



WHO COUNTRY COOPERATION STRATEGY 2008-2011

GHANA



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ABBREVIATIONS

ADB	:	African Development Bank
CCS	:	Country Cooperation Strategy
DOTS	:	directly-observed treatment short course
DPs	:	development partners
DWHIS	:	District-Wide Health Insurance Scheme
GBS	:	General Budget Support
GDP	:	Gross Domestic Product
GHS	:	Ghana Health Service
GPRS	:	Growth and Poverty Reduction Strategy
HIPC	:	heavily-indebted poor country
HIRD	:	High Impact Rapid Delivery
IGF	:	internally-generated funds
IMCI	:	Integrated Management of Childhood Illness
IPO	:	International Programme Officer
IST	:	Intercountry Support Team
JICA	:	Japanese International Cooperation Agency
MDBS	:	Multi-Donor Budget Support
MDGs	:	Millennium Development Goals
MOFEP	:	Ministry of Finance and Economic Planning
MoH	:	Ministry of Health
NCD	:	noncommunicable disease
NHIS	:	National Health Insurance Scheme
NHIF	:	National Health Insurance Fund
NPO	:	National Programme Officer
5YPOW	:	Five-year Programme of Work
SBS	:	Sectoral Budget Support
STI	:	sexually-transmitted infection
SWAp	:	sector-wide approach
UNDAF	:	United Nations Development Assistance Framework
UNDP	:	United Nations Development Programme
UNESCO	:	United Nations Educational, Scientific and Cultural Organization
UNICEF	:	United Nations Children’s Fund
USAID	:	United States Agency for International Development
VPD	:	vaccine-preventable disease
WB	:	World Bank
WCO	:	World Health Organization country office
WHO	:	World Health Organization

PREFACE

The WHO Country Cooperation Strategy (CCS) crystallizes the major reforms adopted by the World Health Organization with a view to intensifying its interventions in the countries. It has infused a decisive qualitative orientation into the modalities of our institution's coordination and advocacy interventions in the African Region. Currently well established as a WHO medium-term planning tool at country level, the cooperation strategy aims at achieving greater relevance and focus in the determination of priorities, effective achievement of objectives and greater efficiency in the use of resources allocated for WHO country activities.

The first generation of country cooperation strategy documents was developed through a participatory process that mobilized the three levels of the Organization, the countries and their partners. For the majority of countries, the 2004-2005 biennium was the crucial point of refocusing of WHO's action. It enabled the countries to better plan their interventions, using a results-based approach and an improved management process that enabled the three levels of the Organization to address their actual needs.

Drawing lessons from the implementation of the first generation CCS documents, the second generation documents, in harmony with the 11th General Work Programme of WHO and the Medium-term Strategic Framework, address the country health priorities defined in their health development and poverty reduction sector plans. The CCSs are also in line with the new global health context and integrated the principles of alignment, harmonization, efficiency, as formulated in the Paris Declaration on Aid Effectiveness and in recent initiatives like the "Harmonization for Health in Africa" (HHA) and "International Health Partnership Plus" (IHP+). They also reflect the policy of decentralization implemented and which enhances the decision-making capacity of countries to improve the quality of public health programmes and interventions.

Finally, the second generation CCS documents are synchronized with the United Nations development Assistance Framework (UNDAF) with a view to achieving the Millennium Development Goals.

I commend the efficient and effective leadership role played by the countries in the conduct of this important exercise of developing WHO's Country Cooperation Strategy documents, and request the entire WHO staff, particularly the WHO representatives and divisional directors, to double their efforts to ensure effective implementation of the orientations of the Country Cooperation Strategy for improved health results for the benefit of the African population.



Dr Luis G. Sambo
WHO Regional Director for Africa

EXECUTIVE SUMMARY

The World Health Organization Country Cooperation Strategy (CCS) defines the medium-term (six-year) strategy for the work of WHO with Ghana and is guided by national and international public health priorities. It provides a framework for cooperation between WHO, Ministry of Health and development partners, and forms the basis of biennial workplans defining WHO's expected results and activities in the country. This second generation CCS (CCS II) covers the period 2008-2011.

The Ghanaian economy has been growing by 5.5% per year since 2004. As a result of this steady growth and initiatives outlined in Ghana's growth and poverty reduction strategies, the incidence of poverty has declined from 52% in 1992 to 29% in 2006. Ghana's current goal is to achieve middle-income status by 2015.

The health sector reflects the essential contribution of good health to economic prosperity in its 2007 National Health Policy and Five-year Programme of Work (2007-2011) whose central theme is "creating wealth through health". To this end, important health sector reforms have included the adoption of a sector-wide approach in 1997 and development of a national health insurance scheme ((2005) designed to provide universal access to basic health care. A strong health sector dialogue, active participation of development partners and civil society in the sector and institutionalized mechanisms for participation and coordination of partners have contributed to improving health indices in recent years.

Despite this performance, Ghana remains off-target for achieving the health-related Millennium Development Goals. Communicable diseases such as malaria, HIV/AIDS, tuberculosis and vaccine-preventable diseases remain the main causes of child mortality. The country remains prone to outbreaks of meningitis, cholera and guinea worm. Maternal mortality has recently been declared a national emergency and is currently a major priority for government and development partners. Health system weaknesses such as insufficient human resources, especially in rural areas with vulnerable populations, poor access to essential medicines and health technology, and insufficient financing all constrain our collective efforts to achieve MDGs 4, 5 and 6.

In its first generation CCS (2002-2005), WHO focused on health systems strengthening, improving health management and information systems, scaling up priority interventions and health promotion. A broad survey of WHO's partners in Ghana suggested that the performance of WHO core functions during the implementation of CCS 1 was between "good" and "very good". Lowest qualitative scores were obtained for promoting the research agenda and for supporting evidence-based policy. Important challenges identified in the CCS I include insufficient priority given to health systems strengthening, confusion by some programme managers at the Ministry of Health around the WHO's mandate and activities in the country, lack of harmonization among some of the development partners, weak supervision and monitoring and insufficient support for building the technical capacity of WHO country office staff.

CCS II builds on the successes of, and challenges identified in, CCS I. It was developed through extensive consultations with government, development partners and civil society. The CCS II identifies three priority and seven strategic areas which will be the focus of WHO's work in Ghana between 2008 and 2011. The three priority areas include Health

Security; Health System Capacity and Performance; and Partnerships, Governance, Gender and Equity. These, and the seven strategic focus areas, are closely aligned with Ministry of Health's strategic priorities outlined in the National Health Policy and the Five-Year Programme of Work. The CCS 2008-2011 is aligned with Ministry of Health's programmes both chronologically and in substance.

The WHO country office will focus on its core functions to support the Ministry of Health to achieve these strategic priorities. We will continue to develop the capacity of our local staff and to solicit the technical, administrative and financial support of the Inter-country Support Teams, the Regional Office and Headquarters. By focusing on the key elements of Health Security, Systems Strengthening, and Partnerships, we expect that WHO will provide the effective support where it is most needed, and that together we will achieve health-related Millennium Development Goals and realize Ghana's vision of "creating wealth through health".

SECTION 1

INTRODUCTION

The WHO Country Cooperation Strategy (CCS) defines the medium-term (six-year) strategy for the work of WHO at country level. The Country Cooperation Strategy for Ghana describes how the three levels of WHO, namely Headquarters, WHO Regional Office for Africa and Country Office, will work to achieve the country's health sector objectives.

The first CCS (CCS I– 2002-2005) outlined four major areas of cooperation, namely: Health System Strengthening; Scaling up of Priority Health Interventions; Strengthening Health Management Information System and Surveillance; and Health Promotion. These were selected to provide close support to the Growth and Poverty Reduction Strategy 2001-2005, the Medium-term Health Strategy, and the health sector's second Five-year Programme of Work 2001-2006.

This second generation Country Cooperation Strategy (CCS II) builds on the successes and failures of CCS I to increase the effectiveness of WHO and improve its responsiveness to national needs and priorities. The CCS II reflects the changing aid environment embodied in the Paris Declaration and the Accra Agenda for Action. The 2008-2011 timeline of the CCS II was selected to align with Ghana's Health Sector Programme of Work and with the UNDAF which, at the time of writing of this CCS, was to be extended by one year to 2011. The CCS II therefore provides an opportunity for WHO to align with government priorities and harmonize activities with other development partners. The CCS will focus on supporting the priority needs of Ghana for which WHO has a comparative advantage among the development partners.

The CCS II has been guided by national and international priorities outlined in:

- (a) The Millennium Development Goals;
- (b) Ghana's third health sector Five-year Programme of Work (2007-2011);
- (c) Ghana's second Growth and Poverty Reduction Strategy (GPRS II) 2006 -2009;
- (d) The United Nations Development Assistance Framework (UNDAF II 2006-2010) and the Common Country Assessment;
- (e) The WHO Eleventh General Programme of Work 2006–2015;
- (f) The WHO Medium-term Strategic Plan 2008-2013;
- (g) Strategic Orientations for WHO Action in the African Region, 2005–2009.

To develop the CCS II, extensive consultations were held with senior officials of the Ministry of Health, the Director-General of the Ghana AIDS Commission, the leadership of the Coalition of NGOs in Health and the Christian Health Association of Ghana, heads of training institutions, including the Provost of the College of Health Sciences, Principal of the School of Public Health, Rector of the Postgraduate College of Surgeons and Physicians and the Registrar of the Nurses and Midwives Council. The Ministers of Health, Local Government and Women and Children's Affairs were also consulted. Discussions were held with the heads of UN agencies, the World Bank, Department for International Development/Netherlands Embassy, Danish International Development Assistance, JICA, USAID and the European Union, as well as representatives from academia and trade unions.

SECTION 2

COUNTRY HEALTH AND DEVELOPMENT CHALLENGES

2.1 BRIEF INTRODUCTION TO GHANA

Ghana is located on West Africa's Gulf of Guinea with a total land area of 238 533 km² and a total population estimated at 21 029 853¹. Ghana has ten administrative/political regions which are further divided into 170 District Assemblies. The District Assemblies develop, plan and mobilize resources for plans, programmes and strategies for the development of the district. The political situation is stable, with presidential and legislative elections every four years. The transition of power between political parties took place without any incident in 2000 and 2008.

2.2 BROAD DESCRIPTION OF DEVELOPMENT STATUS AND CHALLENGES

The country's economy is dominated by agriculture and the service sector which contribute 42% and 38% of Gross Domestic Product (GDP) respectively. Ghana's GDP per capita is US\$538, and it was classified as one of the 41 heavily-indebted poor countries (HIPC) in the late 1990s. As a result of good monetary and fiscal policies and a favourable international economic environment, the economy has been growing steadily by at least 5.5% per year since 2004². This positive growth has not been felt by most Ghanaians due to increasing interpersonal, inter-regional, inter-ethnic and gender inequalities. Programmes such as the Lively Empowerment Against Poverty, School Fees Capitation grants, free health care for pregnant women and the National Health Insurance Scheme (NHIS) are being implemented to further reduce poverty levels and disparity and to create wealth. Poverty levels in Ghana decreased from 51.7% in 1991-1992 to 28.5% in 2005-2006. Extreme poverty has also declined from 36.5% to 18.2% over the same period³.

Ghana developed and implemented GPRS I which resulted in outright debt cancellation of US\$2 billion in July 2004 and provided the opportunity for a further US\$2 billion to be forgiven in instalments over the next twenty years. The government developed GPRS II 2006-2009 which focuses on "accelerated growth as a means of wealth creation, poverty reduction and equitable social development". The central goal of the country's economic policy is to achieve middle-income status (GDP per capita of US\$1000) by 2015. This vision is guided by three strategic pillars: private sector competitiveness, human resource development, and good governance and civic responsibility.

¹ Extrapolated from the 2000 census which revealed a population of 18 412 247 with an annual growth rate of 2.7%.

² GDP growth rates: 2000:4.4%; 2001:4.2%; 2002:4.5%; 2003:5.2%; 2004:5.8%; 2005:5.8%; 2006:6.2%; 2007:6.3%; 2008:6.2% (Sources- *Budget Statement and Economic Policies of Government of Ghana*).

³ Ghana Living Standards Survey (GLSS 5) 2005/2006, Ghana Statistical Service.

2.3 THE HEALTH SECTOR

The health sector adopted the sector-wide approach (SWAp) principles in its 1996 sector reform process with the active participation of government, partners, civil society and the private sector. As a result of this reform, the Ministry of Health (MoH) retained responsibility for policy formulation, monitoring and evaluation, resource mobilization and regulation of health service delivery. The Ghana Health Service (GHS) was created to assume responsibility for service delivery and implementation of the health policies and programmes designed by the ministry. To make the health sector more responsive, all public-owned health institutions, divisions, facilities and agencies were given responsibility for their own planning, budgeting, implementation, monitoring and evaluation. National, regional, district, sub-district and community levels are organized to implement the Five-year Plan of Work (5YPOW) which is developed by the ministry and all key partners/stakeholders. The private sector and NGOs, including the Christian Health Association of Ghana, provide over 40 per cent of health care in Ghana, especially in the rural areas.

A common management arrangement has been developed in which partners and stakeholders participate in sector dialogues and develop sector plans. A joint planning, budgeting, supervision, monitoring and reporting framework is available and there is joint ownership of most processes and products of the sector.

In 2005, Ghana introduced the National Health Insurance Scheme (NHIS)⁴ to improve financial accessibility to health care. The NHIS is administered peripherally through District-Wide Health Mutual Insurance Schemes (DWHIS). The scheme is tax-based⁵ and covers most services offered at the district hospital level. Despite a number of constraints, it has registered over 50% of Ghana's population. In 2008, free maternal care was included in the range of services covered by the NHIS.

Life expectancy at birth is 57.5 years on average (55.4 years for men and 59.6 years for women). Ghana is experiencing an epidemiologic transition with an increasing prevalence of noncommunicable diseases. The major causes of child mortality include malaria, diarrhoea, and upper respiratory infection⁶. HIV infection, hypertension, diabetes mellitus and road traffic accidents are major causes of mortality in adults⁷. Low level of literacy, poor sanitation, under-nutrition, alcohol abuse, sedentary life styles and unhealthy diets constitute the broad determinants of ill-health contributing to high mortality rates.

2.4 BURDEN OF COMMUNICABLE DISEASES

Malaria

Malaria is the leading cause of morbidity and mortality in children, accounting for about 40% of all outpatient attendance at health facilities in 2007⁸. The multiple strategies adopted for malaria control have been moderately successful. Insecticide-treated bednet use by children under five years of age and pregnant women has increased as a result of their distribution during integrated mass campaigns and Child Health Weeks during which over three million were distributed. The antimalaria drug policy was reviewed in 2004 and the artemisinin-based combination therapy became the recommended therapy.

⁴ National Health Insurance Act 650 and LI1809; Sept 2003.

⁵ NHI is funded by 2.5 % SSNIT contribution of workers; 2.5% value-added tax levy of selected goods and services and minimum premium of 7.2 Ghana cedi (US\$ 7.74) per annum from informal workers.

⁶ 2007 Annual Report, Ghana Health Service.

⁷ 2007 Annual Report, Ghana Health Service.

⁸ 2007 Annual Report, Ghana Health Service.

Tuberculosis

Moderate progress has been made in the control of tuberculosis with cure rates for new smear positive TB increasing from 22% in 1996 to 76% in 2006⁹. Case detection (33% for 2007) and defaulter rates (6.4% for 2007) have also been improving since 2001. The high defaulter rate in Western Region (21.8%) is worrisome given the possibility of multi-drug resistant forms of TB. A new integrated policy has been developed to address the challenge of HIV- TB coinfection and the emerging threat of TB drug resistance.

HIV/AIDS/sexually-transmitted infections

The HIV/AIDS epidemic is stable though firmly established within the society. HIV prevalence among pregnant women in Ghana has declined from 3.6% in 2003 to 2.6% in 2007 according to Sentinel Surveys. Strategies including behaviour change communication, prevention of mother-to-child-transmission, the provision of treatment care and support (Highly-Active Antiretroviral Therapy) have been implemented. The major challenges to achieve Millennium Development Goal (MDG) 6 are improving surveillance and scaling up access to treatment.

Neglected tropical diseases (NTDs)

The number of cases of guinea worm has decreased dramatically from 3358 in 2007¹⁰ to 501 in 2008; disease transmission is now limited to the Northern Region which reported 96% of Ghana's total cases in 2008. Microplans have been developed to improve surveillance, case containment and effective vector control. Various water projects have targeted endemic communities. Effective surveillance in recently guinea-worm-freed and high-risk areas and behavioural change are major challenges for eradication.

Other neglected tropical diseases prevalent in Ghana include lymphatic filariasis, onchocerciasis, soil transmitted worms, schistosomiasis, trachoma and leishmaniasis. While trachoma control has attained break of transmission, about half of the country's population is at risk of the remaining four NTDs.

2.5 NONCOMMUNICABLE DISEASES AND MENTAL HEALTH

The prevalence of noncommunicable diseases (NCDs) such as diabetes mellitus, asthma, hypertension and other cardiovascular diseases is rising in Ghana as a result of increasing life expectancy, abuse of alcohol, tobacco use, poor dietary habits, inadequate physical activity and increasing stress. Newly reported cases of injuries, cardiovascular diseases and musculoskeletal disease steadily increased from 1998 to 2003 (Report on a national forum on integrated control and prevention of NCDs and injuries, GHS 2005). Currently, it is estimated that NCDs constitute over 20% of all cases of outpatient attendance (Ghana Macroeconomic and Health Initiative). The government's new policy on regenerative health and nutrition is expected to provide the basis for prevention and management of NCDs. This programme focuses on healthy eating, improving food safety, regular exercise, drinking potable water, rest, improving environmental sanitation, improving personal hygiene and ensuring lifestyles that promote health.

⁹ NTP Annual Report 2007.

¹⁰ National Guinea Worm Database, 2008.

The recent rise in injuries due to road traffic accidents and violence is worrying. Road traffic crashes and fatalities increased by 3 per cent and 4 per cent respectively in 2006 and 2007 and are estimated to cost the nation 1.6% of its GNP. A National Ambulance Service has been initiated but emergency response services are inadequate.

In Ghana, approximately 650 000 people suffer from a severe mental disorder and a further 2 166 000 from a moderate to mild mental disorder. Yet the treatment gap for severe mental disorders is estimated to be as high as 95% and the gap is even larger if one includes people with moderate to mild mental disorders (WHO country summary series; Ghana 2007). In addition to the lack of access to care, there are issues of serious human right violations against people with mental disorders. Great efforts are being made to address the lack of access to community care, the over-reliance on institutional care, and human right violations through the drafting of a new mental health law. This law is yet to be approved by Parliament.

2.6 MATERNAL AND CHILD HEALTH

Maternal health

The MoH has declared maternal mortality a national emergency and has made MDG 5 a national priority. The Ghana Maternal Health Survey (2007) estimates the MMR to be 451 per 100 000 live births. Ninety-six per cent of pregnant women in Ghana receive antenatal care from a trained provider while only 55 per cent are delivered by a skilled provider. Socio-cultural beliefs and practices which discourage institutional delivery, inadequate knowledge of danger signs of pregnancy, poor referral systems, lack of transportation and communication infrastructure permitting the transfer of obstetric emergencies, inadequate numbers of skilled attendants and lack of equipment and supplies account for the three major delays¹¹ which are responsible for the high maternal mortality ratios. The Ministry of Health and partners have responded with the introduction of the High Impact Rapid Delivery (HIRD) approach, aimed at using an integrated intervention approach to reduce the morbidity and mortality of mothers and children.

Child and adolescent health

The under-five mortality rate in Ghana is high (111/1000 live births) with worsening neonatal mortality rates. The Demographic and Health Survey 2003 indicates an increase in neonatal mortality rates over the preceding 15 years from 38/1000 live births to 43/1000 live births in 2003. Most childhood deaths are caused by malaria (26%), pneumonia (18%), diarrhoea (18%) and neonatal factors (38%).

Health issues affecting adolescents in Ghana include inadequate nutrition, early initiation of sexual activity, unprotected sexual activity and its consequences – sexually-transmitted infections (STI) and HIV –, unwanted pregnancies and complications of abortion. In addition, adolescents are at risk of substance abuse, mental illness and injuries. Adolescent Health Friendly Services are limited and under-used at all levels.

¹¹ The three major delays responsible for maternal deaths are (i) delay in the decision to seek care; (ii) delay in transportation to a health care facility; and (iii) delay in receiving appropriate care at the health care facility.

Nutrition

The prevalence of malnutrition remains high but is decreasing. Between 2003 and 2006, the prevalence of stunting among children under the age of five declined from 29% to 22% and that of underweight declined from 22% to 18% between 2003 and 2006. The prevalence of low birth weight among infants with known birth weight also declined from 7% in 2004 to 6% in 2006. The Demographic and Health Survey 2003 shows that 77% of children aged 6-59 months and 47% of women aged 15-49 years were anaemic.

2.7 IMMUNIZATION AND VACCINE-PREVENTABLE DISEASES (VPD)

The WHO has supported the Reaching Every District (RED) approach and vaccine-preventable disease surveillance to achieve an improvement in performance indicators. National coverage with the 3rd dose of the pentavalent vaccine was 88% in 2007 compared to 76% in 2004. Measles coverage was 89% in 2007, up from 78% in 2004; 71% of pregnant women had received at least two doses of tetanus toxoid in 2007 compared to 61% in 2004.

The burden of vaccine-preventable diseases is declining. No measles deaths have been reported following a 2003 national campaign targeting children of less than 15 years of age. Acute flaccid paralysis surveillance for polio eradication remains weak in some regions, decreasing nationally from a rate of 1.7 cases detected/100 000 children in 2005 to 1.52 cases/100 000 in 2007. Despite this deterioration, no wild polio cases were detected in Ghana from 2003 to 2007 as a result of improving routine immunization and integrated maternal/child health campaigns. Ghana successfully presented documentation for polio free status at the 9th annual general meeting of the African Regional Polio Eradication Certification Committee.

2.8 INTEGRATED DISEASE SURVEILLANCE AND RESPONSE AND EMERGENCY PREPAREDNESS AND RESPONSE

Cholera has become endemic in the country and there have been outbreaks every year over the last six years. Nine regions reported a total of 3 386 cases with 108 deaths in 2006 giving a case fatality rate of 3.2%. Access to safe drinking water especially in urban slums is paramount if this situation is to be reversed. Periodic outbreaks of cerebrospinal meningitis occur, particularly in the northern regions of the country and widespread epidemics remain a public health threat.

2.9 ENVIRONMENTAL HEALTH

Access to water and sanitation services is improving; coverage by functioning water facilities in rural areas has risen from less than 30% of the population in 1994 to slightly more than 50% in 2005. Urban water supply coverage is currently estimated at 58%. Providing adequate water and sanitation cannot keep pace with the rapid expansion of urban settlements.

2.10 HEALTH PROMOTION

In Ghana, ageing and changes in lifestyles associated with tobacco and alcohol use, physical inactivity, poor eating habits and road traffic accidents are causing a silent epidemic of chronic diseases in the country. National capacity has been strengthened to plan, implement and evaluate setting-based health promotion programmes for the reduction of the risks

associated with leading causes of death, diseases and disability. Advocacy for the development of policies for promoting healthy lifestyles is now receiving favourable response.

2.11 HEALTH SYSTEM RESPONSE

Health policy, strategies and programme of work

The 2007 National Health Policy proposed seven priority areas to address sector objectives, concerns and challenges:

- (a) Promoting healthy lifestyles and healthy environments;
- (b) Promoting health, reproduction and nutrition services;
- (c) Investing equitably in capacity development for health delivery;
- (d) Promoting the use of information for planning and management;
- (e) Ensuring sustainable and equitable financing;
- (f) Promoting a local health industry;
- (g) Ensuring good governance and partnership.

On the basis of this National Health Policy, the third Five-year Programme of Work (5YPOW) 2007-2011 has been developed with the same theme as the national health policy “*Creating wealth through health*”. The focus of the POW is to re-energize and scale up the delivery of priority interventions for human capital development and thereby contribute to wealth creation and poverty reduction in line with the country’s GPRS.

The 5YPOW is composed of four main strategic objectives:

- (a) **Healthy lifestyles and the environment:** Promoting healthy individual lifestyle, behavioural models, environmental and occupational health and safety.
- (b) **Healthy reproduction and nutrition services:** Rapidly scaling up high impact health, reproductive and nutrition interventions targeting vulnerable groups.
- (c) **General health systems development:** Strengthening the health system to expand, manage and sustain a high coverage of quality health interventions and services for promoting health, preventing diseases, treating the sick and rehabilitating the disabled.
- (d) **Governance and financing:** Promoting good governance and ensuring sustainable financing at all levels of the health sector.

Medicines and health technology

Access to basic essential medicines has improved due primarily to the NHIS. Proliferation of counterfeit medicines poses a huge burden for medicines regulation and therefore the need for the regulatory agency to build capacity in post-market surveillance. Efforts to improve access to medical products and technologies continue to face major challenges in a rapidly changing national and international policy environment.

Institutionalization of traditional medicine into the health system has taken great strides in the country. The Food and Drugs Board, the Centre for Scientific Research into Plant

¹²<http://www.moh-ghana.org/moh/docs/reports/>

Medicine and the Noguchi Memorial Institute for Medical Research have increased their efforts to ensure that traditional medicine products meet approved standards of safety, efficacy and preservation.

During 2006 – 2007, the WHO *Integrated Management for Emergency & Essential Surgical Care* (IMEESC) toolkit was introduced to a number of district hospitals in Ghana. Further, a road map was drawn for the development of health technology policy with the involvement of partners.

Human resources for health management and development

Human resources for health development remain a critical issue for quality health service delivery. The total workforce for health in the public sector in 2007 was 43 000. This includes medical officers (4.8% of total workforce), nurses/midwives (34.7%), pharmacists (3.3%), allied health professionals (less than 1%) and auxiliary workers (57.2%). Each medical doctor in Ghana attends to an average of 10 000 people. Health workers are disproportionately distributed to the advantage of the southern part of the country and urban areas. The Greater Accra and Ashanti regions which account for about 33.1% of the total population of the country are overly catered for by over 60% of all doctors and nurses in Ghana.

The establishment of the Ghana College of Physicians and Surgeons in 2003 and other health training institutions, the expansion in health training infrastructure, the increase in the number of health trainees and improved remunerations are expected to have a positive impact on the sector. The “brain drain” peaked in the years 2001/2002 with totals of 435 and 464 health professionals emigrating respectively¹². Programmes like “Brain Gain” are encouraging Ghanaian health workers in the diaspora to return.

Health care financing

The policy environment on financing the sector is changing gradually as there is a shift from SWAp “basket funding” to Multi-donor Budget Support (MDBS) and Sector Budget Support (SBS) which aims at long-term development in partnership with government in conformity with the Paris Declaration. The government of Ghana has signed a memorandum of understanding with nine development partners (African Development Bank – ADB, Canada, Denmark, Germany, the EU, the Netherlands, Switzerland, the UK and the World Bank) to support the MDBS.

Sources of funds for the health sector are shown in Table 1, and include Government of Ghana (GOG) through the regular budget (45%), National Health Insurance Fund (NHIF) which is largely tax-base accounts (23%), making government to provide about 68% of the health budget, Health Fund and Earmarked Funds (13% each), Internally-Generated Funds (IGF) from out-of-pocket payment to facilities (3%) and HIPC inflows (3%). Since its inception in 2005, the NHIF is increasingly a major funding source for the health sector, contributing a quarter of the available revenue in 2006. The NHIF is not yet providing full protection to the poor and vulnerable: only 29% of individuals in the lowest socioeconomic quintile are registered, compared with 64% in the highest quintile¹³. Registration for and timely issuance of identity cards for NHIS membership, submission and payments of claims as well as the sustainability of the NHIS are some of the challenges to be addressed.

¹³ 2008 NDPC PM&E survey.

Table 1: Health sector revenue shares by source 2000 - 2006¹⁴

Sources	2000	2001	2002	2003	2004	2005	2006
GOG	55%	49%	50%	49%	44%	56%	45%
Financial credits	5%	2%	11%	10%	11%		0%
NHIS							23%
IGF	12%	14%	14%	14%	13%	15%	3%
Health Fund	8%	13%	17%	14%	21%	24%	13%
Earmarked Funds	20%	22%	8%	10%	6%	5%	13%
HIPC	0%	0%	0%	3%	5%	0%	3%
TOTAL	100%	100%	100%	100%	100%	100%	100%

2.12 HEALTH SYSTEMS CHALLENGES

The health status of Ghanaians as measured by mortality, fertility and nutritional indices has improved gradually since independence. The disease profile is characterized by high levels of communicable and pregnancy-related conditions and rising noncommunicable diseases rates resulting from the unfavourable socioeconomic and sociocultural environment. The disease pattern continues to be dominated by communicable diseases, under-nutrition and poor reproductive health. The health sector is under-funded, and there is low human resource capacity because of the emigration of health professionals.

The third 5YPOW identifies challenges facing the health sector as: slow improvements in health outcomes; persistent under-nutrition; persistence of some diseases that could easily be controlled; neglect of other diseases which intensify poverty; growing burden of NCDs; uneven performance and productivity; and missed opportunities for mobilizing resources for health development.

2.13 POST-CCS I CHALLENGES¹⁵

The review of the CCS I identified the following challenges:

- (a) Many programme managers at MoH/GHS are not familiar with the WHO's mandate, operations and capacities, and usually think of the Organization as a funding agency. This generates high expectations and frequent disillusionment when funds are not forthcoming.
- (b) The conflicting roles between some divisions in MoH and GHS which hinder programme implementation.
- (c) Limited financing preventing scaling up of interventions. Competing demands from many priority interventions and programmes in the context of limited resources and general delays in accessing funds for activities prevent effective programme implementation. The WHO country office (WCO) has not effectively mobilized local resources to offset these challenges.

¹⁴ Sources: Ministry of Health financial reports for 2000, 2001, 2002, 2003 and 2004; financial report up to the quarter ending 30 September 2005; budget for 2006.

¹⁵ Review of WHO Country Cooperation Strategy 2002-2005, August 2005.

- (d) The CCS I was characterized by a focus on activities in the three priority diseases, namely TB, malaria and HIV/AIDS; areas like health systems and health promotion were under-emphasized.
- (e) Staff at WCO received little support to build their own technical capacities to better implement the strategic agenda of the CCS I.
- (f) The inability of partners and the United Nations system to harmonize their programmes through joint planning/implementation resulted in duplication of efforts and lack of synergy.
- (g) Support for monitoring and supervision was weak.

SECTION 3

DEVELOPMENT ASSISTANCE AND MAJOR PARTNERS

3.1 DEVELOPMENT ASSISTANCE

Collaboration between the MoH and partners in health development in Ghana is a major reason for successes achieved in the health sector. Since the reform of the sector under the 1997 SWAp, development partners (DPs) have provided financial and technical support and participated in developing sector plans. As depicted in Table 2, most of the DPs give grants to the health sector. NGOs and CSOs are playing an increasingly active role in the sector.

Table 2: Health development partners mapping 2007-2010

	Development Partners	Health Systems Strengthening	Health Management Information System/Surveillance System	Scaling Up Priority Health Interventions	Health Promotion	Aid Modality	Grant	Amount in US\$ (contribution between 2007-2010)	Participation in SWAp
1	AFRICAN DEVT BANK	✓				PA	N	106	Limited
2	EUROPEAN UNION	✓					Y		Active
3	DENMARK	✓	✓	✓	ü	BF	Y	327,16	Active
4	GAVI	✓	✓	✓		PA	Y	9,85	Active
5	GLOBAL FUND	✓	✓	✓		PA	Y	106,33	Active
6	ITALY			✓			Y		Limited
7	JAPAN	✓	✓	✓	✓	PA	Y	21,19	Active
8	NETHERLANDS	✓	✓	✓	✓	BF/SBS	Y	104,24	Active
9	NORDIC DEVT FUND	✓				PA	N	13,09	Limited
10	SPAIN	✓				PA	Y	16,18	Limited
11	UNITED KINGDOM	✓	✓	✓	✓	SBS,	Y	81,72	Active
12	USA	✓	✓	✓	✓	PA	Y	51,79	Active
13	ILO						Y		Limited
14	IOM						Y		Limited
15	UNAIDS	✓	✓	✓	✓	PA	Y	1,31	Active
16	UNFPA	✓	✓	✓	✓	BF/PA	Y	13,46	Active
17	UNICEF	✓	✓	✓	✓	PA	Y	25,76	Active
18	UNDP	✓				PA	Y	0,32	Limited
19	THE WORLD BANK	✓	✓	✓	✓	PA,BF	N,Y	55,56	Active
19	WFP	✓	✓	✓	✓	PA	Y	3,68	Active
20	WHO	✓	✓	✓	✓	PA	Y	22,72	Active

The implementation of the Paris Declaration on Aid Effectiveness and the Ghana Harmonization and Alignment Plan has provided many options for health sector support, including:

- (a) General Budget Support (GBS), via the Ministry of Finance and Economic Planning (MOFEP), not linked to health;

- (b) Sectoral Budget Support, (SBS) via MOFEP, linked to health;
- (c) Loans, via MOFEP, linked to health;
- (d) Health fund or Basket Funding (BF), via MoH;
- (e) Programme/project approach including capital development with different mechanisms like:
 - (i) Earmarked health fund;
 - (ii) Earmarked programme funds, via MoH but restricted in use;
 - (iii) Programme/project funds, notified to MoH but passed via other channels and levels;
 - (iv) Other unnotified aid funds (including NGO expenditure and other projects, which the MoH is not informed about);
 - (v) Silent partnership with financing;
 - (vi) Silent partnership without financing;
- (f) Active but no funding.

The tendency for development partners to use GBS as the means for financing Ghana's GPRS II, including health, conforms to the Paris Declaration, and the Ghana Harmonization and Alignment Plan and is seen as a positive development. Direct donor contributions to the sector have dropped dramatically since 2006; the Health Fund or common basket under SWAp decreased by more than 50%, and earmarked funding dropped by roughly half. While this movement to GBS or SBS by the donors was anticipated, the reduction in earmarked funds is surprising. This appears, however, to be in line with the Paris Declaration as shown in Table 2.

How to handle aid which does not contribute to the direct implementation of the 5YPOW is a challenge.

3.2 PARTNERSHIP AND AID COORDINATION

Since the 1997 health sector reform, MoH and DPs have worked in a partnership based on the principles of a SWAp of which the key elements were:

- (a) a clear nationally-owned sector policy and strategy;
- (b) a medium-term expenditure programme that reflects the sector strategy;
- (c) systematic arrangements for programming the resources that support the sector;
- (d) a performance monitoring system that measures progress and strengthens accountability;
- (e) broad consultation mechanism that involves all significant stakeholders;
- (f) a formalized government-led process for aid coordination and dialogue at sector level;
- (g) an agreed process for moving towards harmonized systems for reporting, budgeting, financial management and procurement.

Partners' coordination in the health sector has a number of processes and mechanisms including a monthly government partners meeting chaired by MoH. This meeting discusses topical issues in the sector, initiates responses and serves as an information dissemination

forum for partners. There is also an annual joint review and reporting mechanism which culminates in a formal, biannual health summit for all stakeholders in the sector. Each summit ends with a business meeting and the signing of an aide memoire by the key partners and government. To guide the partnership is a Common Management Arrangement which was supposed to be reviewed under each five-year POW.

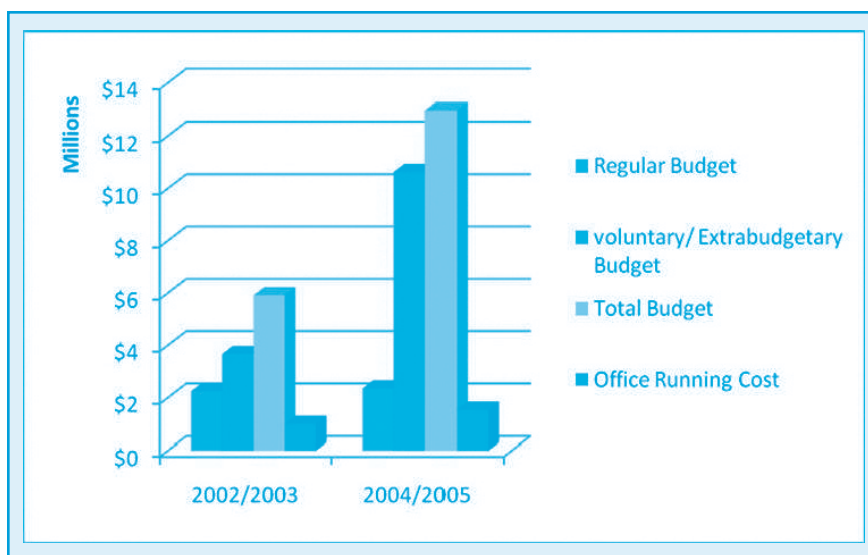
SECTION 4

CURRENT WHO COOPERATION

4.1 WHO'S FINANCIAL CONTRIBUTION TO GHANA 2002-2005

The WHO provided US\$16.67 million to implement CCS I covering the programme areas illustrated in Figure 1. Extrabudgetary funds increased from 62% of the total budget in 2002-2003 to 82% in 2004-2005. Office running costs including staff costs as a percentage of *total budgets* decreased from 17% in 2002-2003 to 12% in 2004-2005. On the other hand, office running costs as a percentage of total *regular budgets* increased from 45% to 66% during the same periods. During CCS I, the WCO had 48 staff, including four international professional officers (IPO), 16 national professional officers (NPO) and 28 general service/administrative staff (GS). Since the beginning of the 2008/2009 biennium, the staff strength has dropped to 40 comprising 2 IPO, 12 NPO and 26 GS.

Figure 1: Budget allocation during the 2002-2005 CCS



The 2002-2005 CCS included four strategic areas: Health Systems Strengthening (HSS), Health Management Information/Surveillance System (HMIS), Scaling up Priority Health Interventions (SURV) and Health Promotion (HP). Fifty-seven per cent of the total budget of US\$16.67 million was allocated to priority health interventions, compared to about 1% for health promotion. Health Systems Strengthening received about 19% and Health Management Information/Surveillance System received about 23% of the total budget respectively during the CCS I implementation period.

Table 3: Budget allocation by strategic area under CCS I

PRIORITY AREAS	2002	2003	2004	2005	Total	%
HSS	658 000	516 800	1 016 000	908 800	3 099 600	0.19
HMIS & SURV.	756 900	652 700	1 168 400	1 249 600	3 827 600	0.23
PRIORITY INT	1 692 480	1 512 800	2 844 800	3 464 800	9 514 880	0.57
HP	59 120	6 200	50 800	56 800	229 920	0.01
TOTALS	3 166 500	2 745 500	5 080 000	5 680 000	16 672 000	1

Health Systems Strengthening

During the period of the CCS 2002-2005, a wide range of activities were introduced to improve the health system. Staff of DWHIS were trained and supplied with computers and office equipment. WHO supported the development of the Ghana Macroeconomics and Health Initiative which estimated Ghana's investment needs for achieving health-related MDGs. Human resources for health policy and plans were supported and capacity developed through fellowships and sponsorships offered to the MoH.

WHO also supported the development of a new health policy, the third Medium-term Health Strategy 2007-2011 and the second Human Resources for Health Policy Plan 2007-2011. Other interventions were the adoption of strategies to turn the brain drain into brain gain, expansion of health training infrastructure and increase in the number of trainees and the introduction of the National Health Insurance Scheme (NHIS) which was able to register 50% of the population within the three years of its existence.

Health Management Information /Surveillance System

During the CCS I period, WHO supported the strengthening of health information generation and management systems at the MoH, including training staff in the use of Personal Digital Assistants (PDA) and GIS for health service availability mapping in the country. WHO also supported vaccine-preventable disease surveillance for acute flaccid paralysis, measles, yellow fever, neonatal tetanus, rotavirus and paediatric bacterial meningitis.

With WHO support, the Integrated Disease Surveillance and Response system is functioning countrywide and has been successful in early detection and response to epidemics of cholera, meningitis, yellow fever and other diseases of public health interest. WHO supported the introduction of PDA for integrated supervision of child health interventions (EPI, malaria, IMCI, HIV/AIDS and Surveillance) at the district and sub-district levels.

Scaling up Priority Health Interventions

Scaling up priority health interventions is a priority strategy of the Ministry of Health which was limited by lack of capacity to plan, mobilize, manage and monitor the required resources. During the CCS I, WHO supported the scaling up of priority interventions such as immunization and vaccine-preventable diseases, maternal and child health, HIV/AIDS and malaria control by building a broad coalition of partners and by providing guidelines and standards to improve quality control. Community IMCI and the Community-based Health Planning and Services initiative offered useful lessons for engaging communities in health promotion and disease prevention. Achievements include a steady increase in immunization coverage with no measles deaths since 2003 and interruption of indigenous polio virus transmission.

Health Promotion

WHO's health promotion objective in the CCS I was to increase public awareness about health and encourage people to adopt healthy lifestyles. It supported development of IEC strategies; ratification and adoption of the Framework Convention on Tobacco Control; local legislation to address substance and alcohol abuse, sponsorship of healthy school competitions and promotion of WHO work during World Health Days.

Advocacy for consolidating and expanding health promotion has resulted in some important achievements. Health promotion is now a cross-cutting issue that features prominently in all health policy documents. It is the first of the four strategic objectives of the 5YPOW 2007-2011 of the Ministry of Health as well as the New Health Policy document- "Creating wealth through health". The Ghana Health Service has developed a health promotion policy aimed at streamlining health promotion activities and including other sectors such as education, local government and environment and civil society.

Through advocacy, a number of health policies and legislation have been reviewed or developed and are awaiting passage. These include the Mental Health Act of 1972, the Tobacco Control Bill and the National Health Policy – "Creating wealth through health".

Responsiveness of CCS to Changing Priorities in Ghana

Table 4: General views on WHO's performance in core functions in Ghana

Core Functions	Scoring							Average score
	0	1	2	3	4	5	Total	
Leadership	1	2	5	10	14	6	38	3.4
Research agenda	1	3	7	11	8	6	36	3.1
Norms and standards	0	2	3	10	9	14	38	3.8
Evidence-based policy	0	3	6	10	14	3	36	3.2
Catalyzing change	0	3	4	9	10	11	37	3.6
Monitoring	1	1	2	10	9	11	34	3.7
Total	3	14	27	60	64	51	219	

Scoring: 0-very poor/don't know; 1-poor; 2-satisfactory; 3-good; 4-very good; 5-excellent

The Ghana country office used an innovative consultative process to interview partners and stakeholders to determine WHO's responsiveness to changing country priority needs and to identify strategic directions. The interviews also elicited perceptions of the government and partners about the WHO's role in performing its core functions. The respondents included the Minister of Health, the Director General and Deputy Director General of the Ghana Health Service, and other high-ranking officials of the Ministry of Health. The Ministers of Local Government and Finance were also interviewed. In addition, country directors and officials of other UN agencies (WB, UNDP, UNICEF and UNESCO) were interviewed together with officials of other stakeholders such as training institutions and other development partners. Table 4 illustrates the general views of the respondents. Most respondents perceive WHO as responsive to country needs (average score was greater than 3) though there are few areas where more strategic actions are required.

4.2 SUPPORT FROM WHO REGIONAL OFFICE AND HEADQUARTERS

The WHO country office in Ghana receives significant support from the Inter-country Support Team of the West (IST-West), the WHO Regional Office for Africa and HQ. They support the participation of WHO staff as well as government officials in meetings of WHO governing bodies, technical and programme review meetings, joint mission to countries, production of advocacy and training materials, and increasing information exchange. They provide funds to the country office to support implementation of programmes.

4.3 IMPLEMENTATION CHALLENGES

For the 2008-2011 CCS, WHO will be challenged to support sufficient technical staff for the implementation of its plans of work, and to provide consistent and reliable funding to run its office and carry out its activities. Lack of consistent and reliable funding has limited the bargaining power of WHO among bilateral and other UN organizations in the country. These and other issues are outlined in the Strengths, Weaknesses, Opportunities and Threats (SWOT) analysis table shown in Annex 1.

Office premises

The WCO rents an office space for the entire professional and general service staff. All staff have access to personal computers, Internet/email, laptops if appropriate, and all modern office functions. Office running costs exceed allocations made under the Regular Budget and this creates problems when Voluntary Contributions are not received. The WCO has a country sub-office in Tamale in the Northern Region of Ghana which is staffed by one surveillance officer and one driver.

Staffing

The current staffing level stands at 2 IPO, 12 NPO, 13 administrative/secretarial staff, 13 drivers and other support staff. The WCO will spend US\$ 3 140 200 on personnel for the 2008/2009 biennium. This represents 118.5% of the Regular Budget or 30% of the total amount allocated for the biennium.

A training/learning needs assessment demonstrated that professional staff lack competencies in areas like negotiation, advocacy, resource mobilization, partnership development and monitoring and evaluation. For the general service, it was identified that there is a need for skill improvement in office administration, management practices, and driver management science for drivers. In order to improve communication across countries, it was recommended that all staff of the WCO should benefit from a French language course for bilingual skills training.

SECTION 5

WHO CORPORATE POLICY FRAMEWORK: GLOBAL AND REGIONAL DIRECTIONS

WHO has been undergoing significant 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 and the achievement of the health-related MDGs. This organizational change process has, as its broad frame, the WHO Corporate Strategy¹⁶

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, the Eleventh General Programme of Work 2006-2015¹⁷ and the Strategic Orientations for WHO Action in the African Region 2005-2009¹⁸ outline key features through which WHO intends to make the greatest possible contribution to health. The Organization aims at strengthening its technical, and policy leadership in health matters, as well as its management capacity to address the needs of Member States, including the MDGs.

5.2 CORE FUNCTIONS

The work of the WHO is guided by its core functions which are based on its comparative advantage¹⁹. These are:

- (a) Providing leadership in matters critical to health and engaging in partnership where joint action is needed;
- (b) Shaping the research agenda and stimulating the generation, dissemination and application of valuable knowledge;
- (c) Setting norms and standards, and promoting and monitoring their implementation;
- (d) Articulating ethical and evidence-based policy options;
- (e) Providing technical support, catalyzing change, and building sustainable institutional capacity;
- (f) Monitoring the health situation and assessing health trends.

¹⁶ WHO EB 105/3A Corporate strategy for the WHO Secretariat.

¹⁷ Eleventh General Programme of Work 2006 – 2015. A Global Health Agenda.

¹⁸ Strategic Orientations for WHO Action in the African Region 2005 – 2009.

¹⁹ Eleventh General Programme of Work 2006 – 2015. A Global Health Agenda.

5.3 GLOBAL HEALTH AGENDA

In order to address health-related policy gaps in social justice, responsibility, implementation and knowledge, the Global Health Agenda identifies seven priority areas.

These include:

- (a) Investing in health to reduce poverty;
- (b) Building individual and global health security;
- (c) Promoting universal coverage, gender equality, and health-related human rights;
- (d) Tackling the determinants of health;
- (e) Strengthening health systems and equitable access;
- (f) Harnessing knowledge, science and technology;
- (g) Strengthening governance, leadership and accountability.

The global health agenda has become more imperative for the health of people in resource-poor countries like Ghana. The agenda has captured the attention of world leaders, governments, philanthropists, policy-makers and the general public as never before. This attention has focused on scientific, public health and humanitarian challenges and implementation of public health measures among several others.

For more specificity, the Director-General of WHO has proposed a six-point agenda as follows: 1. Health Development; 2. Health Security; 3. Health Systems; 4. Evidence for Strategies; 5. Partnerships; 6. Improving the performance of WHO. In addition, she has indicated that the success of the Organization should be measured in terms of results on the health of women and the African population.

5.4 GLOBAL PRIORITY AREAS

The global priority areas have been outlined in the Eleventh General Programme of Work²⁰. They include:

- (a) Providing support to countries in moving to universal coverage with effective public health interventions;
- (b) Strengthening global health security;
- (c) Generating and sustaining action across sectors to modify the behavioural, social, economic, and environmental determinants of health;
- (d) Increasing institutional capacities to deliver core public health functions under the strengthened governance of ministries of health;
- (e) Strengthening WHO's leadership at global and regional levels and supporting the work of governance at country level.

5.5 REGIONAL PRIORITY AREAS

The regional priorities have taken into account the global documents and the resolutions of the WHO governing bodies, the health millennium development goals, and the New Partnership for Africa's Development health strategy, resolutions on health adopted by heads

²⁰ Eleventh General Programme of Work 2006 – 2015. A Global Health Agenda.

of state of the African Union and organizational strategic objectives which are outlined in the Medium-term Strategic Plan 2008-2013. These regional priorities have been expressed in the “Strategic Orientations for WHO Action in the African Region 2005-2009”. They include prevention and control of communicable and noncommunicable diseases, child survival and maternal health, emergency and humanitarian action, health promotion, and policy making for health in development and other determinants of health. Other objectives cover health and environment, food safety and nutrition, health systems (policy, service delivery, financing, technologies and laboratories), governance and partnerships, and management and infrastructures.

In addition to the priorities mentioned above, the Region is committed to support countries attain the health MDGs, and address their human resource challenges.

5.6 MAKING WHO MORE EFFECTIVE AT THE COUNTRY LEVEL

The outcome of the expression of WHO’s Cooperation Strategy at country level will vary from country to country depending on the country-specific context and health challenges. But building on WHO’s mandate and its comparative advantage, the six critical core functions of the Organization, as outlined in section 4.2, may be adjusted to suit the needs of each country.

SECTION 6

STRATEGIC AGENDA: PRIORITIES AGREED FOR CURRENT WHO COOPERATION

6.1 INTRODUCTION

The mission of WHO is to promote the attainment of the highest sustainable level of health of all people living in Ghana. Accordingly, the overall goal of the WHO Country Cooperation Strategy 2008-2011 is to provide the highest quality support to the national health agenda as outlined in national policies and programmes of work. In addition to CCSI priorities which are still relevant for the health sector, CCS II will strengthen WHO's role in providing leadership in health issues.

6.2 GUIDING PRINCIPLES

- (a) The strategic agenda reflects national priorities indicated in the Ghana Poverty Reduction Strategy, the Health Sector Policy, and the Five-Year Programme of Work 2007-2011.
- (b) WHO will achieve its objectives by concentrating on its core functions of developing health policies, technical guidelines, norms and standards; providing technical policy advice; contributing to sustainable capacity building; strengthening management capacity; providing health leadership; and coordination at the national level.
- (c) The strategy is guided by the Millennium Development Goals, WHO resolutions and other regional strategies and resolutions.
- (d) WHO will work with the Government of Ghana and partners according to its mandate and comparative advantage, under the principles set out in the Paris Declaration and the Accra Agenda for Action.
- (e) WHO will work as a specialized agency within one UN Country Team. WHO will integrate health into the plans and activities of the UN Country Team and prioritize harmonization with other UN agencies.
- (f) CCS II will take into account the technical challenges identified during the review of CCS I and seek to address them through the various strategic areas.

6.3 OVERVIEW OF THE STRATEGIC AGENDA OF THE WHO COUNTRY OFFICE

Based on a broad consultative process, WHO has identified the strategic agenda below on which to concentrate its cooperation efforts with Ghana between 2008-2011.

Table 5: WHO strategic agenda and WCO strategic priorities and focus for CCS II

Strategic priorities	Country-specific strategic focus
Health security	Reduce morbidity and mortality linked to priority communicable diseases, including HIV/AIDS, tuberculosis and malaria.
	Eradication and elimination of target diseases.
	Improve reproductive health and child survival.
	Strengthen the control of noncommunicable diseases, health promotion and nutrition.
	Improved preparedness and response to epidemics and other complex health emergencies.
Health system capacity and performance	Strengthen health systems for more effective health service delivery.
Partnerships, governance, gender and equity	Improved health sector partnerships, governance, gender and equity.

6.4 STRATEGIC PRIORITY 1: HEALTH SECURITY

Strategic focus 6.4.1: Reduce morbidity and mortality linked to priority communicable diseases, including HIV/AIDS, tuberculosis and malaria

Support for HIV/AIDS control will focus on improving surveillance, prevention and control of infection, and the care and support of people living with HIV. Access to antiretroviral medicines beyond the targets of The 3 by 5 Initiative will be emphasized, and local production of generic medicines will be promoted.

Support will be provided for expanding the coverage and quality of the DOTS. In addition, WHO will strengthen partnerships with research institutions, NGOs and the private sector. WCO will focus on improving institutional capacity to quantify, supply and distribute anti-TB drugs and monitor drug resistance and coinfection with HIV.

Malaria control will be supported through increasing the availability of artemisinin-based combination therapy at community level, and through private providers. WCO will promote intermittent preventive treatment for pregnant women, and vector control through the use of insecticide-treated materials and residual spraying.

The Global Fund to Fight AIDS, Tuberculosis and Malaria provides an opportunity for the country to finance its national priorities for these diseases. WHO will work to support such resource mobilization for evidence-based interventions.

Strategic focus 6.4.2. Eradication and elimination of target diseases

WHO will support the implementation of the national immunization programme by strengthening the Reaching Every District (RED) approach and by integrating immunization services with other maternal and child survival interventions. The WCO will provide technical support for introducing new, cost-effective vaccines beginning with the pneumococcal conjugate vaccine in 2010. Surveillance and immunization activities to control measles, eliminate neonatal tetanus and eradicate polio will continue.

WHO will support MoH and the development partners, private sector, research institutions, training institutions and NGOs to eradicate or eliminate neglected tropical diseases as required by the WHO global and regional strategies and resolutions. This will be done by integrating neglected tropical disease control into existing health services and programmes. WHO will prioritize guinea worm, onchocerciasis, trachoma and lymphatic filariasis, using the strategies of improving surveillance and mass drug administration.

Strategic focus 6.4.3: Improve reproductive health and child survival

Improving maternal health and reducing maternal and neonatal mortality is the Ministry of Health's first priority, and this will be reflected in WHO country activities. WHO will support interventions that increase antenatal care coverage, skill attendance at birth, emergency obstetric care and postnatal care services, many of which are comprehensively organized in strategies like HIRD and the Road Map for Reduction of Maternal Mortality. WHO will work against 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. Further support will be provided for repositioning of family planning as an essential element of maternal mortality reduction, and for integrating SRH, HIV/AIDS/STI into reproductive health.

WHO will focus on a life-course approach from the community level to referral health facilities. Integrated interventions targeting the neonate, infants and children will be supported at all levels. This includes coordinated approach to community child survival interventions for pregnancy and newborn care, community case management of malaria, diarrhoea and pneumonia, community growth promotion and management of severe malnutrition and immunization and surveillance. Maternal and child health campaigns will be used to increase the uptake of vitamin A, deworming, immunization and insecticide-treated nets. WHO will support improvements in quality of care at first and referral levels through adaption of guidelines, orientation and training in emergency training and assessment, essential newborn care, integrated infant and young child feeding counselling, IMCI including children exposed to and infected with HIV. WHO will assist pre-service institutions to update their curricula in accordance with WHO and national guidelines.

In accordance with the Strategic Plan on Adolescent and Young People's Health and Development, WHO will support access to appropriate health information and quality health services; enhancement of social, legal and cultural environment, and community participation by adolescents and young people and the development of standards, review of guidelines and training for the effective delivery of adolescent health friendly services in public and private facilities. WHO will help to integrate adolescent and young people friendly health services at all facilities providing services.

Strategic focus 6.4.4: Strengthen control of noncommunicable diseases; health promotion and nutrition

WHO will promote good health by reducing population risk factors such as use of tobacco, alcohol, drugs and other psychoactive substances; unhealthy diets, and physical inactivity. WHO will support interventions to reduce injuries and disability due to violence and road traffic accidents, including the improvement of medical rehabilitation services and training of personnel in prosthetics and orthotics. Through national implementation of the Global Strategy on Diet, Physical Activity and Health and the implementation of the Framework Convention on Tobacco Control, WHO will work to decrease premature mortality from chronic noncommunicable diseases. Priorities will include pushing the passage and promulgation of a tobacco control law, and working with other sectors, including the Ministry of Finance, on policies to tax tobacco products, create smoke-free public places and institute smoking cessation programmes.

WHO will support Ghana to finalize and implement the mental health policy and strategic plan and to ensure that the new mental health law is implemented.

A national nutrition policy to address malnutrition in the country will be developed. In addition, WHO will assist the national implementation of the Global Strategy for Infant and Young Child Feeding, programmes for the control of micronutrient deficiencies, nutrition surveillance, monitoring and evaluation and nutritional research. Guidelines will be developed and capacity strengthened for the management of severe acute malnutrition and nutritional assessment during complex emergencies.

WHO will participate in an analysis of the food security situation and develop policy and national action plans in the area of food safety. Priorities include formulation and implementation of food policies and regulations; capacity building in food-borne disease surveillance and inspection; and health education. A coordinated national approach to effective food control will be supported, based on scientific principles and guidelines and supporting all sectors of the food chain. A healthy food market programme will be supported as a best practice for scaling up food safety.

Strategic focus 6.4.5: Improved preparedness and response to epidemics and other complex emergencies

WHO will work to strengthen the integrated disease surveillance and response system to detect, identify and respond to threats to health security arising from epidemic-prone, pandemic and emerging diseases of known or unknown aetiology, and to integrate these activities with the strengthening of communicable disease surveillance and response systems, national health information systems, and public health programmes and services. Specific diseases which will receive priority include cholera, meningitis and avian influenza. WHO will also support the implementation of the revised International Health Regulations (IHR-2005).

WHO will continue to strengthen its role as sector lead during complex emergencies. WHO work will focus on creating national contingency plans, building national capacity, provision of logistical and technical support, enhancing community participation, coordination of partners, and resource mobilization.

Support will be provided for the UN Humanitarian Depot to improve logistics for complex emergencies in the West Africa sub-region. The WHO and the MoH will support improved water and environmental sanitation facilities as the most effective way to control guinea worm and cholera.

6.5 HEALTH SYSTEM CAPACITY AND PERFORMANCE

Strategic focus 6.5.1: Strengthen health systems for more effective service delivery

For health improvement to operate as a poverty-reduction strategy, health services must reach poor and underserved populations. WHO will address the improvement of access (financial and physical), provision of adequate numbers and mix of appropriately trained staff, innovative social health financing scheme, suitable systems for collecting vital statistics, and access to appropriate technology including essential drugs. The active participation in efforts to improve system-wide policy, human resources, financing, management, service delivery and information systems are also very prominent in strengthening the health system.

Human resources – WHO is continuing its support for the expansion of human resources for health to ensure that there are adequate numbers of appropriately trained staff with the right skill mix who are equitably distributed throughout the country. This will be done through appropriate HR policy and strategies leading to improved human resources development and management, enhancing the capacity of training facilities to meet the emerging challenges within the health sector, and harnessing the national capacity by special agreements with research, service and teaching institutions within and outside the country.

Stewardship – WHO will support the development of policies and strategies that improve the environment and promote private sector participation and public-private partnerships for improved access to health care. The capacity of civil society will be enhanced for participation in policy dialogue and for assessment of health system performance and in particular the stewardship functions to ensure an equitable distribution of resources at all levels. In this regard, WHO will continue its collaboration with CHAG and the Coalition of NGOs in health for capacity building and institution strengthening to better position them to support government efforts for scaling up services.

Financing – WHO will work with the MoH and other collaborators to sustain and strengthen the NHIS to ensure that the poor and other disadvantaged populations are protected against the financial risk/uncertainty and catastrophic health expenditure. WHO and other partners will advocate for an increase in, and more effective use of, resources for the health sector. Also in line with the Paris Declaration and the Accra Agenda for Action, WHO will work to contribute to the practical, action-orientated road map to improve the quality of aid and its impact on development in the country while seeking to ensure the effectiveness of aid to the country. In line with the principles of the International Health Partnerships, WHO will further support efforts to improve coordination and reduce duplication to ensure that all resources are used efficiently.

Essential medical products and technologies – WHO will work with MoH and other partners to develop policies and strategies, and improve national capacity to ensure access to good quality, affordable essential medicines, medical products including vaccines and other health technologies. In providing cost-effective solutions to health problems, there is the need to adopt essential health technologies which are evidence-based. WHO will work closely with the MoH and its agencies in the introduction of the appropriate health technologies for the various levels of the health care system, by reinforcing the fact that they form the backbone of the services medicine can offer in the prevention, diagnosis and treatment of illness and disease.

The use of WHO *Integrated Management for Emergency & Essential Surgical Care* (IMEESC) toolkit will be scaled up to cover all district hospitals. Support will also be provided to complete the development and implementation of the health technology policy.

Health information management – WHO will work with the MoH, its agencies and partners like the Ghana Statistical Service to strengthen the health information management system through support to development and deployment of the appropriate information management tools for the various levels. WHO will work with health training institutions to introduce health information management.

6.6 PARTNERSHIPS, GOVERNANCE, GENDER AND EQUITY

Strategic focus 6.6.1: Improved health sector partnerships, governance, gender and equity

Using its comparative advantage as an international agency with a global health mandate, WHO will engage all partners in dialogue on WHO global resolutions and regional strategies on health and remain active in the national health sector policy dialogue. WHO will provide evidence-based policy and strategic directions, and brief partners on local and international health developments.

WHO will encourage other sectors and agencies such as water and sanitation, education, roads and transport, agriculture and population, to include health issues in their activities. The principles of the social determinants of health will be included in the planning and implementation of projects and programmes.

Through the UNDAF, WHO will work with the UN Country Team to coordinate efforts that address similar priority health concerns and to jointly facilitate the mobilization of additional resources from facilities such as GFATM and UNFIP. WHO will continue to work with the UN Country Team to harmonize with other agencies and to plan jointly when appropriate.

WHO will also intensify its work with the MoH, other government ministries, departments and agencies, the media, schools, city councils, the private sector, civil society and individuals in support of advocacy and the development of IEC strategies that will promote healthy lifestyles and behaviour. WHO will work with the MoH, law enforcement agencies, schools, churches, mosques and NGOs to establish baseline data and develop relevant policies and strategies to address substance abuse including alcohol.

SECTION 7

IMPLEMENTING THE STRATEGIC AGENDA

To effectively implement the CCS 2008-2011 in Ghana, the three levels of the Organization, namely the WHO country office in Ghana, the WHO Regional Office for Africa (AFRO) in Brazzaville and WHO Headquarters (HQ) in Geneva, will work as different parts of one entity.

7.1 IMPLICATION FOR WHO COUNTRY OFFICE

The implications of the CCS 2008-2011 for WCO in Ghana will be addressed as follows:

- (a) disseminating the CCS as a basic technical assistance tool;
- (b) reorganizing the structure of technical staff;
- (c) capacity building;
- (d) integrated approach from IST/regional office and headquarters;
- (e) knowledge management and information;
- (f) integrated approach at national level with organizations of the United Nations system and development partners.

WCO Ghana in line with its core functions and the challenges identified in CCS I will continue to provide technical assistance, support for policy development and advocacy for health issues. The country office will maintain a balance of highly experienced national and international professionals and general service staff to deliver its core functions.

Disseminating the CCS as a technical assistance tool at country level

WCO in Ghana will ensure that the CCS will be the basic tool for all planning and budgeting processes. The CCS will be used as an advocacy instrument for both WCO biennial and annual workplans. The CCS will be presented to the government and other stakeholders and will be revised and updated periodically.

Capacity building

Given diminished resources and increasing expectations at country level, the scope of work for professional and general service staff would be expanded. Existing NPOs and all supporting staff will take on additional functions which will require new skills such as advocacy, communication, negotiation, resource mobilization, management and administration. In addition, there will be the need to recruit additional full-time programme officers to address some of the strategic issues such as human resources and partnerships under health systems strengthening, noncommunicable diseases and nutrition.

The capacity of administrative and secretarial support staff will be strengthened to cope with the demand for rapid and accurate information processing. A comprehensive human resource plan has been developed to ensure that professional staff and support staff benefit from important developments in their respective areas of work. The following extracts from the human resource plan will receive priority attention:

- (a) Office administration, management and practice for general and administrative staff;
- (b) French course for bilingual skills for all staff;
- (c) Driving management science for drivers;
- (d) Monitoring and evaluation for technical staff;
- (e) Annual office retreat for all staff.

The field office in Tamale has been maintained to support the implementation of priority health activities in the three northern regions of Ghana, notably vaccine-preventable disease and guinea worm surveillance. Given the range and complexity of health problems in northern Ghana, WCO plans to recruit one more professional and one more general service staff.

To promote the WHO as a knowledge-based organization, the library should be made a full resource centre. This requires training sessions for the library staff, procuring document lists from medical and nursing institutions and some online peer review journals and databases such as Health Inter-Network Access to Research Initiatives (HINARI) and its sister databases (OARE and AGORA) and Global Information Full Text (GIFT). These databases which are classified as some of the world's biggest libraries will provide affordable online access to academic and professional peer-reviewed journals.

The WCO/Ghana website will be improved through frequent updates with information and reports of activities and programmes from the clusters such as news items, press releases, reports including annual reports, features on best practices, publications including the e-newsletter.

Integrated approach from IST/regional office and headquarters

To effectively respond to national needs and based on the CCS, an integrated programmatic and technical support will be required from AFRO and the WHO Inter-country Support Team (IST).

Integrated approach at national level with the United Nations system and development partners

The WCO work will be reflected in the UNDAF, SWAp, GPRS and other development processes to ensure synergy and harmonization as one UN system working towards achieving MDGs in Ghana.

7.2 IMPLICATION FOR IST/REGIONAL OFFICE

The WHO Regional Office for Africa will distribute the Ghana CCS to regional advisers and other technical/administrative staff. This will provide a better understanding of the health situation in Ghana and the work of the country office. AFRO will review and identify the implications of the Ghana CCS for the Regional Office and will provide technical support to the country office in the areas where expertise is not available in the country.

The IST/Western Area is expected to be a provider of special expertise regarding national demands, especially in emergency situations.

AFRO will also use the CCS to assist the country office to mobilize the additional resources required to implement the strategic agenda. In this regard, the CCS document will be disseminated to key donors and stakeholders in health both within the country and internationally.

In the areas 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's decentralization of financial responsibilities has facilitated the work in the country office and it needs to be sustained.

7.3 IMPLICATION FOR 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 Ghana's CCS.

Headquarters will also work with AFRO to document lessons arising out of the CCS process and the impact of the CCS on WHO's work as a whole as well as in individual countries. Headquarters will distribute Ghana's CCS document to HQ clusters/departments, emphasizing that all HQ support needs to be aligned with the strategic agenda.

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.

At country level, many projects and activities take 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.

SECTION 8

MONITORING AND EVALUATION

The CCS strategic agenda will be translated into the Programme Budget (PB) and Biennial Plans of Action (BPOA) through the WHO's regular managerial processes. The WCO will develop adequate expected outputs, targets, milestones, baseline and performance indicators to monitor the progress of the PB and BPOA. The implementation of the BPOA will be subjected to the six-monthly WHO monitoring process of semi-annual, mid-term and biennial reviews.

In addition, a CCS support network involving the three levels of the Organization, MoH and selected key partners will evaluate and review the Country Cooperation Strategy for impact and adjustments as deemed necessary or at least six months before the end of the year indicated in the document.

ANNEXES

ANNEX 1: SWOT ANALYSIS FOR IMPLEMENTING THE CCS

The possible strengths, weaknesses, opportunities and threats have been identified for implementation of the CCS as reflected in Table 6 below.

Table 6: SWOT analysis for implementing CCS II in Ghana

Strengths	Weaknesses
<ul style="list-style-type: none"> • Broad consultations during development of both CCS1 and CCS II. • Team spirit within WHO country office. • Consultative leadership style of the WR. • Collaboration of Government officials and partners on consultation. • Technical ability of staff to support country programme. • Easy access to information for evidence-based planning. • Comparative advantage of WHO in technical expertise 	<ul style="list-style-type: none"> • Inadequate marketing of the CCS and POA to stakeholders. • CCS not sufficiently being used as a planning tool. • Weak monitoring and supervision of lower levels within the country. • Human resource constraints within the health sector and at the country office due to current contractual difficulties. • Inadequate funding to support implementation of the plans. • Regular reviews/monitoring of CCS implementation by all partners have not been formalized.
Opportunities	Threats
<ul style="list-style-type: none"> • Easy access to international technical expertise(IST, AFRO and HQ). • Clear monitoring mechanisms from AFRO and HQ. • Partnering opportunities with other UN agencies to support the health sector. • Availability of clear guidelines and tools for development and implementation of CCS and for ensuring compliance with WHO regional and global priorities. • Availability of multi-professional human resource base within the UN system 	<ul style="list-style-type: none"> • Inadequate commitment of the MoH/GHS to WHO operations. • Perceptions that WHO is a funding institution. • Lack of ownership of the CCS from the Ministry of Health. • Weakness of the health systems (Human resource capacity, attitude of staff to work, etc. as noted in the in-depth interview). • Differences between the Ministry of Health and the Ghana Health Service.

ANNEX II: WCO ORGANIZATION CHART

