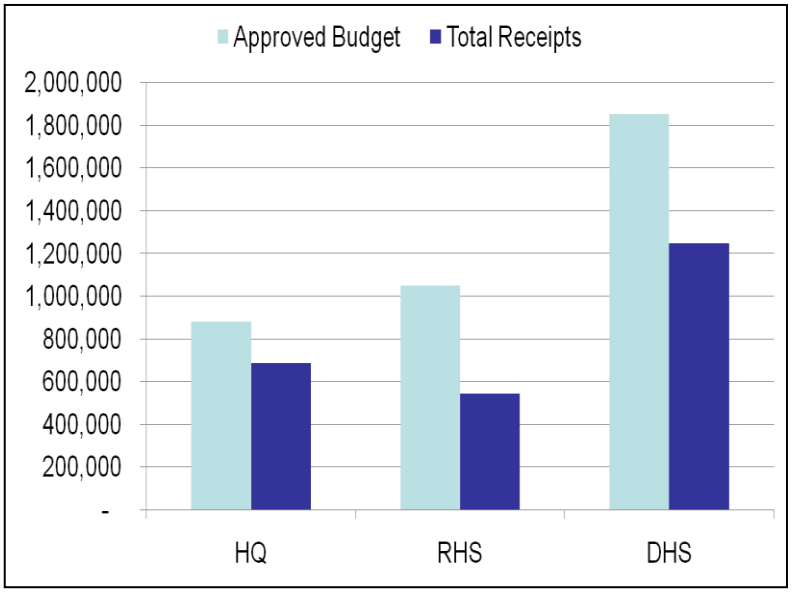
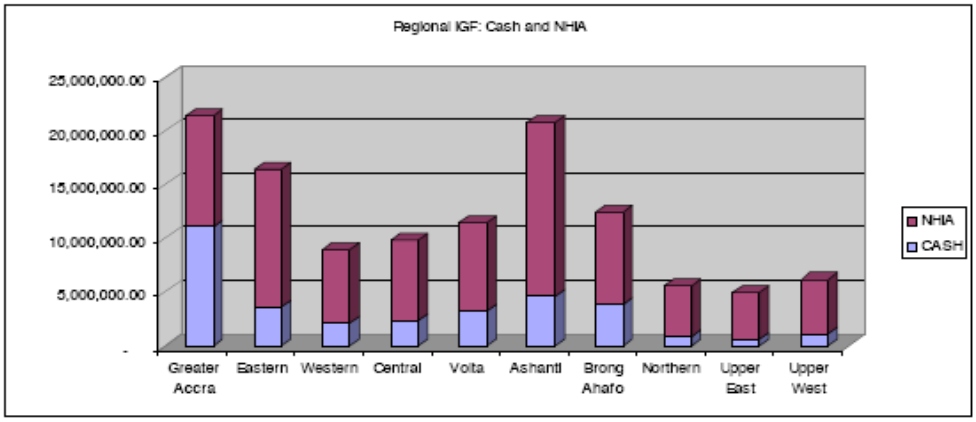


FIGURE 9: COMPARISON OF BUDGETS AND RECEIPTS BY LEVEL - 2008

IGF revenues continue to increase and are made up of two sources: "cash and carry" and through NHIS claims. In 2008 "cash and carry" represented 33% of IGF revenues compared to 67% in 2007. The shares vary by region (see figure 10) but overall NHIS is becoming an important source of revenue, with highest contributions in the northern region and less so in the GAR. While "cash and carry" is readily available the NHIS revenue is only received when claims are paid.

However processing of claims on the both the side of the GHS aside and NHIS is causing severe delays affecting service delivery in our health facilities.



Source: Draft 2008 Financial Statements: Schedule 9

FIGURE 10: REGIONAL IGF INCOME BY SOURCE (NHI AND CASH & CARRY)

Delays between releases of funds from the MOH persisted this year. The graph below shows no funds were received for the first 3 months of 2008. Thereafter releases were less than the budgeted. As at the end of 2008 only GH ¢2.9 million was received from the GH ¢3.8 million budgeted.

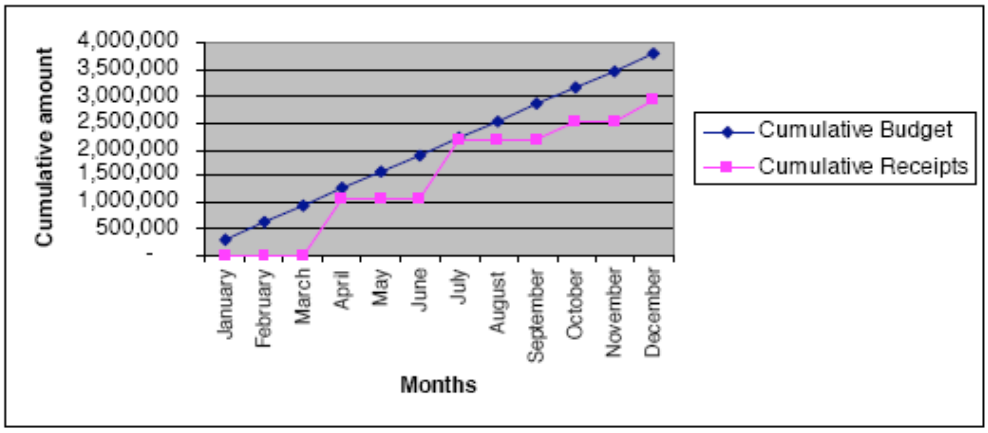


Figure 11: GHS item 3 receipts in 2008

ANNEXES

Annex 1:

Trends in Key Sector Performance Indicators

Indicator	2006 Actual	2007 Actual	2008 Actual
Number of Infants deaths – Institution	5,291	5,811	4,935
Number of Infants admissions – Institutional	51,184	36,622	38,363
Number of under five deaths – Institutional	6,057	5,287	2,233
Number of under five admissions – Institutional	172,411	113,792	95,100
Maternal Mortality ratio – Institutional (per 100,000 LBs)	187	224	200
Number of Under five years who are under weight presenting under facility and outreach	73,900	161,350	
% Under five years who are underweight - Institutional	4.5	8.6	
Number of outpatient visits	12,241,163	15,712,070	18,142,008
Outpatient visits per capita	0.55	0.69	0.77
Number of admissions	748,136	891,747	846,753
Hospital Admission rate	33.6	38.9	35.9
Disease Surveillance			
TB cure rate	71	N/A	
TB Treatment Success Rate	76.6	84.7	
HIV prevalence (among pregnant women)	3.2	2.6	2.2
No. of guinea worm cases seen	4,129	3,981	501
No. of AFP cases seen	168	163	
Total number of malaria cases	3,869,406	5,201,427	

TABLE 10: LIST OF SECTORWIDE INDICATORS (1)

Indicator	2006 Actual	2007 Actual	2008 Actual
Reproductive & Child Health			
Safe Motherhood			
Number of Family planning Acceptors	1,419,998	1,317,755	1,912,169
% of WIFA accepting FP	26.8	23.9	33.8
Number of ANC registrants	1,419,998	1,317,755	1,798,727
% of ANC coverage	88.4	89.5	97.4
Number of PNC registrants	500,801	507,494	542,286
% PNC coverage	55.9	55.3	57.7
Number of Supervised Deliveries (includes deliveries by trained TBAs)	522,522	467,467	516,260
% of supervised Deliveries	58.4	51	
Number of deliveries by skilled attendants	398,750	322,127	397,778
% of Deliveries by skilled Personnel	44.5	35.1	36.9
CHPS			
No. of functional CHPS zones	277	345	401
Child Survival			
EPI coverage Penta 3 (%)	84.0	88.0	87.0
EPI coverage OPV 3 (%)	84.0	88.0	90.0
EPI coverage Measles (%)	85.0	89.0	86.0
Total number of Under five malaria cases – Admissions	78,464	62,072	78,904
Number of maternal deaths audited	557	679	799
Total number of maternal deaths	951	995	953
% maternal death audits	58.6	75.6	84.0
Total number of Under five deaths due to malaria	2089	1,506	1,455
Under five malaria case fatality rate	2.7	2.4	
%Tracer Drugs available out of the tracer drug list at the Regional Medical store	74	87	
Total Number of TB Cases Cured	5,519	N/A	
AFP Non-Polio AFP rate (/100,000) population under 15 years	1.65	1.55	2.17

TABLE 11: LIST OF SECTORWIDE INDICATORS (2)

Indicator	2006 Actual	2007 Actual	2008 Actual
Revenue Mobilization			
IGF (GH¢)	61,480,000	102,600,000	115,070,598
GOG subsidy (GH¢)	263,890,000	284,500,000	268,517,035
Health Fund (GH¢)	39,080,000	39,800,000	126,731,219
MOH Programmes (Earmark Funds) (GH¢)	44,410,000	16,200,000	
Other Sources e.g. Financial Credits, HIPC (GH¢)	66,800,000	110,200,000	6,485,000
Expenditure by item			
Item 1: Personal Emoluments (GH¢)	235,215,428.66	264,800,000.00	276,037,885
Item 2 : Administration Expenses (GH¢)	27,417,725.02	53,500,000.00	45,565,502
Item 3: Service Expenses (GH¢)	129,997,119.07	123,200,000.00	240,594,569
Item 4: Investment Expenses (GH¢)	109,460,436.10	86,100,000.00	40,287,919
Population to doctor ratio	1:15,423	1:13,683	1:12823
Population to nurse ratio	1:1,537	1:1,415	1:1541

TABLE 12: LIST OF SECTORWIDE INDICATORS (3)